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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services – 75-0390-0-1-551
CLINICAL SERVICES

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Request	Increase or Decrease
BA	$2,090,642,000	$2,176,220,000	$2,323,317,000	+$147,097,000
FTE	7,679	7,924	8,141	+217

SUMMARY OF THE BUDGET REQUEST

The FY 2007 budget request of $2,323,317,000 and 8,141 FTE is an increase of $147,097,000 and 217 FTE over the FY 2006 Enacted budget of $2,176,220,000 and 7,924 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
Services – 075-0390-0-1-551
HOSPITALS AND HEALTH CLINICS

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

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Request	Increase or Decrease
Discretionary	$1,289,418,000	$1,339,539,000	$1,429,772,000	+$90,233,000
FTE	6,492	6,684	6,852	+168
IHS Direct	39,382	39,400	39,700	+300
Tribal Direct	21,263	21,300	21,400	+100
Total Admissions	60,645	60,700	61,100	+400
IHS Direct	4,404,394	4,405,000	4,440,000	+35,000
Tribal Direct	5,029,888	5,030,000	5,071,000	+41,000
Total OPVs	9,434,282	9,435,000	9,511,000	+76,000

Note: Inpatient Admissions and Outpatient visits are based on FY 2004 data.

STATEMENT OF THE BUDGET REQUEST

The budget request of $1,429,772,000 for Hospitals and Health Clinics (H&HC) funds predominantly the provision of direct, personal health care services to federally recognized American Indians and Alaska Natives (AI/AN) through IHS and Tribal hospitals and health clinics.

PROGRAM DESCRIPTION

These funds are provided to 12 Area (regional) Offices which in turn provide resource distribution, program monitoring and evaluation activities, and technical support to over 240 Federal and Tribal operating units (local level) for over 600 health care facilities providing care to 1.8 million AI/ANs primarily in rural or isolated portions of the country. The Hospitals and Health Clinics budget supports essential personal health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, etc. In addition, the program includes public health initiatives targeting health conditions disproportionately affecting AI/ANs such as specialized programs for diabetes, maternal and child health, youth services, communicable diseases including HIV/AIDS, tuberculosis, and hepatitis, and a continuing emphasis on women's and elders' health and disease surveillance. **These health programs support the HHS Goal 3 to increase the percentage of the Nation's children and adults who have access to health care services and expand consumer choices.** Collecting, analyzing,

and interpreting health information leading to the identification of these and other health conditions as well as possible interventions is done through a network of Tribally-operated Epidemiology Centers in collaboration with a national IHS coordinating center. Information technology that supports both personal health services and public health initiatives is primarily funded through the Hospitals and Health Clinics budget. Almost *one-half* of the H&HC budget is transferred to Tribal governments or Tribal organizations under P.L. 93-638 contracts or compacts which provide these individual and community health services.

PERFORMANCE ANALYSIS

The IHS budget request for Hospitals and Health Clinics support the Secretary's 500-Day Plan to close the health care gap, particularly among racial and ethnic minority populations, as well as the HHS Strategic goals and objectives.

GPRA Measure 5: During FY 2007, increase the proportion of patients with diagnosed diabetes assessed for nephropathy to 50%.	IHS met this measure in FY 2005. The FY 2005 measure was to maintain the proportion of patients with diagnosed diabetes assessed for nephropathy at the FY 2004 level. This goal was met and exceeded, with a 5 percent increase in the number of patients assessed.	Diabetes can cause kidney disease by damaging the parts of the kidneys that filter out wastes. Diabetes is the leading cause of end stage renal disease (ESRD) or kidney failure, a growing problem in Indian communities. Early identification of patients at risk helps prevent or delay the need for dialysis or renal transplant. Microalbumin in the urine is an early sign of diabetic kidney disease. Proteinuria is also an independent predictor of cardiovascular disease, which is the number one killer of American Indian and Alaska Native adults.

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

Supplemental funding, key Tribal involvement, collaboration with other Federal agencies and community emphasis all contributed to the IHS exceeding four of five continuing diabetes GPRA elements and achieving the fifth in FY 2005. Increased funding has allowed greater access to more sophisticated interventions. These include more effective pharmaceuticals, more aggressive screening for the secondary effects of diabetes, earlier intervention when complications are identified, and greater patient compliance with care regimens. The level and quality of services provided to over 100,000 diabetics throughout the IHS are audited annually to improve standardized care and patient

outcomes. A wide range of IHS performance measures including foot care, eye care, end organ status, and adequacy of blood sugar control, have been incorporated into the National Committee for Quality Assurance/American Diabetes Association national performance diabetes care benchmarks.

GPRA Measure 20: During FY 2007, maintain 100 percent accreditation of all IHS-operated hospitals and outpatient clinics (excludes tribally operated facilities).	IHS met this measure in FY 2005. The FY 2005 measure committed to maintaining 100 percent accreditation of all IHS hospitals and outpatient clinics. During FY 2005, seven IHS hospitals were evaluated by either the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) or CMS; all maintained full accreditation. In addition, 6 ambulatory health centers participated in accreditation visits from JCAHO or the American Association of Ambulatory Health Centers (AAAHC) and all were accredited.	Accreditation is essential for maximizing third-party collections, and contributes both directly and indirectly to improved clinical quality. The local IHS multidisciplinary team approach to accreditation and ongoing quality management, with guidance and support from Area staff, has been the mainstay of success. This is one of the most demanding measures to meet, given the growing clinical quality of care assessments that are required as well as issues related to health facilities maintenance and renovation that are critical to accreditation.

Accreditation **--** The JCAHO, the AAAHC, and the Centers for Medicare and Medicaid Services (CMS) regularly conduct in-depth quality reviews of IHS and Tribal hospitals. The average accreditation grid scores are consistently at or above the average score for all U.S. hospitals. The most frequently cited area for improvement is physical plant safety and efficiency which is due to old, undersized facilities. The average age of IHS facilities is greater than 30 years.

In conjunction with the GPRA measures described above, 16 other performance measures are directly related to the H&HC budget. These measures include pap smear and mammography screening, domestic violence screening, improving automated extraction of clinical performance measures and data quality, immunization rates, community-based cardiovascular disease and obesity prevention, and reducing tobacco usage. Assessing performance data from the most current reported data demonstrates effective H&HC outcomes.

FY GPRA Data Reported	GPRA Measures Met or Exceeded	GPRA Measures Not Met	Total H&C GPRA Measures Reported
2005	20	1	21

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

The H&HC sub sub activity was included in the Direct Federal program that was evaluated using the Performance Assessment Rating Tool (PART). The current PART recommendations are to develop a long-term performance goal to decrease obesity rates in the AI/AN population and to develop an annual target for decreasing obesity in AI/AN children. In FY 2006, the IHS GPRA measure #31 changes its focus to childhood weight control. As a first step in addressing childhood obesity, IHS will establish the baseline proportion of children ages 2-5 years who are overweight, with a body mass index at or above the 95th percentile.

Obesity is a significant factor and co-morbidity with many chronic diseases facing American Indian and Alaska Native people. According to data from over 400,000 patients that receive services through the IHS, 70 percent are overweight and 44 percent of our user population over age 2 years old is obese. To address this issue an internal obesity initiative planning group has been formed and is setting goals and priorities for the agency in order to eliminate health disparities associated with obesity and overweight. Six goals were developed to provide a culturally appropriate framework to move AI/AN people towards healthier weights. They are: **1**) enhance and create actionable data; **2**) transform policy into action; **3**) partner with Tribes to build and maximize community capacity; **4**) create a new organizational workforce model to improve access to quality nutrition and physical activity services; **5**) enhance integrated quality care systems; and **6**) leverage and strengthen partnerships to mobilize and maximize resources.

Following are brief descriptions of several other notable activities that impact performance:

<u>Emergency Preparedness</u> – The IHS' emergency preparedness functions involve**:**

(1) Continuous planning and regular testing of the continuity of operations plan (COOP) so that the agency can carry out its critical functions in any situation;
(2) building capacity in public health infrastructure through linkages among its hospitals and clinics with local, county, Tribal and State agencies throughout the country;
(3) working with and expanding the capacity of 82 local Tribal emergency medical systems (EMS);
(4) enhancing its ability to deploy Commissioned Officers for national and international emergencies as was done for the tsunami in southeast Asia and for hurricanes Katrina and Rita that hit Louisiana and Mississippi; and
(5) preparing its hospitals and clinics to diagnose and treat victims of a bioterrorism or other mass casualty situation such as pandemic influenza.

The Indian health system has participated in numerous local, regional, and national exercises to test its response capabilities and to enhance linkages with public safety elements at all levels. State programs have also supported the development of greater

response capacity particularly in Alaska, New Mexico, and Maine. The IHS continues efforts to assure that the needs of AI/AN communities are addressed by States which have received additional targeted funding for emergency preparedness and response.

One of the Director's Performance Contract program objectives was to develop and implement hospital and clinic emergency management plans by the end of FY 2005. This objective was met. These efforts are in support of **HHS Strategic Goal 2 to enhance the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges as well as the Secretary's 500 Day Plan to secure the Homeland.**

Managing High Cost Pharmaceuticals -- The IHS minimizes and avoids costs, through negotiated rates for purchased services, medical products, and pharmaceuticals. The IHS has partnered with CMS to develop and deploy training on the Medicare Prescription Drug Coverage. These efforts support the Secretary's 500 Day Plan to Modernize Medicare and Medicaid.

In FY 2004, the IHS and Tribes spent $234 million on pharmaceuticals. Between FY 2000 and FY 2004, IHS and Tribal pharmaceutical costs increased an average of 17.2 percent per year. The interventions to control costs include greater use of bulk purchasing methods through the Department of Veterans Affairs pharmaceutical prime vendor, increased use of a limited but more efficacious formulary, and education of providers about specific pharmacoeconomic strategies. This effort was enhanced by the provision of resources to expand IHS pharmacy residency activities. The residency programs now operate in 11 communities and stimulate innovative thinking about the control of pharmaceutical costs and less expensive, but more effective approaches to patient care.

Health Promotion/Disease Prevention -- The IHS program continues to focus on increasing access to preventive and curative services for the underserved in Indian communities through a strategy targeting health programs reflecting community health status to provide the most effective services to the most people. However, these prevention strategies are often difficult to maintain since the impact of the programs is often distant in time and community attention to these efforts may wane in the face of more immediate concerns such as treatment for trauma associated with family violence.

In FY 2005, the agency continued the implementation of a major initiative on Health Promotion and Disease Prevention (HP/DP); it is one of the Director's priorities. This initiative was launched in FY 2003 in order to reduce health disparities. Although the IHS is the model health system in integrating individual and community health, increased emphasis is being focused on both clinical and community-based health promotion and disease prevention efforts. The main focus is on our collective ability to develop and implement programs that will prevent disease, not focusing exclusively on treatment of disease. Some of these strategies include:

- Focusing on traditional practices and values which have a very strong role in promoting wellness.
- Promotion and implementation of effective model programs such as for breast feeding, and language and cultural training in early childhood and elementary settings.
- Continuation of the Healthy Fellowship program, teaching community members the skills needed for building health communities and serving as catalysts for change at the community level.
- Identification and dissemination of best practices in clinical and community-based HP/DP interventions, such as the "Just Move It" campaign.
- Engaging youth and strengthening families to address the burden of disease. The agency is working closely with the national youth organizations, such as Boys and Girls Clubs and United National Indian Tribal Youth, Inc. (UNITY), to promote healthy lifestyles for AI/AN children and youth.
- Engaging professional health experts, Federal leaders, Tribal leaders, and community leaders through the Health Promotion Task Force and Policy Advisory Committee to guide this initiative to eliminate health disparities.

In FY 2005, $2M of new funding was used to fund the Healthy Communities Fellowship program and to develop a new HP/DP grant program to support HP/DP programs at the community level. The focus of the grants is on supporting healthy lifestyles and choices such as eating healthier, being physically active, and avoiding tobacco, alcohol, and other harmful substances to decrease cardiovascular disease, cancer, diabetes, obesity, and unintentional injuries. **This initiative supports the HHS Goal 1 to reduce the major threats to the health and well-being of Americans.**

Epidemiology and Disease Control – Epidemiology provides the foundation for all public health activities, such as reducing the major threats to the health and well-being of Americans. Tribal governments and health facilities as well as IHS direct-service sites deliver public health services such as immunization and cancer prevention and control programs. Efficient delivery of public health services and development of effective interventions to improve health requires in-depth knowledge of the causes of illness and mortality among the population. Epidemiology Center staff from both the IHS national coordinating center and eleven Tribal centers collect, analyze, interpret, and disseminate health information critical to identifying disease to target, suggesting strategies for successful interventions and testing the effectiveness of health interventions that have been implemented.

Congress in FY 1996 funded the innovative IHS Tribal Epidemiology Center program. Initially, four Tribal epidemiology centers were selected following competition and recommendations of an objective review panel and funded up to $155,000 each through cooperative agreements. In FY 2007, IHS will continue to fund the IHS national coordinating center in Albuquerque and up to 11 Tribal epidemiology centers through cooperative agreements with American Indian or Alaska Native Tribes and Tribal organizations, such as Indian health boards at an average of just over $400,000.

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

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

Epidemiology centers assist Tribes in looking at the cost of health care for Indian people in order to improve the use of resources. In the future, in the expanding environment of Tribally operated health programs, epidemiology centers will ultimately provide additional public health services such as disease control and prevention programs. Some existing centers provide additional assistance to Tribal participants in such areas as sexually transmitted disease control and HIV and cancer prevention. They also assist Tribes in activities such as conducting behavioral risk factor surveys in order to establish baseline data for successfully evaluating intervention and prevention activities. **This program promotes HHS Goal 4 to enhance the capacity and productivity of the Nation's health science research enterprise.**

In FY 2007, this program will continue to enhance the ability of the Indian health system to collect and manage data more effectively to better understand and develop the link between public health problems and behavior, socioeconomic conditions, and geography. The Tribal epidemiology program continues to support Tribal communities by providing technical training in public health practice and prevention-oriented research and promoting public health career pathways for Tribal members. Collaborative efforts to implement the Tribal epidemiology programs will be coordinated with the National Institutes of Health and the Centers for Disease Control and Prevention (CDC) to optimize federal resource utilization, create stronger interagency partnerships, and prevent costly duplication of effort.

Information Technology (IT) - IT is essential to effective health care delivery and efficient resource management in the Indian Health Service. As demonstrated in the strategic performance measures sections for each of the three major IT strategic investments, IHS IT directly supports the President's management agenda as well as HHS and IHS strategic goals and objectives. **These efforts support the Secretary's 500 Day Plan to transform the health care system through IT.** Health care is

information intensive and increasingly dependent on technology to assure that appropriate information is available whenever and wherever it is needed. IHS IT infrastructure includes people, hardware and software, communications and security that support every aspect of the IHS mission. IHS IT is based on an architecture that incorporates Federal Health Architecture guidelines and industry standards for the collection, processing and transmission of information. IHS IT is managed through three major programs as a strategic investment by senior management, fully integrated with the agency's programs, and critical to improving service delivery.

The Resource and Patient Management System (RPMS) is the IHS enterprise health information system. RPMS consists of more than 60 integrated software applications for patient care and practice management; this health information system is used at approximately 400 IHS, Tribal and urban (I/T/U) locations. IHS also maintains an enterprise level data repository (currently being upgraded to the IHS National Data Warehouse) that provides a broad range of retrospective clinical and administrative information to managers at all levels of the Indian health system to allow them to better manage individual patients, local facilities, regional and national programs and to allow IHS management to provide legislatively required reports to the Administration and Congress. The IHS telecommunications infrastructure connects IHS, Tribal, and urban facilities as part of the larger HHS telecommunications network. The IHS participates in HHS enterprise-wide initiatives to improve IT infrastructure and works with the Department of Veterans Affairs and other federal partners to develop software and share technology resources. These collaborations are reflected in the IHS IT architecture and five-year plan.

Noteworthy accomplishments for IHS IT include a PART score of “Effective” for RPMS, certification and accreditation of all major IHS IT systems, and adoption of Consolidated Health Informatics e-Gov standards in the IHS IT architecture. Through improvements in IT systems and infrastructure, IHS continues to more effectively measure GPRA performance measures and meet DHHS reporting requirements. IT-related GPRA performance measures are included in the IHS FY 2007 Annual Performance Plan. These measures address the development of improved automated data capabilities that support clinical care and performance measurement. Complete information is available in the Detail of Performance Analysis Section.

The IHS continues to improve its IT infrastructure to support Presidential, Secretarial and IHS goals and priorities, as documented in the Strategic Performance and Measures sections for the three IHS IT major investments. Compliance with E-Gov initiatives will dramatically improve the exchange of health care information. The Secretary’s priority to accelerate the adoption of information technology in health care will reduce medical errors and improve health care quality. The IHS Electronic Health Record project supports the Secretary’s priority by providing computer-based physician order entry, encounter documentation, access to medical literature and other essential capabilities. The EHR project supports the **HHS Goal 5 to improve the quality of health care services and increasing the appropriate use of effective health care services by medical providers.** The RPMS Integrated Behavioral Health initiative is intended to

improve treatment effectiveness by enhancing and integrating data capture, treatment guidelines and reporting for mental health, alcohol and substance abuse, and social services. These initiatives, as well as increasingly affordable health care technologies such as telemedicine, require continuous improvement of IHS IT infrastructure.

Enterprise Information Technology Fund

The IHS request includes funding to support the President's Management Agenda Expanding E-Government and Departmental enterprise information technology initiatives. Operating Division funds will be combined to create an Enterprise Information Technology (EIT) Fund to finance specific information technology initiatives identified through the HHS strategic planning process and approved by the HHS IT Investment Review Board. These enterprise information technology initiatives promote collaboration in planning and project management and achieve common HHS-wide goals. Examples of HHS enterprise initiatives funded by the EIT Fund are Enterprise Architecture, Capital Planning and Investment Control, Enterprise E-mail, Grants Management Consolidation, and Public Key Infrastructure.

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

Fiscal Year	Amount	FTE
2002	$1,153,206,000	6,635
2003	$1,211,988,000	6,368
2004	$1,249,781,000	6,408
2005	$1,289,418,000	6,492
2006	$1,339,539,000	6,684

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $1,429,772,000 and 6,852 FTE is an increase of $90,234,000 and 168 FTE over the FY 2006 Enacted budget of $1,339,539,000 and 6,684 FTE. The request will enable IHS to make the following performance improvements over FY 2005: increase the percent of diabetics with ideal glycemic control by 13%; increase the percent of diabetics assessed for dyslipidemia by 11%; increase the percent of diabetics assessed for nephropathy by 13%; and increase the percent of adult patients immunized with the pneumococcal vaccine by 10%.

Pay Costs: +$27,723,000 to fund pay increases for Federal and Tribal employees who provide direct health care services. The provision of these funds is necessary to maintain the current IHS and Tribal health system which works to eliminate disparities in health status between the American Indian and Alaska Native population and the rest of the U.S. Funds to cover increased pay costs are extremely important to the agency. The IHS is a workforce intensive agency and the Hospitals and Health Clinics budget funds the salaries and benefits of much of the clinical staff necessary to provide health services,

including physicians, nurses, imaging technicians, pharmacists, lab techs, etc., and the administrative staff necessary to manage the health program.

Increased Costs of Delivering Health Care: +$16,210,000 to fund medical (4.0 percent) and non-medical (2.1 percent) inflationary costs, using the FY 2007 Economic Assumptions. The additional funding will cover the increased cost of providing health care using the FY 2007 Economic Assumptions.

Population Growth: +$21,535,000 to fund the increased services needs resulting from the growing AI/AN population. A 1.6 percent growth rate is projected, based on State birth and death data.

Staffing/Operating Cost Requirements for New Facilities: +$13,728,000 and 161 FTE to fund staff in four new facilities which will open during FY 2006 and FY 2007. The following table displays the requested increase.

Facilities	Amount	FTE Federal
Clinton, OK Health Center	$1,877,000	22
Red Mesa, AZ Health Center	$8,495,000	101
Sisseton, SD Health Center	$3,056,000	36
St. Paul, AK Health Center	300,000	2
Total:	$13,728,000	161

Unified Financial Management System (UFMS): +$11,037,000 for the IHS' share of additional costs for both the Operations and Maintenance costs for the UFMS project and for additional costs to the Program Management Office of the UFMS project due to the extension of the implementation dates for both the Program Support Center (October 2006) and the Indian Health Service (October 2007).

UFMS is being implemented to replace five legacy accounting systems currently used across the HHS Operating Divisions (Agencies). The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. The system will also facilitate shared services among the Agencies and thereby, help management reduce substantially the cost of providing accounting service throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable the component agencies and program administrators to make more timely and informed decisions regarding their operations. UFMS has reached a major milestone in April 2005 with the move to production for the Centers for Disease Control and Prevention and the Food and Drug Administration. IHS' FY 2007 budget includes a total of $5,474,000 for this purpose.

Accounting Operations

Operations and Maintenance (O&M) activities for UFMS commenced in FY 2005. The Program Support Center will provide the O&M activities needed to support UFMS. The scope of O&M services includes post-deployment support and ongoing business and technical operations services. Post-deployment services include supplemental functional support, training, change management and technical help desk services. Ongoing business operation services involve core functional support, training and communications, and help desk services. Ongoing technical services include the operations and maintenance of the UFMS production and development environments, ongoing development support, and backup and disaster recovery services. IHS' FY 2007 budget includes a total of $8,800,327 for this purpose.

Automating Administrative Activities

HHS agencies have been working to implement automated solutions for a wide range of administrative activities. As UFMS development and implementation move toward completion, there are added opportunities to improve efficiency through automating the transfer of information from administrative systems to the accounting system. IHS' FY 2007 budget includes a total of $7,408,744 to support coordinated development of these improved automated linkages and administrative systems.

DEPARTMENT OF HEALTH AND HEALTH SERVICE
Indian Health Service
Services: 75-0390-0-1-551
DENTAL HEALTH

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

	FY 2005 Actual	**FY 2006 Enacted**	**FY 2007 Request**	Increase or Decrease
BA	$109,023,000	$117,731,000	$126,957,000	+$9,226,000
FTE	765	807	849	+42
Patient Visits	954,570	1,005,633	1,031,963	+26,330
Services Provided	2,921,978	3,078,283	3,158,882	+80,599

STATEMENT OF THE BUDGET REQUEST

The FY 2007 budget request of $126,957,000 for the Dental Program funds the provision of dental care to the American Indian and Alaska Native (AI/AN) population.

PROGRAM DESCRIPTION

The purpose of the Dental Program is to raise the oral health status of the AI/AN population to the highest possible level through the provision of high quality preventive and treatment services at both the community and clinic levels. The Program has been traditionally oriented toward preventive and basic care, which addresses ***HHS Strategic Plan Goal 3, Objective 3.4: Eliminate racial and ethnic disparities***. Also addressed by this plan of delivering health care services is ***Secretary Leavitt's 500 Day Plan goal to transform health care systems by supporting community-based approaches to close the health care gap, particularly among racial and ethnic minority populations, including American Indians and Alaska Natives***. Within the Schedule of Services, which is a service priority hierarchy used by the Dental Program, over 90 percent of services provided are basic and emergency care. Estimates of demand for treatment remain high; however, a continuing emphasis on community oral health promotion/disease prevention is essential to long-term improvement in the oral health of AI/AN people.

Services which alleviate pain or prevent disease are given a higher priority than those intended to contain or correct damage caused by disease. Thus, priority is given to services such as treating dental emergencies, procedures aimed towards preventing the onset of disease and services deemed necessary for routine diagnosis and treatment to control the early stages of disease.

Beginning in FY 2000, the IHS developed a process to build public health infrastructure through Tribal and IHS partnerships. Four Tribal health boards were funded to

implement Dental Clinical and Preventive Support Centers, whose purpose is to provide technical support, training, and assistance in clinical and preventive aspects of dental programs providing care to American Indians and Alaska Natives. The **four health boards** initially funded were: Alaska Native Tribal Health Consortium, All Indian Pueblo Council, Intertribal Council of Arizona, and Northwest Portland Area Indian Health Board. In FY 2001, **three additional awards** were made: Confederated Salish and Kootenai Tribes of the Flathead Nation in cooperation with the Billings Area IHS, Oklahoma City Area Inter-Tribal Health Board, and the Aberdeen Area IHS. Each of the support centers approaches the objectives in a unique manner, but all strive towards providing the technical support, training and assistance needed for the improvement of access to care and quality of care provided to American Indian and Alaska Natives, which addresses ***HHS Strategic Plan Goal 3, Objective 3.6: Increase access to health services for American Indians and Alaska Natives***. The seven support centers continue to develop and implement the unique and innovative dental public health programs that have addressed the dental public health needs of the communities served.

PERFORMANCE ANALYSIS

One key dental performance measure of the IHS is centered on the application of dental sealants. A dental sealant is a thin "plastic" coating that is applied primarily to the biting surface of posterior teeth. It occludes the many grooves, pits, and fissures of the biting surface, effectively eliminating the potential for dental decay on these surfaces, the most prone to decay of any in the mouth. Sealants are especially effective in children and adolescents, those individuals in the "caries-prone" years of life.

The Healthy People 2010 goal for dental sealants is stated in terms of prevalence of sealants in children and adolescents: at least 50 percent of children age 8 and adolescents age 14 will have sealants on molar teeth by 2010. Data from the most recent IHS national oral health survey completed in 2000 indicate the 62 percent of American Indian/Alaska Native children and adolescents ages 6 – 14 had sealants on molar teeth. This means that by the year 2000, with the HP2010 objectives were formulated, the IHS had already surpassed the national goal set for 2010 for dental sealants. Identifying and treating this high risk group of children and adolescents with this proven dental preventive service directly addresses ***HHS Strategic Plan Goal 3, Objective 3.5: Expand access to health care services for targeted populations with special health care*** needs as well as ***Secretary Leavitt's 500 Day Plan goal to transform health care systems by supporting community-based approaches to close the health care gap, particularly among racial and ethnic minority populations, including American Indians and Alaska Natives***.

In terms of the number of sealants applied annually, the IHS has the largest dental sealant program in the world. Each year, approximately a quarter of a million sealants are applied to the teeth of roughly 90,000 patients. While production is assessed every year, the program is not able to assess the prevalence of sealants annually. Hence, the annual performance goal is expressed in terms of production rather than prevalence.

Performance Goal	Results	Context
Place at least as many dental sealants in FY 07 as were placed in FY 06.	Production for the most recent FY 05 was 249,882 individual sealants, an increase of 19,587 sealants over FY 04 data. The IHS has increased the annual production of dental sealants in every consecutive year since 1999.	Properly placed and maintained dental sealants effectively eliminate dental decay on the biting surface of teeth, the surface most susceptible to decay. The world's largest dental sealant program, in terms of annual production, continues to increase production with each successive new year.

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

Fiscal Year	Amount	FTE
2002	$95,305,000	775
2003	$99,633,000	738
2004	$104,513,000	760
2005	$109,023,000	765
2006	$117,731,000	807

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $126,957,000 and 849 FTE is an increase of $9,226,000 and 42 FTE over the FY 2006 enacted budget of $117,731,000 and 807 FTE. The increase will enable IHS to increase the number of patients served by 2 percent.

Pay Cost: +$2,519,000 – this will fund federal and Tribal pay cost increases which will assist the IHS in maintaining access to services for the IHS patient population. Provision of these funds is necessary to maintain the current IHS and Tribal health system which works to eliminate disparities in health status between the American Indian and Alaska Native population and the rest of the U.S.

Increased Costs of Delivering Health Care: +$1,069,000 – this additional funding will cover the increased costs of providing dental services using the FY 2007 Economic Assumptions of 4.0 percent for medical inflation and 2.1 percent for non-medical inflation.

Population Growth: +$1,893,000 - these resources will support the dental program's ability to provide dental services to the increasing AI/AN population.

Staffing and Operating Cost Requirements for New Facilities: +$3,745,000 and 42 FTE to fund staff in four new facilities which will open during FY 2006 and FY 2007. The following table displays the requested increase

Facility	Amount	FTE	
		Federal	Tribal
Clinton, OK Health Center	$773,000	9	0
Red Mesa, AZ Health Center	2,251,000	25	0
Sisseton, SD Health Center	721,000	8	0
St. Paul, AK Health Center	0	0	0
Total:	**$3,745,000**	**42**	**0**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services – 75-0390-0-1-551
MENTAL HEALTH

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

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Request	Increase Or Decrease
Discretionary	$55,060,000	$58,455,000	$61,695,000	+$3,240,000
FTE	252	263	270	+7
Outpatient Visits*	372,337	379,000	382,000	+3,000

* These data are actual counts. Previous data were estimates based upon a range of variables, but with the increased use of IHS data systems, all subsequent data will reflect actual counts, not estimates. Also, due to PL 93-638, Tribes are not compelled to share such data with IHS, thus it represents a marked undercount.

STATEMENT OF THE BUDGET REQUEST

The budget request of $61,695,000 for the Mental Health and Social Services (MH/SS) program supports mental health and social service treatment, rehabilitation, and prevention services.

PROGRAM DESCRIPTION

The purpose of the MH/SS program is to raise the behavioral health status of the American Indian and Alaska Native (AI/AN) population to the highest possible level through the provision of preventive and treatment services at both the community and clinic levels. Approximately 45 percent of these funds go directly to Tribally-contracted and compacted programs in accordance with Tribal self governance provisions of P.L. 93-638.

The IHS MH/SS program is a community oriented clinical and preventive mental health service program that provides inpatient hospitalization, outpatient mental health and related services, crisis triage, case management, prevention programming and outreach services. The IHS MH/SS Program provides general executive direction, management and administrative support, and recruitment of MH/SS Program staff to 12 Area Offices (regional) that, in turn, provide resource distribution, program monitoring and evaluation activities, and technical support to 167 Service Units. These Service Units consist of IHS and Tribal programs whose MH/SS staffs are responsible for the delivery of comprehensive mental health care to over 1.8 million American Indians and Alaska Natives (AI/AN). Ninety-four percent (94 percent) of the budget supports direct service operations in Tribal and IHS centers. Mental Health is crucial for the well being of AI/AN and their communities; it must be considered integral in the healing process.

The most common MH/SS Program model is an acute, crisis-oriented outpatient service staffed by one or more mental health professionals. On-call emergency mental health services are provided outside of usual clinic or hospital hours. Medical and clinical social work are usually provided by one or more social workers who assist with discharge planning and provide family intervention for child abuse, suicide, domestic violence, parenting skills, and marital counseling.

Director's Behavioral Health Initiative -- Specifically, the initiative will focus on 4 behavioral health strategic goals: 1) mobilize Tribes and Tribal programs to promote behavioral health in systematic, evidence based approaches, which embrace traditions and culture as critical foundations for that health; 2) support and promote programmatic collaborations within communities, as well as with state and federal programs and other agencies; 3) promote leadership development from the community to national level, with training and mentorship; and 4) provide advocacy for behavioral health programming in Indian communities among federal, state, Tribal, local, and private organizations. **This initiative also supports the HHS goal to reduce the major threats to the health and well-being of Americans including reducing behavioral health and other factors that contribute to chronic disease.**

Partnerships / Collaborations -- Major partnerships currently exist with the Bureau of Indian Affairs, Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, Department of Justice, and Administration for Children and Families. These partnerships often result in increased services to American Indian and Alaska Native communities. Areas of concentration are suicide prevention; program development particularly to assist Tribes and Tribal communities in developing community based prevention and treatment services; information technology program and service development; and to provide convening opportunities nationally to share information and promote collaborations.

PERFORMANCE ANALYSIS

In evaluating performance, workload, and programs, the Government Performance and Results Act (GPRA) measures and initiatives were used. Disparities and emergent clinical and community situations continue throughout the system, including significant tragedies that captured the nation's attention.

The following represents specific workload approximations for FY 2005, based on data from the MH/SS Program data set. They reflect the most current complete year for which information is available from the MH/SS Program reporting system and should be considered estimates because, in accordance with P.L. 93-638, Tribes are not required to submit this information to the IHS data reporting system. The number of MH/SS client services provided and documented were 372,337 and by the following categories:

- Depression and related issues (i.e., suicide) – 40 percent
- Anxiety-based disorders (including trauma-related disorders) – 21 percent
- Family conflict (including marital and adult/child relationship concerns) – 10 percent

- Child abuse – 6 percent
- Attention Deficit Hyperactivity Disorder – 7 percent
- Other abuse (i.e., other than child abuse) – 2 percent
- Variety of direct, indirect, and administrative categories services – 14 percent

Government Performance Results Act Measures for FY 2005 are detailed in the table below:

Performance Goal	Results	Context
During FY 2005, integrate the Behavioral Health suicide reporting tool into RPMS. Baseline data will be collected in FY 2006. During FY 2007, maintain baseline data on suicide using the RPMS suicide reporting tool.	IHS met this measure in FY 2005. Suicide surveillance data can be entered electronically into the RPMS Behavioral Health System by providers.	The suicide death rate for the American Indian and Alaska Native population has increased in the 1990s and is currently 72% greater than the national average. This measure is part of an expanding systematic effort aimed at reducing the prevalence of suicide in the American Indian and Alaska Native population.
During FY 2005, improve the behavioral health data system by increasing the number of programs reporting minimum agreed-to behavioral health-related data to warehouse. In FY 2006 this goal will change to collecting baseline data of adults ages 18 and over who are screened for depression. The goal in FY 2007 will be to maintain the FY 2006 level of depression screening.	IHS met this measure in FY 2005.	The purpose of this measure is to collect data in order to track and evaluate improvements in the behavioral health status of American Indian and Alaska Native people. Better behavioral health data collection and analysis will improve planning, implementation and evaluation of mental health, alcohol and substance abuse, and social services efforts across I/T/U programs.

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

Fiscal Year	Amount	FTE
2002	$47,142,000	265
2003	$50,297,000	255
2004	$53,294,000	253
2005	$55,060,000	252
2006	$58,455,000	263

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $61,695,000 and 270 FTE is an increase of $3,240,000 and 7 FTE over the FY 2006 enacted budget of $58,455,000 and 263 FTE. The increase will provide for:

Pay Costs: +$1,167,000 to fund pay increases for Federal and Tribal employees who provide direct mental health and social services for eligible beneficiaries in the service population.

Increased Costs of Delivering Health Care: +$601,000 to fund inflationary costs associated with mental health and social service care delivery using the FY 2007 Economic Assumptions of 4.0 percent for medical inflation and 2.1 percent for non-medical inflation.

Population Growth: +$940,000 to fund a 1.6 percent growth expected in the service population.

Staffing/Operating Cost Requirements for New Facilities: +$532,000 and 7 to fund staffing for new facilities at Red Mesa, AZ and Sisseton, SD. These funds will be used to increase access to mental health services for the patient population.

		FTE	
Facility	Amount	Federal	Tribal
Red Mesa, AZ Health Center	$456,000	6	0
Sisseton, SD Health Center	$76,000	1	0
Total:	**$532,000**	**7**	**0**

DEPARTMENT OF HEALTH AND HEALTH SERVICE
Indian Health Service
Services: 75-0390-0-1-551
ALCOHOL AND SUBSTANCE ABUSE

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

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Request	Increase or Decrease
Discretionary	$139,073,000	$143,198,000	$150,634,000	+$7,436,000
FTE	169	169	169	0
Outpatient Visits*	63,957	64,000	65,000	+1,000
Inpatient days*	2,879	3,000	3,000	0

*These data are actual counts. Previous data were estimates based upon a range of variables, but with the increased use of IHS data systems, all subsequent data will reflect actual counts, not estimates. Also, under PL 93-638, Tribes are not compelled to share such data with IHS, thus it represents a marked undercount.

STATEMENT OF THE BUDGET REQUEST

The budget request of $150,634,000 for Alcohol and Substance Abuse supports alcohol and other drug dependency treatments, rehabilitation, and prevention services.

PROGRAM DESCRIPTION

The purpose of the Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral health status of American Indian/Alaska Native (AI/AN) to the highest possible level through the provision of preventive and treatment services at both the community and clinic levels. About 84 percent of these funds go directly to Tribally-contracted and compacted programs in accordance with Tribal self governance provisions of P.L. 93-638. These programs provide alcohol and substance abuse treatment and prevention services within communities, with a focus on holistic and culturally-based approaches. The ASAP exists as part of an integrated Behavioral Health Team that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in AI/AN communities.

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

Presently there are 11 operating Youth Regional Treatment Centers (YRTC). All programs are accredited by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities and 3 are

State Certified. Many of the approximately 300 Tribal alcohol programs are State-licensed and/or certified. Alaska currently has two YRTC programs, and they are in the process of seeking funds to build an additional facility. The two YRTCs that are congressionally authorized for the California Area IHS are moving from planning to implementation with program justification documents approved by IHS Headquarters. In addition, there are more than a dozen alcohol/substance abuse adult residential treatment facilities, including two serving pregnant women and/or women with children.

Alcohol & Substance Abuse
Youth Regional Treatment Centers

	Name	Town	State	Area
1	Graf	Fairbanks	AK	Alaska
2	Raven's Way	Sitka	AK	Alaska
3	*Desert Visions	Sacaton	AZ	Phoenix
4	Hayool K'aal	Chinle	AZ	Navajo
5	*Unity	Cherokee	NC	Nashville
6	*New Sunrise	San Fidel	NM	Albuquerque
7	Shiprock	Shiprock	NM	Navajo
8	Jack Brown	Tahlequah	OK	Oklahoma
9	Wemble House	Klamath Falls	OR	Portland
10	*Chief Gall	Mobridge	SD	Aberdeen
11	Healing Lodge	Spokane	WA	Portland

* Federally operated

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

- The latest data available from *Trends in Indian Health 2001-2002, published in 2004,* indicate that alcoholism mortality rates have shown marginal decreases over the last 10 years nationally, yet are still as much as 10 times the alcoholism death rate of the overall U.S. population in some locations. The American Indian and Alaska Native drug-related death rate is 18 percent higher than the rate for the overall U.S. population. Comprehensive care requirements favor dually trained staff in mental health and alcohol/substance abuse disorders to effectively and safely meet the needs of people with diagnosed dual disorders.

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

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

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

Director's Behavioral Health Initiative -- Specifically, the initiative will focus on 4 behavioral health strategic goals: 1) mobilize Tribes and Tribal programs to promote behavioral health in systematic, evidence based approaches, which embrace traditions and culture as critical foundations for that health; 2) support and promote programmatic collaborations within communities, as well as with state and federal programs and agencies; 3) promote leadership development from the community to national level, with training and mentorship; and 4) provide advocacy for behavioral health programming in Indian communities among federal, state, Tribal, local, and private organizations.

To support the initiative, the two major foundational activities include:

1. Data Systems and Technology Infrastructure: Ongoing behavioral health data systems and software development are program priorities for IHS to ultimately make completely electronic health care documentation and comprehensive national data collection a reality. This activity supports the Secretary's 500 Day Plan to transform the health care system by employing health information technology to the benefit of the patients, providers and payers as well as the HHS strategic goal to improve the quality of health care services. Data collection, management and improvement efforts include expansion of the MH/SS system in IHS and Tribal facilities including suicide, child abuse, and domestic violence in addition to other ongoing clinical information gathering and analysis. Two integrated behavioral health clinical documentation and data platforms have been deployed and there are currently over 340 clinics and Tribal programs reporting to the IHS National Database using one of them. In addition, the ASAP is supporting two software enhancement projects that further integrate and coordinate assessment, treatment planning, and case management utilizing the American Society of Addiction Medicine Patient Placement Criteria and the CSAT Alcohol Severity Index. These systems are still in development and testing at the 11 YRTCs and in the Billings Area.

2. Collaborative Activities and Joint Initiatives: In FY 2005, the IHS collaborated with the Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, Bureau of Indian Affairs, Department of Housing and Urban Development, Department of Transportation, Administration on Aging, and the Department of Justice. Multiple programs and collaborations are in place, which bring together convergent interests and resources to support alcohol and substance abuse activities nationally. In addition, IHS is the lead agency for the Memorandum of Understanding between the Department of Health and Human Services and Health Canada, signed in FY 2003, to promote program partnerships and collaborative efforts between the two countries over the next 5 years. Suicide; FAS/FAE; cross border issues, including care across borders were identified as primary areas for collaboration. This activity supports the

Secretary's 500 Day Plan to protect life, family and human dignity as well as to improve the human condition around the world.

PERFORMANCE ANALYSIS

In evaluating performance, workload, programs, the Government Performance and Results Act measures and initiatives were used. Disparities and emergent clinical and community situations continue throughout the system, including significant tragedies that captured the nation's attention.

Alcohol dependence and related alcohol problems account for the majority of visits for ASAP services for FY 2005, the most recent full year data set available. It is important to note these data are now being drawn from the new behavioral health data systems developed over the last 3 years and deployed within the last year. While having specific data is encouraging, they should be considered estimates for this year as the data systems are still being deployed and, in accordance with P.L. 93-638, Tribes are not required to submit this information to the IHS data reporting. The data reveal little change in the overall demand or type of service, although some increase in substances other than alcohol are noted and may be due to increased methamphetamine use, which is troubling:

- 60 percent of total visits were for alcohol abuse related services
- 18 percent of total visits were for substance abuse other than alcohol
- 7 percent of total visits were for polysubstance abuse/dependence
- 7 percent of total visits were for people who were in remission for both alcohol and substances
- 8 percent are scattered among various unspecified substance abuse categories

Selected performance goals are detailed in the chart below.

Performance Goal	Results	Context
During FY 2005-2006, the Youth Regional Treatment Centers that have been in operation for 18 months or more will achieve 100 percent accreditation either through CARF, or a comparable accreditation process. This Goal remains the same for FY 2007.	IHS met this measure in FY 2005 with 100% of YRTCs acquired accreditation.	This measure has changed to focus on accreditation, as the components of the previous measure are met and surpassed with accredited facilities. Accreditation by JCAHO, CARF, or comparable state accrediting bodies ensures that the Youth Regional Treatment Centers met acceptable standards of treatment.
During FY 2005, increase the screening rate for alcohol use in female patients 15 to 44 over the FY 2004 rate. The goal remains the same for FY 2006 and 2007, including an ongoing commitment to increase the screening rate for alcohol use in this population	The IHS not only met this objective in FY 05 but exceeded it by 4% to reach 11%. A total of 27,360 female patients 15 to 44 were screened for alcohol	The purpose of this measure is to improve screening for alcohol use in women of childbearing age. The baseline screening rate was established in FY 2004. FAS (fetal alcohol syndrome) is the most preventable cause of mental retardation. Rates of FAS are higher among AI/AN women than the general

(this is one of the four measures targeted for a ten percent improvement by FY 2007)	use.	population. Screening for alcohol use and dependency in women of child bearing age should result in appropriate interventions.

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

Fiscal Year	Amount	FTE
2002	$135,005,000	180
2003	$136,849,000	178
2004	$138,250,000	174
2005	$139,073,000	169
2006	$143,198,000	169

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $150,634,000 and 169 FTE is an increase of $7,436,000 over the FY 2006 enacted budget of $143,198,000 and 169 FTE. The increase will provide for:

Pay Costs: +$2,868,000 to fund pay increases for Federal and Tribal, employees who provide direct alcohol and substance abuse services for eligible beneficiaries in the service population.

Increased Costs of Delivering Health Care: +$2,266,000 to fund inflationary costs associated with drug and alcohol abuse treatment using the FY 2007 Economic Assumptions of 4.0 percent for medical inflation and 2.1 percent for non-medical inflation.

Population Growth: +$2,302,000 to fund a 1.6 percent growth expected in the service population.

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

CONTRACT HEALTH SERVICES

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

	FY 2005 Actual	**FY 2006 Enacted**	**FY 2007 Request**	Increase or Decrease
BA	$498,068,000	$517,297,000	$554,259,000	+$36,962,000
FTE	1	1	1	0
Gen. Med & Surg. Hospitalization: ADPL	217	216	222	+6
Ambulatory Care: Outpatient Visits	497,899	511,000	527,000	+16,000
Patient & Escort Travel: One-Way Trips	36,782	37,000	38,000	+1,000
Dental Services	59,934	60,000	62,000	+2,000

STATEMENT OF THE BUDGET REQUEST

The FY 2007 budget request of $554,259,000 for Contract Health Services (CHS) is to provide funds for medical and health care services outside the IHS direct care program. The CHS program supports the provision of care in IHS and Tribal operated facilities with the acquisition of health care and medical services that are otherwise not available.

PROGRAM DESCRIPTION

The CHS program is administered through the12 IHS Area Offices that consists of 167 IHS and Tribal service units. The facilities include two major IHS-operated medical centers and one Tribally operated medical center. For some Tribes and Service Units that do not have access to IHS or Tribally-operated facilities, all medical care services are sometimes dependent on the CHS program to provide the needed health care. The CHS program purchases medical care and urgent health care services from private, local, and community health care providers that include hospital care, physician services, outpatient services, laboratory, dental, radiology, pharmacy, and transportation services.

The CHS funds are used in situations where:

- No IHS direct care facility exists,
- The direct care element cannot provide the required emergency or specialty services,
- The direct care facility has an overflow of medical care workload.

The CHS budget also includes a Catastrophic Health Emergency Fund (CHEF) in the amount of $18,000,000 that provides funds for high cost cases and catastrophic illnesses. Accessing CHEF requires meeting a threshold; for FY 2006, the threshold is $25,000. The CHEF program provides funding for over 703 high cost cases in amounts ranging from $500 to $575,000 over the $25,000 threshold.

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

PERFORMANCE ANALYSIS

Embrace innovations in support of the IHS and Office of Resource Access and Partnerships (ORAP) Director's program objectives that enhance Business Practices, Infrastructure, and the CMS MMA provisions and Medicare-like rates.	Ensure accountability for IHS/CHS business plan and implement elements for all ORAP/DCC Staff in support of purchasing CHS health care services based on the IHS payment policy and Medicare-like rates.	Supports all CHS sections of the IHS Business plan, maintains the FI Contract, and monitors CHS program and MMA regulations.

With the implementation of regulations on the Medicare Modernization Act (MMA) provision for Medicare-like rates in FY 2006 or FY 2007, the IHS will no longer be required to pay open market rates for inpatient services for hospitals that participate in Medicare programs. Until the Medicare-like rates are implemented, the CHS program will continue to purchase health care services at open market rates and in accordance with the IHS payment policy. While the MMA Medicare like-rates are being implemented the CHS program continues to strive to attain the best prices available from the private providers and negotiate contracts at the best possible rate as well as maximizing all available alternate resources and continue to enforce CHS regulations and requirements.

The goal is to implement the MMA Medicare-like rates to its fullest extent to maximize CHS resources.

- Service Units will refer or transfer patients only to hospitals that participate in the Medicare reimbursement programs.
- Service Units will inform Medicare-participating hospitals as an institution, including all hospital departments and provider-based entities that the MMA Medicare-like rates will be applied.
- Service Units must transfer emergency patients to Medicare hospitals as soon as the patient is medically stable.

The CHS program will continue to support IHS performance goals. These include reducing heart disease, substance abuse, injuries, glycemic control for diabetics, control high blood pressure, nephropathy; cancer screening for women through pap smears and

mammography; immunizations for 19 to 35 month-old children; and vaccination for influenza and pneumococcal for 65 years and older.

The funds requested will enable the CHS program to extend CHS services for diabetes, cancer, heart disease, injuries, mental health, domestic/community/family abuse/violence, maternal and child health, elder care, refractions, ultrasound examinations, physical therapy, dental hygiene, orthopedic services, and transportation.

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

Fiscal Year	Amount	FTE
2002	$460,776,000	2
2003	$475,022,000	1
2004	$479,070,000	1
2005	$498,068,000	1
2006	$517,297,000	1

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $554,259,000 and 1 FTE is an increase of $36,962,000 over the FY 2006 Enacted budget of $517,297,000 and 1 FTE.

The increase will provide funds to increase the number of hospitalizations and outpatient services purchased by approximately 3% and maintain the current IHS and Tribal health system which works to eliminate disparities in health status between the AI/AN population and the rest of the U.S. population by funding the following:

Pay Cost: +$11,000 for pay increases associated with on-going CHS operations. The IHS will continue to strive to increase access for the IHS patient population.

Increased Costs of Delivering Health Care: +$20,768,000 for funding 2.1 percent non-medical, and 4.0 percent medical inflationary costs using the FY 2007 Economic Assumptions

Population Growth: +$8,316,000 for 1.6 percent growth expected for the CHS program. This will enable the CHS program to address the growing AI/AN population.

Operating Cost Requirements for New Facilities: +$7,867,000 The new Clinton facility and the new Sisseton outpatient facility replaces the old inpatient facilities and will no longer provide inpatient or emergency care services.

These funds will be used to purchase inpatient and emergency care services from the private sector that were previously provided at the inpatient facility. The following table displays the requested increase:

Facilities	Amount	FTE	
		Federal	Tribal
Clinton, OK Health Center	$3,301,000	0	0
Sisseton, SD Health Center	4,566,000	0	0
Total:	$7,867,000	0	0

The funds will be used for the additional workload and to maintain the level of services at these new facilities.

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

PREVENTIVE HEALTH

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Request	Increase or Decrease
BA	$110,381,000	$117,110,000	$125,031,000	+$7,921,000
FTE	271	295	316	+24

SUMMARY OF THE BUDGET REQUEST

The FY 2007 budget request of $125,031,000 and 316 FTE is an increase of $7,921,000 and 24 FTE over the FY 2006 Enacted budget of $117,110,000 and 295 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
Services – 75-0390-0-1-551
PUBLIC HEALTH NURSING

Authorizing Legislation: 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	$45,015,000	$48,959,000	$53,043,000	+$4,084,000
FTE	240	259	277	+18
Total Visits	438,376	459,000	475,000	+16,000

STATEMENT OF THE BUDGET REQUEST

The FY 2007 Public Health Nursing (PHN) budget request of $53,043,000 supports outreach activities including community screenings, home visits, well-child examinations, immunizations, prenatal care, postpartum care, and follow-up visits for skilled nursing services.

PROGRAM DESCRIPTION

The PHN program integrates nursing practice and public health practice for individuals, families, and groups; thereby impacting the health of the community. Forty-six percent of this budget request falls under P.L. 93-638 and supports tribally compacted and contracted PHN programs. The AI/AN population experiences disproportionate rates of diabetes mellitus, cardiovascular disease, obesity, suicide, and unintentional injuries. It is the goal of the IHS PHN program to continue and increase primary prevention efforts by targeting health interventions towards individuals, families, and groups before a disease process begins; and to increase patient and community-based interdisciplinary collaboration to effectively address the health disparities that face the AI/AN population.

The PHN program faces unique challenges in providing services to a diverse population whose health care needs range from health promotion/disease prevention (HP/DP) education for young populations to complex nursing care related to chronic disease for the elderly, both in the home and other community settings. The PHN is a major link to accessing health care for many AI/AN who live in rural and isolated communities.

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

PERFORMANCE ANALYSIS

The IHS PHN program is a community-based program and continues to promote HP/DP activities through health education and access to care.

In FY 2005, the PHN program continued to support activities that focused on measurable outcomes relating to the following: obesity, cardiovascular disease prevention in women, maternal child health, tobacco cessation, and immunizations. These programs have measurable outcomes for intervention activities. These activities have been made possible through appropriation funding distributed in the form of competitive awards for IHS and Tribal PHN programs. The 16 awards issued in FY 2004 and supported in FY 2005, emphasized Departmental and Agency goals of access to health care, health promotion, disease prevention, and advocacy in policy appropriate for the development and implementation of HP/DP activities.

The prior performance measures have been based on the number of PHN visits in any setting and number of home visits, targeting populations at high risk for disease and poor accessibility to health care. For FY 2005, the PHN GPRA indicator logic was reviewed and revised to improve data quality, and focused on overall PHN activities. This PHN indicator focused on implementing a data system capable of recording time spent and the nature of public health activities other than one-on-one patient care, with the emphasis on activities that serve groups or the entire community.

In addition to the PHN GPRA Indicator, PHN program activity contributes to other GPRA Indicators including: diabetes; PAP screening; mammography screening; alcohol screening; childhood immunization; influenza and pneumococcal vaccination in adults; cardiovascular disease; obesity; and tobacco use. These indicators address Departmental and Agency goals of health promotion and disease prevention and coincide with the HHS strategic goal to reduce the major threats to the health and well-being of Americans and increasing access to health services.

Public Health Nursing is also striving to address the Secretary's 500 Day Plan of wellness and prevention activities, specifically supporting community-based approaches to address the health gap in the AI/AN population. The PHN program continues with data assessments and efforts to improve documentation in order to improve PHN data quality.

Performance Goal	Results	Context
During FY 2005, maintain the total number of public health nursing services (primary and secondary treatment and preventive services) provided to individuals in all settings at the FY 2004 levels.	The IHS exceeded the FY 2004 target to maintain the number of visits provided at the FY 2004 level. FY 04 = 423,379 FY 05 = 438,376	Public Health Nurses provide health assessment, health promotion, disease prevention, and infectious disease management services. Maintaining patient access to these services is associated with improved health outcomes.

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

Fiscal Year	Amount	FTE
2002	37,781,000	278
2003	39,616,000	261
2004	42,580,000	252
2005	45,015,000	240
2006	48,959,000	259

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $53,043,000 and 277 FTE is an increase of $4,084,000 and 18 FTE over the FY 2006 Enacted budget of $48,959,000 and 259 FTE. The increase will enable IHS to increase the number of patient visits by 3.5% and provide the following:

Pay Costs: +$1,138,000 to fund pay increases for Federal and Tribal employees to assist the IHS in maintaining access to public health nursing services for the AI/AN patient population.

Increased Costs of Delivering Health Care: +$347,000 to fund inflation costs using the FY 2007 Economic Assumptions of 4.0 percent for medical inflation and 2.1 percent for non-medical inflation.

Population Growth: +$787,000 to fund the 1.6 percent growth projected for the AI/AN population.

Staffing/Operating Cost Requirements for New Facilities: +$1,812,000 and +18 FTE to fund the following:

Facilities	Amount	FTE Federal
Clinton, OK Health Center	$405,000	4
Red Mesa, AZ Health Center	$972,000	10
Sisseton, SD Health Center	$299,000	3
St. Paul, AK Health Center	136,000	1
Total:	$1,812,000	18

Maintaining services and increasing access is critical to preventing the widening of the health care disparities gap.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services –75-0390-0-1-551
HEALTH EDUCATION

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

	FY 2005 Actual	**FY 2006 Enacted**	**FY 2007 Request**	Increase or Decrease
BA	$12,429,000	$13,584,000	$14,490,000	+$906,000
FTE	25	30	33	+3
Clients Served	1,214,646	1,293,316	1,307,056	+13,740

STATEMENT OF THE BUDGET REQUEST

The budget request of $14,490,000 for Health Education will assist IHS facilities, Indian Tribes and Tribal organizations develop comprehensive health education programs for American Indian and Alaska Natives.

PROGRAM DESCRIPTION

The Health Education Program:

(1) Communicates the importance and on-going need for comprehensive clinical and community health education services to American Indian/Alaskan Native clients,
(2) Provides these services both as individual one-on-one counseling education sessions and in group encounters in the community;
(3) Standardizes, coordinates and integrates education issues within the IHS including health literacy, professional education and training, as well as educational materials for staff, patients, families and communities.
(4) Assists to transform the Health Care System to increase access to high quality, effective health care that is predictably safe.

The Health Education Program is addressing the Secretary's 500 Day Plan to transform the health care system by supporting community-based programs to close the health care gap among American Indians and Alaska Natives.

Comprehensive Health Education -- The Health Education Program has identified the following areas of emphasis as the core basis for public health education in the IHS: community health, school health, worksite health promotion, and patient education. Funding to the Health Education Program strives to:

- To develop and strengthen a standardized, nationwide patient and health education program as evidenced by the integration of the IHS Patient Education Protocols into

all IHS software packages including the PCC, PCC+ and the Electronic Health Record; with the continued provision of ongoing training to IHS and Tribal staff on the documentation and coding of patient and health education. **This effort supports the HHS strategic goal improve the quality of health care services.**

- To enhance the capacity of staff that provide educational services to AI/AN clients by providing standardized professional education and training for staff and patient and family education in the clinical facilities as well as in the community;

- To increase a concentrated focus on the area of the HP2010 Focus Area: Health Literacy:
  - Increase the proportion of American Indian/Alaskan Native households with access to health information in the home
  - Improve the health literacy of persons with inadequate or marginal literacy skills.
  - Increase the proportion of health communication activities that include research and evaluation.
  - Increase the proportion of health-related World Wide Web sites that are quality-assured to disclose information, or link with www.ihs.gov
  - Increase the number of centers for excellence that seek to advance the research and practice of health communication.
  - Improve the communication skills of health care providers working with AI/AN populations.

- Increase consumer and patient use of health care quality information.

The IHS Health Education program has renewed the focus within the IHS on education. IHS statistics indicate a decline in the number of sites employing a full-time health educator; however, the IHS can demonstrate a steady increase in the health and patient education encounters that are being provided to American Indian and Alaska Native clients by all providers within the IHS. This demonstrates not only the collaboration between the IHS Health Education Program and all IHS health disciplines and programs but also demonstrates an agency-wide focus on education. All disciplines and programs are being trained to provide education services and a mechanism for tracking these services is in place.

PERFORMANCE ANALYSIS

The IHS Health Education performance emphasizes Healthy Living and Prevention of Disease, Illness, and Disability to reduce unhealthy behaviors and other factors that contribute to the development of chronic diseases (diabetes, obesity, asthma, heart disease, stroke and cancer).

1. Establish the proportion of tobacco using patients that receive tobacco cessation intervention.
2. Increase consumer and patient use of health care quality information by:
   - Increasing the number of AI/AN clients that received patient education services.

- To improve health literacy, install and evaluate 7 new patient education kiosks to improve consumer access to health care materials.

3. Specific areas of concentration are supported by the Health Education Program in the Clinical Reporting System (CRS) and GPRA. These include:
   a. cardiovascular disease education
   b. exercise education
   c. medication education
   d. FAS Prevention
   e. Domestic Violence Education.

These programs support the HHS Strategic goal to reduce the major threats to the health and well-being of Americans. A single sample of one education area, tobacco education:

<table>
<tr><th></th><th colspan="2"></th><th></th></tr>
<tr><td rowspan="3">Tobacco Cessation
In FY 2005, the GPRA indicator was to assess the percent of patients receiving a tobacco assessment.</td><td colspan="2">The IHS met and exceeded this measure by 7% in FY 2005 so that 34% of the patient population was assessed for tobacco use and appropriate education provided.
RPMS PCC Outpatient Visits: Tobacco Patient and Family Education Codes Documented</td><td rowspan="3">Tobacco is a major cause of morbidity and mortality as well as co-morbidity to many other diseases such as heart disease and diabetes.</td></tr>
<tr><td>2004</td><td>27,576</td></tr>
<tr><td>2005</td><td>54,859</td></tr>
</table>

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

Fiscal Year	Amount	FTE
2002	$10,628,000	30
2003	$10,991,000	25
2004	$11,793,000	25
2005	$12,429,000	25
2006	$13,584,000	30

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $14,490,000 and 33 FTE is an increase of $906,000 and 3 FTE over the FY 2006 enacted budget request of $13,584,000 and 30 FTE. The increase will provide for:

Pay Costs +$294,000 - The request will fund federal and Tribal pay increases which will assist the IHS in maintaining access to services for the IHS patient population.

Increased Costs of Delivering Health Care +$167,000 - The request will fund inflation costs using the FY 2007 Economic Assumptions of 4.0 percent for medical inflation and 2.1 percent for non-medical inflation.

Population Growth +$219,000 – The additional resources will fund the 1.6% growth projected for the AI/AN population.

Staffing and Operating Cost Requirements for New Facilities +$226,000 and +3 FTE - The completion of new facilities and facility replacements require additional staffing because of the increased workload as a result of the additional services.

These funds will be used for Health Education services which in turn will increase access to services by increasing community-based HP/DP, chronic disease, and behavioral health outreach activities. The following table displays the requested increase.

		FTE	
Facility	Amount	Federal	Tribal
Clinton, OK Health Center	$150,000	2	0
Red Mesa, AZ Health Center	76,000	1	0
Total:	**$226,000**	**3**	**0**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services – 75-0390-0-1-551
COMMUNITY HEALTH REPRESENTATIVES

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

	FY 2005 Actual	**FY 2006 Enacted**	**FY 2007 Request**	Increase or Decrease
BA	$51,365,000	$52,946,000	$55,790,000	+$2,844,000
FTE	6	6	6	0
Patient Contacts	1,654,294	1,654,000	1,680,000	+26,000

STATEMENT OF THE BUDGET REQUEST

The budget request of $55,790,000 for the Community Health Representatives (CHR) program funds quality HP/DP services along with health care outreach services to AI/AN people within their communities.

PROGRAM DESCRIPTION

The CHR Program is primarily a Tribally administered program under P.L. 93-638 as amended. The program was designed to bridge gaps between AI/AN persons and resources by integrating basic medical knowledge about health promotion/disease prevention and local community knowledge in specially trained indigenous community members. The Indian Health Care Improvement Act provides the authority for the CHR Program. The 264 CHR programs are administered and operated by the Tribes through contracts/compacts under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA).

The CHR Program also supports the National Association of Community Health Representatives (NACHR) in a cooperative agreement. NACHR is charged with the responsibilities to organize national and Area training conferences for CHRs, to develop and distribute a national newsletter addressing health issues pertinent to CHRs in the field; and to actively garner support/advocacy for other funding channels as well as establish contacts nationwide for CHR programs and initiatives.

PERFORMANCE ANALYSIS

The CHR Program supports the achievement of GPRA measures including immunization rates for children and elders, blood pressure and glycemic control for diabetics, and injury prevention programs. To meet those measures requires a collaborative effort on the part of CHRs, Public Health Nurses, Health Educators, Maternal and Child Health

workers, Diabetes specialists and Environmental Health specialists. IHS utilizes a multidisciplinary approach to maximize health resources to meet health care needs. The GPRA measures above reflect cross-cutting strategies involving CHRs in the community and reveal only a limited snapshot of the critically important role CHRs serve in AI/AN communities. Across the scope of IHS' CHR programs, CHRs provide many links to effectively integrate efforts designed to positively impact chronically underserved AI/AN communities, **thus supporting the HHS goal to increase the percentage of the Nation's children and adults who have access to health care services and expand consumer choices.** At an individual level CHRs positively impact health-promoting behaviors, provide interagency coordination at the agency level and build community competence among AI/AN communities, all of which support DHHS goals.

CHRs typically supply social support services as well as health services to their communities thus supporting the **HHS goal to improve the economic and social well-being of individuals, families and communities, especially those most in need.** CHRs connect local/state/federal resources with community members – especially elders and children - needing assistance for energy costs, completing Medicare/Medicaid eligibility forms, and assisting with tax returns. CHRs are trusted within their communities oftentimes to the point that on a home visit the resident will not open the door unless a CHR accompanies another health or social services provider.

CHRs help community members cope with stressors and promote positive health outcomes in a variety of ways, complementing in a "high-talk, low-tech" manner the specialized services of medical providers. Such ancillary health services are not captured by GPRA measures but add tremendous value to reaching the *DHHS Goal to improve economic and social development of distressed communities*. The Performance Goal listed below is not an official GPRA indicator for IHS; rather it represents a goal undertaken by the IHS national CHR Program to obtain specific categorical information based on certain IHS GPRA indicators but drawn from the CHR Patient Care Component software package.

Performance Goal	Results	Context
Address the number of Chronic Disease services for CVD, Diabetes and Cancer provided by CHRs to support clinical and community-based initiatives. In FY 07 CHRs will increase by 5 percent the baseline for these services established by the CHR Program in FY 2005.	Baseline for Cancer, Diabetes, Obesity, Hypertension and Heart-related services by type and number performed by CHRs with an emphasis on activities that serve groups or the entire community to be established by CHR Program software in FY 06.	This performance goal refers to assisting the IHS Cardiovascular and Diabetes teams to identify early indications of heart disease through screening and prevention efforts, and ties into interdisciplinary chronic disease initiatives targeting triglycerides, blood pressure and obesity. Upon every visit or patient contact, CHRs will provide an appropriate chronic disease service or screening referral to the proper health clinician. This goal will necessarily include further CHR training on the health problems of CVD, Diabetes and Cancer, close cooperation with IHS and Tribal clinical colleagues, and a review of all CHR PCC data and RPMS provider code data.

The CHRs contribute directly to the IHS Director's Prevention Initiative, by actively supporting building healthy communities. In FY 2005, over 65 percent of CHR patient contacts involved HP/DP activities, including efforts regarding diabetes, hypertension and nutrition. Below are only a few CHR projects and activities which contribute toward the journey to accomplish **HHS and IHS goals to reduce the major threats to the health and well being of Americans, enhance the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges, expand access to health care services for AI/AN persons; expand community partnerships and build healthy communities; reduce tobacco and alcohol use among young people; emphasize prevention programs; and increase immunization rates:**

- Continued implementation and evaluation in at least 3 communities of the school based curriculum "Protecting You/Protecting Me" to teach youngsters about alcohol as designed for American Indian/Alaska Native communities by Mothers Against Drunk Driving.
- Continued successful implementation of a project whereby Tribal CHR Programs have arranged for patient transportation via a non-profit corporation, resulting in cost-savings to the Federal government;
- Continued successful implementation of projects with the Centers For Disease and Control Prevention (CDC) and National Heart, Lung and Blood Institute (NHLBI) regarding diabetes control and cardiovascular Programs;
- Continued successful implementation of projects with CJ SIDS Foundation to reduce the incidence of Sudden Infant Death Syndrome in AI/AN babies, additionally impacting goals to reduce tobacco and alcohol use among young mothers and fathers;
- Continued successful implementation of First Responder trainings for CHRs and community members within the 12 IHS Areas;
- Provision of education and outreach services targeting prevention activities including injuries, diabetes, obesity, cardiovascular problems, exercise and lifestyle changes and incorporating patient education outcomes;
- Injury prevention activities to reduce the tremendous injury rates among AI/AN persons to include home assessments for elders and toddlers, child safety seat usage, safe cycling and helmet use classes, smoke detectors in homes, etc.;
- Increased activities in and awareness of local, county, regional, and Area Emergency Preparedness efforts and the important partnership role for CHRs in the Tribal community to help affect those disaster plans; and
- Successful implementation of the beginning phases of an Antibiotic Resistance campaign in partnership with CDC.

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

- Diabetes and associated kidney and eye problems
- Cancer
- FAS/FAE
- Hypertension
- Nutrition, lifestyle choices and obesity
- Maternal and child health
- Elder care
- Alcohol/drug abuse prevention and referral

The CHR Program is also working to meet the **Secretary's 500 Day Plan of adopting information technology** in health care by implementing a desk or laptop-based software program which allows for the remote movement of patient data from the field to the Patient Care Component Software at the service facility or Area. The CHR Program is reviewing data requirements (including collection and entry capability) and training needs to improve documentation practices in order to enhance its data quality and reporting capability.

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

Fiscal Year	Amount	FTE
2002	49,789,000	3
2003	50,444,000	5
2004	50,996,000	4
2005	$51,365,000	6
2006	$52,946,000	6

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $55,790,000 and 6 FTE is an increase of $2,844,000 over the FY 2006 enacted budget of $52,946,000 and 6 FTE. The increase will enable IHS to increase patient contacts by 1.6% and will provide:

Pay Costs: **+$1,139,000** to fund pay increases for Federal and Tribal employees who provide outreach and health promotion and disease prevention services to the IHS patient population.

Increased Costs of Delivering Health Care: +$854,000 to fund inflationary costs for medical supplies, educational materials and fuel to allow the CHR Program to maintain the level of services of prior fiscal years using the FY 2007 Economic Assumptions of 4.0 percent for medical inflation and 2.1 percent for non-medical inflation.

Population Growth: +$851,000 to fund a projected 1.6 percent growth in the AI/AN population. These funds will allow the CHR Program to address the health disparities of an increasing AI/AN population.

The overall increase of 5.37 percent will provide for CHR Programs to more effectively target emerging chronic diseases and behavioral health issues facing the AI/AN population through HP/DP activities focusing on blood pressure monitoring and referrals and cholesterol screening to address health conditions like diabetes and obesity along with injury prevention through community outreach.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services –075-0390-0-1-551

HEPATITIS B AND HAEMOPHILUS IMMUNIZATION PROGRAMS (ALASKA)

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

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Request	Increase or Decrease
Discretionary	$1,572,000	$1,621,000	$1,708,000	+$87,000
FTE	0	0	0	0

Services Provided: [1/]				
# Hepatitis Program patient visits for clinical care*	3900	3900	4300	+400
# Chronic carriers surveyed	1300	1300	1300	0
Patients Immunized:				
# Hepatitis A/B**	8400	8400	8400	0
Hepatitis C patients followed	1500	1700	1900	+200
Studies evaluating need for Hepatitis A and Hepatitis B booster doses:				
Infants/Children	1050	1050	500	-550 2/
Adults	1000	1000	250	-750 2/
Non-Alcoholic Fatty Liver Registry patients***	350	450	600	+150
Autoimmune Hepatitis Registry Patients***	90	100	110	+10
Immunization Records Audited:				
# Trained in RPMS	120	150	150	0
# Health Aide Training	90	100	120	+20
# Tribal Site Visits	5	6	7	+1
3-27 month old Alaska Native immunization rates reported:	5,000	5,000	5,200	+200
Purchase of Vaccine (Adult):				
Hepatitis A****	$50,000	$45,000	$40,000	-$5,000
Hepatitis B****	$50,000	$45,000	$40,000	-$5,000

[1/] Resources from IHS and other sources support services provided

2/ Decrease for Hepatitis A and Hepatitis B booster doses for Infants/Children and Adults is currently in the process of being evaluated. We have done tremendous job of covering susceptible persons with Hepatitis A and Hepatitis B vaccine purchases. However, questions concerning the need for vaccine booster doses have yet to be resolved. We continue to conduct long-term immunogenic studies to assess the future need for booster doses and while this data is reviewed we will recruit patients for further assessment and/or vaccination. In addition, the number of field clinics and patient visits will increase.

STATEMENT OF THE BUDGET REQUEST

The FY 2007 budget request of $1,708,000 would maintain program activities of the Haemophilus Influenza type B Immunization and Viral Hepatitis Programs for Alaska Natives.

PROGRAM DESCRIPTION

The Viral Hepatitis Program (Hepatitis B Program) and the Immunization (Haemophilus Influenza) Program are distinct programs of the Alaska Native Tribal Health Consortium. Based on demonstrated high rates of disease, these activities include clinical care of chronic liver disease patients, consultation on immunization and hepatitis issues, follow-up of hepatitis B carriers, training and technical assistance for Tribal health providers and Community Health Aides, consultation for the RPMS Immunization Package, patient and public education, immunization audits, vaccine-preventable disease surveillance, and coordination with the State of Alaska.

PERFORMANCE ANALYSIS

The Hepatitis and Immunization (Hib) Program addresses GPRA measures 24, 25 and 26 on immunization rates, and the Department of Health and Human Services Strategic Goals 2004-2009 to eliminate racial disparities in rates of immunization and vaccine preventable disease by "increasing immunization rates."

- Evidence of the Immunization (Hib) Program's success includes: (**1**) Alaska Area reports immunization rates on one of the largest proportion of the 3-35 month user population, 93 percent, than any Area. (**2**) The 2003-2004 National Immunization Survey, shows that Alaska Native children have higher 2-year-old immunization rates for 4DTaP-3polio-1MMR-3Hib-3HepB (93.2 percent) than all Alaska (78.2 percent) or the U.S. general population (80.5 percent). (**3**) There has been a 90 percent decrease in vaccine-type pneumococcal cases among Alaska Natives < 2 years old. Only 3 Hib disease cases have occurred in the past 3 years. (**4**) Alaska Native elders have high rates of pneumococcal vaccination (up to 95 percent).
- The Hepatitis Program has decreased the annual incidence of acute symptomatic hepatitis B infection from 215 per 100,000 prior to 1982, to < 2 per 100,000, more than a 100-fold decrease. In addition 1,300 Alaska Natives chronically infected with hepatitis B are monitored for cancer screening and development of active liver disease and cirrhosis so early interventions be performed.
- The Hepatitis Program is conducting studies on the immunogenicity, safety and long-term efficacy of hepatitis A and B vaccines in infants and adult with 1,050 patients enrolled.

The Hepatitis B Program is currently developing an active program to diagnose, evaluate and counsel patients with non-alcoholic fatty liver (NAFLD). The Hepatitis Program monitors over 1,600 Alaska Natives with hepatitis C infection twice yearly for Alpha Feto Protein (AFP) testing to detect liver cancer early and perform liver function tests to identify potential treatment candidates.

GPRA measure 24 – Childhood Immunizations – During FY 2005, maintain the baseline rates for	During the 3rd quarter of FY 2005 the 19-35 month old immunization rate for	This performance goal refers to completion of the basic childhood vaccine series (4DTP 3polio 1MMR 3Hib 3HepB) by 19-35 months old. This data is submitted from 12

recommended immunizations for AI/AN children 19-35 months. The national goal is 72 percent.	Alaska Area was 87 percent, increased from the baseline rate of 82 percent in FY 2004.	Alaska Tribal corporations as computerized RPMS reports and compiled quarterly and submitted to headquarters.
GPRA measure – in FY 2005 maintain the FY 2004 rate for pneumococcal vaccination levels among adult patients age 65 years and older. The national goal is 69 percent.	During FY 2005 the Alaska rate for pneumococcal vaccination in adults ≥ 65 was 88 percent which was increased from 2004.	This performance goal refers to receipt of pneumococcal vaccine by the adult IHS user population ≥ 65 years of age. Results are calculated by the IHS CRS software. Alaska far exceeds the national IHS rate of 69 percent for 2005.
GPRA measure – in FY 2005 this measure was on hold based on anticipated vaccine shortage.	In FY 2005 the Alaska Area Influenza immunization rate in ≥ 65 year olds was 54 percent, which is increased from 52 percent in FY 2004.	This performance goal refers to receipt of influenza vaccine during the Fiscal year by the adult IHS user population ≥ 65 years of age. Results are calculated by the IHS CRS software. This measure was put on hold for 2005 because of influenza vaccine shortages, but will resume in FY 2006.

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

Fiscal Year	Amount	FTE
2002	$1,526,000	0
2003	$1,546,000	0
2004	$1,561,000	0
2005	$1,572,000	0
2006	$1,621,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $1,708,000 is an increase of $87,000 and 0 FTE over the FY 2006 Enacted budget of $1,621,000 and 0 FTE. The increase will provide for:

Pay Costs: +$36,000 to fund pay increases for Tribal employees for immunization coordinators, consultants and the Hepatitis Program Director.

Increased Costs of Delivering Health Care: +$25,000 to fund inflationary costs using the FY 2007 Economic Assumptions of 4.0 percent for medical inflation and 2.1 percent for non-medical inflation.

Population Growth: +$26,000 to fund a projected 1.6 percent growth in the AI/AN population.

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

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

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Request	Increase or Decrease
BA	$31,816,000	$32,744,000	$-0-	($32,744,000)
FTE	7	7	-0-	(7)
Services Provided	680,993	690,612	-0-	(690,612)

STATEMENT OF THE BUDGET REQUEST

The FY 2007 Budget does not request funds for Urban Health. This is a reduction of $32,744,000 below the FY 2006 Appropriation.

PROGRAM DESCRIPTION

The Urban Indian Health Program (UIHP) was created and operates under the legislative authority of Title V of the Indian Health Care Improvement Act, P.L. 94-437. The UIHP works to increase urban AI/AN access to culturally appropriate preventive and primary health care and alcohol and substance abuse services to urban AI/AN communities. The IHS funds, through contracts and grants, 34 urban Indian 501(c)(3) non-profit organizations providing health care services in 41 sites throughout the U. S. These organizations define their scopes of services based upon the documented and unmet needs of the urban AI/AN communities they serve and are governed by Boards of Directors of whom at least 51% are AI/AN.

To initiate close out, the program office will notify all P.L. 94-437, Title V funded Urban Indian Health Organizations (UIHO) that no Title V funds will be available in FY 2007. Additionally, the program office will begin working with other IHS programs in identifying Title V funded grantees that are, due to their Title V status, receiving other IHS program funding, for example: Special Diabetes Program for Indians, Stevens Bill, Alcohol/Substance Abuse, Elders, etc.

In providing monitoring and oversight of the program close out, assistance/guidance will be provided to the UIHO currently funded under Title V, P.L. 94-437, in:

- notifying their user population, the urban Indian community, and other community safety net providers, including hospitals; as well as, other federal, state, county and local agencies; and,

- assuring adherence to IHS Records Management Policy.

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

Fiscal Year	Amount	FTE
2002	$30,947,000	6
2003	$31,323,000	11
2004	$31,619,000	9
2005	$31,816,000	7
2006	$32,744,000	7

RATIONALE FOR THE BUDGET REQUEST

IHS resources have always been targeted to providing health care to communities on or near reservations. For many of these communities, health care from outside the IHS does not exist. Unlike Indian people living in isolated rural areas, urban Indians live near hospitals and health care providers, and they have access to programs such as Medicaid, and other Federal, State and local health care programs, on the same basis as all Americans. One important source of health care for all low income urban Americans is the Health Centers program, administered by the Health Resources Services Administration. The FY 2007 budget includes $2.0 billion for the Health Centers program, allowing it to deliver high-quality affordable health care to 8.8 million low-income urban Americans. Funding increases for this program will allow it to serve 1.5 million more urban Americans in CY 2007 than it served in CY 2004. Health Centers currently operate in all of the 34 cities served by the Urban Indian Health Program and in hundreds of other cities where Indian people live.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services – 75-0390-0-1-551
INDIAN HEALTH PROFESSIONS

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

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Request	Increase or Decrease
BA	$30,392,000	$31,039,000	$31,697,000	+$658,000
FTE	32	32	32	0

STATEMENT OF THE BUDGET REQUEST

The FY 2007 budget request of $31,697,000 for Indian Health Professions supports scholarships, loan repayments, and recruitment and retention of health professionals.

PROGRAM DESCRIPTION

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

PERFORMANCE ANALYSIS

The Indian Health Professions program supports self-determination and access to health care through efforts to enable AI/AN to enter health professions and to support effective recruitment and retention of health professional staff by providing scholarships, loan repayment, temporary employment, and health professions recruitment activities.

The Indian Health Professions budget supports several performance areas that indirectly support the entire set of GPRA measures by developing the IHS workforce, i.e., providers and other professional staff. The scholarship program had 431 participants in FY 2005. They were distributed among its three sections as follows:

Section 103[1]	61
Section 103P[2]	97
Section 104[3]	273

[1]Section 103 is comprised of people in preparatory programs, such as prenursing, prepharmacy, prephysical therapy, etc.

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

In FY 2005, there were 771 people in the IHS loan repayment program, broken down as follows:

New awards[1]	293
Contract extensions[2]	236
New awards in FY 2003[3]	242

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

Health professionals provided temporary services to IHS facilities through direct employment into temporary positions, directly contracting with various facilities, working with contract locum tenens companies, and volunteering their services for various periods of time.

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

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

- IHS Scholarship Programs;
- Tribal Matching Grants;
- Health Professions Recruitment and Retention Grants;
- Nursing Scholarship Program;
- Nursing Residency Program; and
- Advanced General Practice Residency Program for dentists

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

Vacancy Rates for Selected Health Professions
1/2000 vs. 1/2005

Profession	Vacancy Rate 1/2000	Vacancy Rate 1/2005
Dentist	35%	24.0%
Nurse	11%	11.0%
Optometrist	14%	11.0%
Pharmacist	12%	7.2%
Physician	11%	11.0%

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

Assure the efficient placement of scholarship recipients within the Indian health Care system	IHS established a baseline with the FY 2004 graduates of 20 percent being placed in the first 90 days after graduation. The goal is to increase the rate by 2 percent per year from FY 2005 on. The goal has been met for FY 2005.	This performance goal refers to placement of scholars within 90 days of completion of their health professions degree. Indian Health Programs are being provided the number of graduates/names in each discipline to assist the programs in the recruitment of health professionals for their health facilities.

The resources requested for FY 2007 will enable the Indian health programs to be more effective in the recruitment of health professionals in critical health professional shortage areas. Additionally, in order for the Director's goals of reducing uncontrolled depression in individuals and communities and the secondary result of this disease such as addictions, domestic and community violence, and suicide, IHS will be able to fund more professionals in the behavioral health disciplines.

To help accomplish these purposes, funds will be distributed among several different programs as follows:

Proposed Distribution of Indian Health Professions Funds in FY 2007

Section	Title	Amount	Expected Outcome
103	Health Professions Preparatory	$3,678,190	122 agreements, both new and

	Scholarship Program for Indians		continuing.
104	Indian Health Professions Scholarship	$10,512,326	347 contracts, both new and continuing.
105	Indian Health Service Extern Programs	$902,242	200 temporary clinical assignments
108	Indian Health Service Loan Repayment Program	$13,033,555	348 contracts in FY 2006.
112	Quentin N. Burdick American Indians into Nursing Program	$1,734,500	6 grants
114	INMED Program	$1,085 ,187	2 grants
217	American Indians into Psychology Program	$750,000	3 grants
TOTAL		**$31,696,000**	

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

Fiscal Year	Amount	FTE
2002	$31,165,000	24
2003	$31,114,000	31
2004	$30,774,000	32
2005	$30,392,000	32
2006	$31,039,000	32

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $31,697,000 and 32 FTE is an increase of $658,000 over the FY 2006 Enacted budget of $31,039,000 and 32 FTE. The increase will enable IHS to increase the number of individuals in the loan repayment program and provide:

Pay Costs: +$47,000 will fund the federal pay increases for the IHS scholarship, loan repayment, and recruitment program staff who operate the programs described above.

Increased Costs of Delivering Health Care: +$611,000 to fund inflationary costs to cover the increases of educational expenses for students in the IHS Scholarship Program, using the FY 2007 Economic Assumptions non-medical inflation rate of 2.1 percent.

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

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

	FY 2005 Actual	**FY 2006 Enacted**	**FY 2007 Request**	Increase or Decrease
Discretionary	$2,343,000	$2,394,000	$2,488,000	+$94,000
FTE	0	0	0	0

STATEMENT OF THE BUDGET REQUEST

The budget request of $2,488,000 for Tribal Management is to fund grants to Tribes and Tribal organizations to further develop and improve their management capacity and capability in order to contract programs, services, functions and activities performed by the Indian Health Service (IHS).

PROGRAM DESCRIPTION

The Tribal Management Grant (TMG) Program is a national competitive grant program that awards grants annually to Federally-recognized Tribes and qualified Tribal Organizations. Tribes and Tribal Organizations utilize TMG funding to enhance their management capabilities through such projects as conducting health program related feasibility studies; development of Tribal-specific health plans; Tribal health program operations evaluations; the development or improvement of Tribal health management structures such as establishing Tribal health boards and improving Tribal financial management systems to assist them in assuming all or part of existing IHS programs, services, functions, or activities. The IHS distributes the total appropriated amount into two parts – grant awards and program operations.

PERFORMANCE ANALYSIS

The TMG program's outcomes are consistent with the HHS Strategic Goal 5, "Improve the quality of health care services" as well as the IHS' Strategic Goal 3, "Provide compassionate, quality health care." The TMG program also ties to the Secretary's 500-Day Plan within the "Transform the Healthcare System" component as part of "Supporting community-based approaches to closing the healthcare gap, particularly among racial and ethnic minority populations, including American Indian and Alaska Natives. The TMG program encourages Tribes and Tribal Organizations to be knowledgeable of the HHS and IHS goals and considers these factors in the selection of the proposed projects to be undertaken. Tribes and Tribal organizations continually work

to improve the quality of health care provided to their communities by achieving and maintaining not only Federal standards/regulatory requirements but also applicable health care accreditations. An example of these achievements would include the establishment of, and training of Tribal Health Boars which serve as health advisory committees to Tribal Councils. Through Tribal health board initiatives and recommendations Tribal leaders are better prepared to meet their communities' health needs as well as maintain compliance through implementation of policy and procedure manuals in key areas such as quality assurance, medical records, and information technology systems.

Performance Goal	Results	Context
To provide assistance to Tribes and Tribal Organizations to improve health program management overall and assistance to assume all or part of IHS Programs, Functions, Services and Activities.	Tribes and Tribal Organizations increased participation in Self-Determination contracts, improved capacity to provide services and improved systems for management of their Tribally operated health programs.	The IHS supports the participation of Tribes and Tribal organizations in Self-Determination activities

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

Fiscal Year	Amount	FTE
2002	2,406,000	0
2003	2,390,000	0
2004	2,376,000	0
2005	2,343,000	0
2006	2,394,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $2,488,000 is an increase of $94,000 over the FY 2006 Enacted budget of $2,394,000. The increase will provide:

Increased Costs of Delivering Health Care: +$94,000 for non-medical inflation and the TMG program anticipates awarding 20-30 new and continuation grants during the 2006 and 2007 fiscal years.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services – 75-0390-0-1-551
DIRECT OPERATIONS

Authorizing Legislation: Program authorized by 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	$61,649,000	$62,194,000	$63,804,000	+$1,610,000
FTE	354	354	354	0
Managers/analysts fully trained for 08 UFMS implementation	0	0	350	
IHS employees in leadership positions trained to close knowledge gaps in entrepreneurship and financial management.	0	0	138	

STATEMENT OF THE BUDGET REQUEST

The budget request of $63,804,000 for Direct Operations supports the Indian Health Service (IHS) in carrying out its responsibility of providing leadership, oversight, executive direction and administrative support to 12 regional offices serving approximately 1.9 million American Indians and Alaska Natives across the U.S.

PROGRAM DESCRIPTION

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

The **Headquarters** operations are determined by statute and administrative requirements set forth by the Department of Health and Human Services, the Administration, the Congress, and field operations (12 Area Offices, and 167 Service Units). Headquarters actively works with the Department to formulate and implement national health care priorities, goals, and objectives. The agency works with the Department to formulate a budget and necessary legislation. In addition, it responds to congressional inquiries, and interacts with other governmental entities to enhance and support health services for Indian people. The IHS Headquarters also formulates policy and distributes resources,

provides general program direction and oversight for IHS Areas and Service Units, provides technical expertise to all components of the Indian health system (I/T/U), maintains national statistics, identifies trends and projects future needs.

The **12 Area Offices** distribute resources, monitor and evaluate the full range of comprehensive health care and community oriented public health programs and provide technical support to IHS direct and Tribally operated programs. They ensure the delivery of quality health care through the 167 Service Units and participate in the development and demonstration of alternative means and techniques of health services management and delivery to promote the optimal provision of health services to Indian people through the Indian health system.

The **budget funds Headquarters and 12 Area offices operations, and Tribal shares** (as indicated by the table below).

	FY 2005 Enacted	FY 2006 Enacted	FY 2007 Estimate
Headquarters (56.5%)	$34,850,000	$35,140,000	$36,049,000
Title I Contracts (non-add)	*2,100,084*	*2,131,585*	*2,163,559*
Title V Compacts (non-add)	*5,407,354*	*5,488,464*	*5,570,791*
Area Offices (12) (43.5%)	26,899,000	27,054,000	27,755,000
Title I Contracts (non-add)	*787,037*	*800,873*	*812,886*
Title V Compacts (non-add)	*7,265,650*	*7,374,635*	*7,485,255*
BA	**$61,649,000**	**$61,376,000**	**$65,801,000**
FTE	354	354	354
Headquarters	*200*	*200*	*200*
Area Offices (12)	*154*	*154*	*154*

PERFORMANCE ANALYSIS

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

Leadership and direction also includes specific focus on the PMA, the HHS Top 20 Performance Objectives, and the Secretary's 500 Day Plan. The IHS will carry out and report on specific activities in the 7 of the 10 government-wide objectives of the PMA. The Department tracks the performance of all HHS Operating Divisions by the use of a Management Scorecard which reflects the PMA objectives. For FY 2007, IHS activities will continue in the following areas:

1. Strategic Management of Human Capital—performance contracts and workforce planning;
2. Competitive Sourcing—Tribal self-determination;

3. Improved Financial Performance—support the implementation timeline for the HHS Unified Financial Management System and continued audit improvements and fiscal monitoring;
4. Expanded Electronic Government—support and implement current and planned e-Gov activities (e.g., e-grants, e-learning, e-travel, automated position hiring and classification, I procurement, migration to HHS mail, implementation of HSPD-12 access to information systems); and,
5. Budget and Performance Integration—GPRA and Program Assessment Rating Tool;
6. Faith Based and Community Solutions; and
7. Federal Real Property Asset Management-- effectively managing the construction, monitoring and appropriate disposal of health care facilities.

Significant activities include the establishment of performance plans that cascade throughout the agency and provide for performance accountability at all levels of the agency. This activity was fully established in FY 2004 and refined in FY 2005 and FY 2006. Another activity is the complex planning and preparation of the implementation of the HHS Unified Financial Management System in the IHS in FY 2008. This system will substantially improve the management and accounting of financial resources made available to the IHS. It will also enable the replacement of legacy support systems into a complete and comprehensive financial management system.

The Direct Operations budget provides significant leadership and oversight for the accomplishment of the performance measures that are included in the IHS Annual Performance Plan. The measures address many of the administrative aspects of providing health care to American Indian and Alaska Native population. In addition, management improvements will be guided by the President's Management Agenda and the Department's Top 20 Performance Objectives.

Performance Plan FY 2007 -- The IHS FY 2007 Performance Plan complies with the requirements of the GPRA and the objectives contained in the President's Management Agenda (PMA), the Department's Program and Management Objectives, of the Secretary of Health and Human Services (HHS), and the *HealthyPeople 2010* goals of achieving equivalent and improved health status for all Americans over the next decade. The long-term projected outcome of the FY 2007 Performance Plan has been enhanced (in FY 2004) to incorporate revisions to the IHS Strategic Plan and the HHS Strategic Plan. The IHS and its stakeholders have always considered the GPRA and its requirements as a natural extension of the public health model the Agency has used effectively for almost a half century to make significant improvements in the health status of Indian people.

Headquarters, through this activity, will continue to develop and expand its crosscutting collaborations and partnership with other Federal agencies and outside organizations to achieve common goals and objectives addressing health disparities of American Indian and Alaska Natives. The magnitude of health disparities and resources needed require crosscutting networks to meet some GPRA performance measurements, and PMA objectives, such as (**a**) linking performance measurements to the budget and eventually to

cost, and (**b**) preparing the workforce to meet challenges in the delivery and administration of health care and (**c**) developing and refining Information Technology Planning, Capital Planning, and Program Evaluation as the environment changes in response to Tribal contracting and compacting, changes in technology, and health care in the U.S.

Performance Goal	Results	Context
Implement a 4 year (2005-2008) human capital strategy to assist managers with succession planning activities.	The plan has been developed and is currently being implemented. Competency studies have been completed for 13 critical functions at the Service Unit, Area Office and Headquarters office levels and will influence recruitment, training and development of staff for these functions.	Twenty-nine percent of IHS employees will be eligible for retirement in the next 2 years. Enhancing the IHS workforce's knowledge and skills in areas such as financial management, entrepreneurship and the application of regulations has been identified as critical to meet the IHS' current and future needs to fulfilling the mission of the IHS.

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $63,804,000 and 354 FTE is an increase of $1,610,000 over the FY 2006 Enacted budget of $62,194,000 and 354 FTE. The increase will provide for the following:

Pay Costs: +$1,281,000 – for Federal and Tribal pay increases. The provision of these funds is necessary to maintain the current IHS and Tribal health system which works to eliminate disparities in health status between the American Indian and Alaska Native population and the rest of the U.S.

Increased Costs of Delivering Health Care: +$329,000 – The additional funding will cover the increases in costs using the FY 2007 Economic Assumptions non-medical inflation rate of 2.1 percent for travel, training, supplies and equipment, and services required for Federal and Tribal employees.

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

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

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Request	Increase or Decrease
BA	$5,586,000	$5,668,000	$5,847,000	+$179,000
FTE	6	6	6	0

STATEMENT OF THE BUDGET REQUEST

With this budget request the Office of Tribal Self-Governance (OTSG) will provide technical assistance to approximately 362 Tribes and Tribal organizations; fund up to 24 Tribes with planning and negotiation grants; continue to fund the Government Performance and Results Act (GPRA) pilot projects; and address Tribal shares funding needs in Areas and Headquarters for any new Tribes entering self-governance.

PROGRAM DESCRIPTION

In FY 1992, the IHS was instructed by Congress to initiate planning activities with Tribal governments with approved Department of Interior self-governance compacts for the development of a Self-Governance Demonstration Project (SGDP) as authorized by P.L. 100-472. Through enactment of P.L. 102-573, the Indian Health Care Amendments of 1992, authority to fund the Tribal SGDPs was extended to IHS and the OTSG was established. Through enactment of P.L. 106-260, the Tribal Self-Governance Amendments of 2000, permanent authority was given to Title V, Tribal Self-Governance. Since 1993, the IHS, in conjunction with Tribal representatives, has been engaged in a process to develop methodologies for identification of Tribal shares for all Tribes. Tribal shares are those funds historically held at the Headquarters and Area organizational levels of the IHS. **In FY 2007 approximately $1.082 billion will be transferred to support 114 compacts.**

The FY 2007 funding request for Self-Governance of $5.8 million would provide: the OTSG operating budget of $3.3 million and a reserve fund of $2.5 million for shortfall. These funds were appropriated to fund shortfalls in compact funding in cases where there cannot be a direct transfer of funds from IHS to the tribes to fund self-governance compacts without jeopardizing the support provided by IHS to other tribes. Therefore, the **reserve funds** are used (1) to ensure that funding of Tribal shares under Self-Governance compacting does not adversely impact non-Self-Governance Tribes. These funds are provided directly to the Self-Governance Tribes or to Area Offices and/or Headquarters programs and the OTSG so that Self-Governance Tribes may receive their

full funding of Tribal shares as provided for in P.L. 106-260, (2) for Self-Governance costs incurred as the result of special circumstances, and (3) to support special projects that enhance Self-Governance Activities.

PERFORMANCE ANALYSIS

The Self-Governance budget supports a system of care implemented at the local level by Tribal governments through their Compacts and Funding Agreements. The OTSG budget further supports accomplishments through:

- GPRA through various Tribal pilot projects throughout the country which the OTSG continues to fund;
- a Best Practices project which compiled and documented the successful outcomes of the Self-Governance Tribes, which included the following as examples:

  - Expansion of the Community Health Aide program and the use of telemedicine systems;
  - Promoting preventive care, physical fitness and healthy living;
  - The use of traditional medicine in their health system;
  - Medical nutrition therapy, a breast and cervical cancer early detection program, diabetes prevention and intervention;
  - New programs – drug and alcohol, preventive health, dental and expanded elder care;
  - Emphasis on creating a better healthier life for their children and future generations - a Youth Mentor Program was developed.

- Patient Administrative Management System (PAMS) which will help with improved data collection for all Tribes and Tribal organizations.

Performance Goal	Results	Context
Provide support and funding to Tribes and Tribal Organizations in assuming all or part of IHS Programs, Functions, Services, and Activities to manage their own health care.	Tribes and Tribal Organizations participation in Self-Governance compacting, expanding services provided, and improving their Tribally operated health programs, clinics and hospitals.	The IHS supports the participation of Tribes and Tribal Organizations in Self-Governance activities.

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

OTSG is currently addressing the following elements of the Secretary's 500-day plan – Transform Health Care System. These are:

- Expressing a clear vision of health information technology that conveys the benefits to patients, providers and payers. In 2003, the Choctaw Nation, Chickasaw Nation and Gila River (CCG) Consortium formed a partnership with IHS to create PAMS.

OTSG continues to work conjointly with the Office of Information Technology in order to promote and expand the PAMS. The developed software pulls information from RPMS and creates claims, runs through edit checks, prints claims, manage work queues, edits claims, period closing, etc and services are being pulled from RPMS. PAMS was in beta phase in November 2005. Distribution will be available for all Tribes in early 2006.

- Expressing a clear vision of health information technology that conveys the benefits to patients, providers and payers. OTSG continues to provide funding for GPRA pilot projects. Specifically, the Alaska and Nashville Areas have worked conjointly with the IHS in developing the Clinical Reporting System software, which is a reporting tool for GPRA as well as other indicators. It was first released in FY 2002, and is currently released every year. It is available to all Tribes.

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

Fiscal Year	Amount	FTE
2002	$9,876,000	8
2003	$5,553,000	8
2004	$5,644,000	8
2005	$5,586,000	6
2006	$5,668,000	6

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $5,847,000 and 6 FTE is an increase of $179,000 over the FY 2006 enacted budget of $5,668,000 and 6 FTE. The increase will provide for:

Pay Costs: +$20,000 to fund pay increases for Federal employees, specifically for the Office of Tribal Self-Governance located within IHS Headquarters.

Increased Costs of Delivering Health Care: +$159,000 to fund inflationary costs associated with ongoing operations using the FY 2007 Economic Assumptions non-medical inflation rate of 2.1 percent.

DEPARTMENT OF HEALTH AND HEALTH SERVICE
Indian Health Service
Services: 75-0390-0-1-551
CONTRACT SUPPORT COSTS

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

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Request	Increase or Decrease
BA	$263,683,000	$264,730,000	$270,316,000	+$5,586,000
FTE	0	0	0	0

STATEMENT OF THE BUDGET REQUEST

The budget request of $270,316,000 for Contract Support Costs will fund costs which are required to be provided to Tribal governments and Tribal organizations, to assist in establishing and maintaining support systems (e.g., administrative and accounting systems) needed to administer self-determination agreements and to ensure compliance with the contract and prudent management.

PROGRAM DESCRIPTION

The Indian Self-Determination and Education Assistance Act (ISDEAA) allows Tribes to assume operation of Federal programs and to receive not less than the amount of direct program funding that the Secretary would have otherwise provided for the direct operation of the program. Currently about $1.6 billion of the Agency's appropriation is under Tribal Health Administration under Title I and V of the ISDEA. The ISDEAA also provides that there be added to the program amount, contract support costs. The CSC are defined in the ISDEAA as the reasonable costs for activities either not normally provided by the Secretary in his/her direct operation of the program, or were provided by the Secretary in support of the program from resources other than those under contract.

Specific elements of CSC include are:

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

The IHS has had a CSC policy in existence since 1992 that governs the administration and allocation of CSC. The policy was developed through extensive consultation and participation of Tribes. The original policy has been revised on several occasions, most recently September 1, 2004, based on the Agency's accumulated experiences and

discussion with Tribal leaders. The policy, Circular on CSC No. 2004-03, conforms to applicable OMB Circular A-87 cost principles.

PERFORMANCE ANALYSIS

The Congress and the Office of Management and Budget have requested that the IHS continue to review the soundness of its allocation policies concerning CSC and to take steps to assure that CSC provided to Tribes are reasonable and do not replicate other funding provided to Tribes by the IHS under self-determination agreements. Consequently, the IHS established an element under the Government Performance and Results Act (GPRA) to provide specific technical assistance to Tribes in the area of calculating CSC, and to review each Tribal request that is submitted for CSC using a protocol to ensure that CSC that are approved are consistent throughout the IHS system and not duplicative of other funding provided to Tribes.

This element ties in directly with seven of the eight HHS Strategic Goals and Objectives (Goal 4: Enhance the capacity and productivity of the Nation's Health science research enterprise, would not apply).

Performance Goal	Results	Context
Review each Tribal request that is submitted for CSC using a protocol to ensure that CSC that is approved is consistent throughout the IHS system and not duplicative of other funding provided to Tribes.	The IHS continues to provide technical assistance to Tribes regarding the calculation of CSC as defined by requirements articulated in the Agency's CSC Policy (i.e., IHS CSC Circular 2004-03). Further, the IHS has implemented protocols, "Standards for the Review and Approval of Contract Support Costs in the Indian Health Service," to ensure the consistency, as well as non-duplication, of all types of costs approved as CSC in the IHS.	This performance goal is a process administrative measure and refers to the Agency's mission of supporting Tribal self-determination by equitably distributing and funding CSC requirements.

Throughout calendar year 2005, IHS funded tribally operated health programs (TOHP) were the subject of the performance assessment rating tool (PART) in preparation of the 2007 budget cycle. CSC accounts for approximately 16% of the total funding provided to TOHP yet it is a key element of cost affecting the overall performance of TOHP. TOHP received a rating of Adequate. Generally, this rating describes a program that needs to set more ambitious goals, achieve better results, improve accountability or strengthen its management practices. The PART assessment found that TOHP maintain or improve the overall health of AI/ANs each year, as measured by independent evaluations and clinical indicators like screening rates for medical conditions. Most notably, the programs have reduced Years of Productive Life Lost by 11% over the past decade. However, performance information is only available for programs that voluntarily report the data, or 85% of AI/ANs served in 2005. By law, the government cannot require tribal programs to submit performance data or hold them accountable for

improving program performance. These restrictions make it difficult to identify deficiencies and improve program performance. Tribes do not inform the Indian Health Service of how much funding they receive from other sources, such as Medicare and Medicaid. As a result, it is difficult to determine the relationship between overall funding levels and program performance. More information on this PART assessment can be found at www.expectmore.gov.

Finally, in continuing to manage CSC funding, and in response to the March 2005 Supreme Court decision in Cherokee Nation v. Leavitt[1], the IHS has issued additional guidance concerning any new or expanded contracts or compacts being entered into for the balance of FY 2006 or anticipated in FY 2007. This guidance requires that Tribes and the IHS reach agreement concerning the amount of ISD/CSC funding available and the obligation of the IHS to fund CSC pursuant to the appropriations "cap" on CSC. If there is no agreement on the part of the Tribe then the new or expanded program request will likely be declined. These principles need to be adhered to in the face of limited CSC appropriations, or in instances where CSC funding may not be available in order for the IHS to enter into new contracts or compacts under the Indian Self-Determination and Educations Assistance Act. If the Tribe and the IHS could not reach agreement, the proposal to contract for the new and expanded PFSA/PSFA would be declined.

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

Fiscal Year	Amount	FTE
2002	$268,234,000	0
2003	$268,974,000	0
2004	$267,398,000	0
2005	$263,683,000	0
2006	$264,730,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2007 budget request of $270,316,000 and 0 FTE is an increase of $5,586,000 over the FY 2006 Enacted budget of $264,730,000 and 0 FTE. The increase will provide:

Increased Costs of Delivering Health Care: +$5,586,000 to fund increases in Tribes' administrative costs using the FY 2007 Economic Assumptions non-medical inflation rate of 2.1 percent.

[1] In ***Cherokee Nation of Oklahoma et.al. v. Leavitt, Secretary of Health and Human Services, et. al.***, the Supreme Court ruled that the IHS had received an unrestricted appropriation sufficient to provide the plaintiff Tribes full funding of contract support cost pursuant to their ISDEAA contracts with the Federal Government in fiscal years 1995, 1996, and 1997.

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

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

	FY 2005 Enacted	FY 2006 Enacted	FY 2007 Estimate
Medicare:			
Federal	$95,926,000	$96,414,000	$96,414,000
Tribal [1]	6,986,000	6,986,000	6,986,000
Tribal [2]	33,559,000	33,559,000	33,559,000
Subtotal:	136,471,000	136,959,000	136,959,000
Medicaid:			
Federal	375,067,000	381,085,000	381,085,000
Tribal [1]	22,217,000	22,217,000	22,217,000
Tribal [2]	75,181,000	75,181,000	75,181,000
Subtotal:	472,465,000	478,483,000	478,483,000
Medicare/Medicaid Total:	608,936,000	615,442,000	615,442,000
Private Insurance	62,389,000	62,389,000	62,389,000
TOTAL:	**$671,325,000**	**$677,831,000**	**$677,831,000**
FTE	4,173	4,173	4,173

[1] Represents CMS Tribal collection estimates.
[2] Represents estimates of Tribal collections due to direct billing that began in FY 2002.

PROGRAM DESCRIPTION

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

Medicare/Medicaid

The FY 2007 Medicare/Medicaid (M/M) budget estimate continues the FY 2006 revised collection estimate of $615,442,000. The FY 2006 revised estimate assumes the FY 2005 actual collections will be increased by $6,506,000 to fully incorporate the calendar year (CY) 2005 rate changes for M/M. The CY 2005 rate changes were approved following a

review of 46 IHS hospital cost reports for FY 2003. A priority is being placed on the development of FY 2004 hospital cost reports as future rate adjustments will be proposed following their completion and analysis.

In FY 2006 and FY 2007, the IHS will continue to focus on strengthening business office policies and management practices including internal controls, patient benefits coordination, provider documentation training, certified procedural coding training, automated claims processing and system improvements in third party billing and accounts receivable.

In FY 2006, IHS will focus on expanding current policies to strengthen internal controls and revising the business office operations manual to reflect new policies and procedures and improved business practices. The IHS plans to improve the processing of claims through a major rewrite of its third party billing package to ensure increased claims processing accuracy and HIPAA compliance. Continuing efforts to provide appropriate training for operations staff and managers focus on a team approach to third party revenue management.

In FY 2006 and FY 2007, the IHS will continue working with Centers for Medicare and Medicaid Services (CMS) and the State Medicaid Offices to improve each program's capability to identify patients who are eligible to participate in Medicare and Medicaid programs. IHS will also continue to work with the CMS and the Tribes to resolve a number of third party reimbursement issues, including training and implementing key provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

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

Private Third Party Collection

The FY 2007 Private Insurance budget estimate continues the FY 2006 revised collection level. During FY 2006 and in FY 2007, IHS will continue its efforts to enhance each health facility's capability to identify patients who have private insurance coverage and improve claims processing to increase private insurance billing and collections. Funds collected will be used by the local Service Units to improve services, including the purchase of medical supplies and equipment, and to improve local service unit business management practices. Actual FY 2005 collections exceeded FY 2004 collections by $9.5 million or 18 percent.

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

(Dollars in Thousands)

Type of Obligation	FY 2005 Estimate	FY 2006 Estimate	FY 2007 Estimate
Personnel Benefits & Compensation	$300,980	$314,145	$326,886
Travel & Trans.	3,956	3,825	3,610
Trans. of Things	1,881	1,825	1,720
Comm./Util./Rent	5,010	5,162	4,867
Printing & Repro.	183	177	167
Other Contractual Services	87,847	85,345	80,532
Supplies	101,410	98,261	92,698
Equipment	13,068	12,687	11,947
Land & Structures	6,966	6,757	6,359
Grants	11,731	11,365	10,778
Insur./Indemnities	256	248	237
Interest/Dividends	94	91	87
Subtotal	533,382	539,888	539,888
Tribal Collections	$137,943	$137,943	$137,943
Total Collections	**$671,325**	**$677,831**	**$677,831**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services –75-0390-0-1-551
SPECIAL DIABETES PROGRAM FOR INDIANS

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

	FY 2005 Actual	FY 2006 Enacted	FY 2007 Budget	Increase or Decrease
BA	$150,000,000	$150,000,000	$150,000,000	0
FTE	0	0	0	0

The Balanced Budget Act of 1997 (P.L. 105-33) provided that $30 million per year appropriated to the Children's Health Insurance Program (CHIP) be transferred to Indian Health Service for diabetes prevention and treatment for 5 years ending in FY 2002 called the *Special Diabetes Program for Indians* grant program. An additional $70,000,000/year was provided under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 for FY 2001 and FY 2002, and $100,000,000 was provided for FY 2003. These funds support the Secretary's initiative to prevent diabetes and obesity, as well as a focus on healthier youth.

STATEMENT OF THE BUDGET REQUEST

The *Special Diabetes Program for Indians* annual budget of $150,000,000 is to award grants for the prevention and treatment of diabetes among American Indian and Alaska Natives. The Special Diabetes Program for Indians grant was reauthorized in December 2002 (P.L. 107-360) for five years (FY 2004 – FY 2008) at $150 million per year, a $50 million per year increase.

SDPI Appropriation

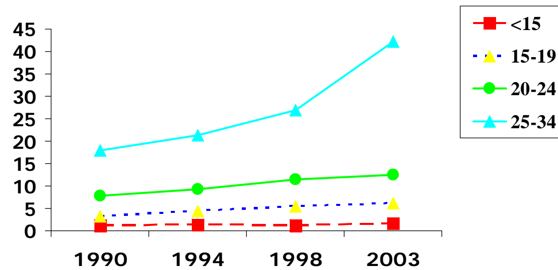
The initial *Special Diabetes Program for Indians (SDPI)* appropriation was authorized by Congress in 1997 in response to alarming trends documenting a disproportionately high rate of type 2 diabetes in American Indian and Alaska Native (AI/AN) communities. It came in the wake of increasing public concern about the human and economic costs of diabetes in the U.S. and the growing prevalence among the AI/AN population. Congress directed the IHS to implement a grant process to distribute the funding of the *SDPI*. The *SDPI* was implemented according to legislative intent through a process that included formal tribal consultation, a methodology and process for distribution of the funds to eligible entities, and a formal grant application and administrative process.

The *SDPI* reauthorization for $150 million for FY 2004-2008, directed the IHS to expand the program and implement a competitive grant program for eligible entities for the implementation of specific interventions proven to prevent diabetes and reduce cardiovascular risk, the most compelling complication of diabetes. Funds were also directed towards data improvement. In addition, distribution of funds to original *SDPI* grantees for the prevention and treatment of diabetes continued.

PROGRAM DESCRIPTION

American Indian and Alaska Native (AI/AN) communities suffer a disproportionately high rate of type 2 diabetes. Between 1997 and 2003, the prevalence of diabetes increased by 41 percent in all major regions (all ages) served by the Indian Health Service (34 percent among adults). The highest rate of increase has occurred among AI/AN young adults aged 25-34 years, with a 135 percent increase from 1990-2003.

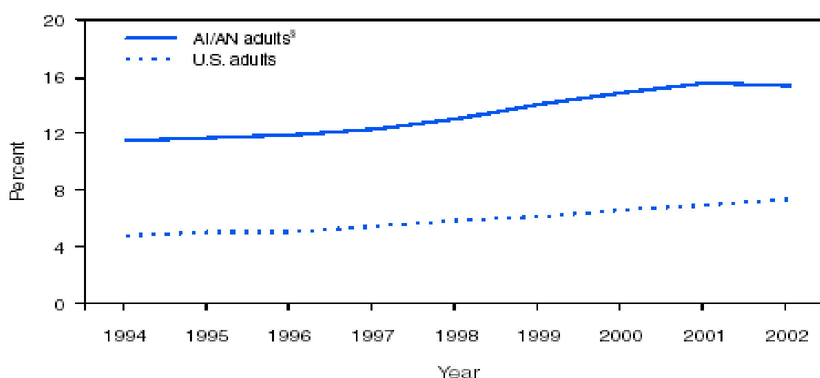
Prevalence of diagnosed diabetes among children and young people, by age group, 1990-2003



In 2003, of AI/AN aged 35 years or older, nearly 70 percent had both diabetes and hypertension. Diabetes mortality is more than 3 times (3.1) higher in the AI/AN population than in the general U.S. population (1999-2001). Complications of diabetes lead to much higher incidence rates of blindness, vascular insufficiency leading to amputation, and End Stage Renal Disease (ESRD) than in the general U.S. population. For instance, in 2000 in New Mexico, the age-adjusted lower-extremity amputation rate was 3.5 times higher for American Indians (AI) with diabetes than for non-Hispanic whites (11.4 versus 3.3; $p<0.05$). In 2001, the age-adjusted ESRD incidence among American Indians in the Southwest was 2.4 times that of persons with diabetes in the U.S. (55.8 vs. 23.4/10,000 persons with diabetes). In 2002, one in every four (24.8 percent) AI/AN elders over age 65 years had coronary heart disease (or one of every five of those aged 55 and older).

There has been some good news recently. Since 1993, the incidence of diabetes-related ESRD among American Indians in the Southwest decreased by 31 percent, which may be due to the reduction in risk factors and improvements in diabetes care practices in Indian communities.

FIGURE. Age-adjusted prevalence* of diagnosed diabetes among American Indian/Alaska Native (AI/AN) and U.S. adults aged ≥20 years, by year — United States, 1994–2002†



* Based on the 2000 U.S. population.
† Based on Indian Health Service ambulatory patient-care data and the Behavioral Risk Factor Surveillance System.
§ Although the rate of increase in diabetes prevalence among AI/ANs slowed during 2001–2002, additional data are needed to assess recent trends.

IHS Division of Diabetes Treatment and Prevention

The IHS Division of Diabetes Treatment and Prevention (DDTP) provides leadership and programmatic administrative oversight to the *Special Diabetes Program for Indians* grant program. The mission is to develop, document, and sustain a public health effort to prevent and control diabetes in AI/ANs. This mission is accomplished by promoting collaborative strategies for the prevention of diabetes and its complications to over 1.8 million American Indians and Alaska Natives through its extensive diabetes network. The network consists of a national program office; Area Diabetes Consultants in each of the 12 IHS Areas; 19 Model Diabetes programs in 23 different IHS and Tribal sites, and 333 non-competitive and 66 competitive local IHS, Tribal and Urban Indian SDPI grant programs. The 66 competitive SDPI grant programs, awarded in FY 2004, are comprised of 30 CVD risk reduction demonstration projects and 36 diabetes prevention demonstration projects. This extensive diabetes network supports the *SDPI* grant programs by providing administrative support, training and technical assistance and the dissemination of the latest scientific findings and best practices to the programs. Now the most comprehensive rural system of care for diabetes in the U.S., the IHS combines both clinical and public health approaches to address the problem of diabetes and its complications.

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

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

Special Diabetes Program for Indians
SDPI funds originally provided "seed money" to the 333 non-competitive grant programs to begin or enhance diabetes prevention programs in Indian communities as well as to address diabetes treatment. The result has been the creation of innovative, culturally appropriate strategies that address diabetes. The *SDPI* funds have significantly enhanced diabetes care and education in AI/AN communities, as well as built a desperately needed infrastructure for diabetes programs. The IHS has continued to develop and operate the original SDPI grant programs with 333 IHS, Tribal and Urban Indian grant programs in 35 states. In FY 2004, an additional 66 competitive grants (30 CVD risk reduction grants and 36 diabetes prevention grants) were added to the funding and creating a total of 399 grants.

Tribes and urban Indian organizations have had to make choices about how to best use their local *SDPI* funding to address the problem of diabetes in AI/AN communities. A study published by the American Diabetes Association in 2002 on the economic burden of diabetes in the U.S., estimated that it costs $13,243 per year to care for one person with diabetes compared with $2,560 per year for persons without diabetes. The Indian health care system recognized from the start of this program that it would have to make careful choices about where to invest these funds and knew these choices would best be made locally.

Targeted Demonstration Projects
In 2004 the IHS, in response to Congressional direction, developed and implemented a SDPI competitive Targeted Demonstration Project. The focus of the competitive Targeted Demonstration Project is on primary prevention of type 2 diabetes in those at risk for developing diabetes and reduction of cardiovascular risk in AI/AN diagnosed with type 2 diabetes. Sixty-six grants were awarded and this 5 year program was launched in November 2004. These targeted demonstration projects were not designed to conduct new research. Rather, they were designed to translate findings from scientific studies into the "real world settings" of AI/AN communities and their health care systems. **These efforts support the Secretary's 500 Day Plan to advance medical research and to improve the clinical research network to advance better prevention, early diagnosis and treatment of disease.**

Primary Prevention of Type 2 Diabetes
The results of the Diabetes Prevention Program (DPP) were issued in the

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

To strengthen diabetes prevention efforts in AI/AN communities, the Diabetes Prevention (DP) Targeted Demonstration Project awardees have designed and begun to implement demonstration projects that specifically translate these results to AI/AN communities. The 36 demonstration sites will translate the DPP at a local level in their respective AI/AN community. They are currently operating in their first implementation and recruitment year.

Cardiovascular Risk Reduction
Individuals with diabetes are at risk for cardiovascular disease (CVD), and the incidence of CVD in AI/ANs now exceeds rates in the general population. The Strong Heart Study, a longitudinal cohort study of the risk factors for cardiovascular disease in American Indians, has demonstrated that diabetes is a major risk factor and accounts for the majority of risk for cardiovascular disease events in American Indians. The results of numerous clinical trials demonstrate that the risk of cardiovascular disease in individuals with diabetes can be reduced through control of blood pressure, reduction in cholesterol levels, glycemic control, aspirin use, smoking cessation, physical activity and weight management. The Cardiovascular Disease (CVD) Targeted Demonstration Project provides funding to selected *SDPI* grantees for a demonstration project to aggressively and comprehensively implement and evaluate defined activities in the prevention of cardiovascular disease in people with diabetes. Thirty demonstration sites are currently operating in their first implementation and recruitment year to address cardiovascular risk reduction.

SDPI Summary
The *SDPI* has brought Tribes together over these past 9 years, working toward a common purpose and sharing information and lessons learned along the way. The IHS has shown through its public health evaluation activities that these programs have been very successful in improving diabetes care and outcomes, as well as the start of primary prevention efforts, on reservations and in urban clinics. Our evaluation of *SDPI* and diabetes clinical measures suggests that population-level diabetes-related health is better among our AI/AN patients since the implementation of *SDPI*. The greatest benefit has likely been in the reduction in microvascular complications due to improvement in hyperglycemia. Further reducing microvascular and macrovascular complications will require continued efforts to improve glucose, blood pressure and cholesterol values. As a reflection of the global effect of quality of care and of resource allocation, these trends

demonstrate the public health impact made possible when community, program, and congressional initiatives are focused on a common outcome.

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

- **Tribal Consultation.** A Tribal Leaders Diabetes Workgroup was established in 1998 to review the Area Tribal input and make recommendations on the administration and distribution of the diabetes funds. Based on their recommendations, funds were awarded through non-competitive grants for a 5-year project term. An evaluation process was created for national and regional levels. Consultation was completed for the new funding, $150 million per year from 2004 – 2008, authorized by P.L.107-360. Tribes provided input into the national distribution formula for the local, community-based grants, development of a competitive grant process for the Targeted Demonstration Projects, and strengthening of the IHS data system with these new funds. The Workgroup, now called the Tribal Leaders Diabetes Committee, continues to meet several times each year at the direction of the IHS Director to review information on the progress of the SDPI activities and to provide general recommendations to IHS.

- **Grant Program Evaluation.** The CDC's *Framework for Public Health Evaluation*, which uses a mixed methods approach (both qualitative and quantitative methods), has been implemented and an ongoing analysis of the non-competitive grant programs is conducted. A number of positive short term and intermediate term outcomes were identified in FY 2002 and an updated analysis of these data are scheduled for FY 2006. In addition, the IHS in partnership with IT and the Tribal Epidemiology Centers, has improved the accuracy of baseline long-term measures (prevalence and mortality) and established a Diabetes Data Warehouse and "Data Mart" using RPMS data to measure accurately the long-term complications of diabetes. This partnership will also provide the means for IHS to conduct further in-depth evaluation and validation studies and key informant interviews of SDPI grant program activities in order to begin the dissemination of successful grant program activities.

- **Prevention Efforts.** Prior to the *SDPI*, AI/AN communities had few resources to devote to primary prevention of diabetes. An overwhelming number of diabetes grant programs (96 percent) report that they now use funds to support diabetes primary prevention activities in their communities. The IHS is currently developing two new curriculums – type 2 diabetes and children and diabetes prevention in youth – for dissemination in AI/AN communities. IHS has also developed and finalized Standards of Care and clinical treatment guidelines for Pre-diabetes and Metabolic Syndrome and made them available through the I/T/U diabetes network.

  The implementation of secondary prevention efforts – the prevention of complications such as kidney failure, amputations, heart disease and blindness – and tertiary prevention efforts to reduce morbidity and disability in those who already have complications from diabetes has also been a focus of *SDPI* activities.

Improvement in the treatment for risk factors of cardiovascular disease, the detection and retardation of the progression of diabetic kidney disease, and the detection and treatment of diabetic eye disease have also been achieved since the implementation of *SDPI*.

- **Obesity Prevention Efforts.** Prior to the *SDPI*, AI/AN communities had few resources to devote to obesity prevention efforts which are directly related to prevention of diabetes efforts. In our 2004 SDPI grant program assessment, 62 percent of programs report that they now offer obesity prevention programs for children and 66 percent offer them for youth; 52 percent provide family consultations when children are identified as overweight or obese; 67 percent of programs refer to a dietitian for weight management; and 47 percent of programs offer breastfeeding consultation, in light of the scientific evidence that breastfeeding reduces childhood obesity and diabetes in AI/AN.

  IHS has begun to develop other strategies and approaches to address childhood and adult obesity including: 1) continued training on motivational interviewing and clinical management of adult obesity and childhood overweight; 2) development or adaptation and dissemination of education materials aimed at addressing obesity among AI/AN girls (BodyWorks); and 3) participation in pilot testing a demonstration project aimed at providing training and educational support to clinicians dealing with overweight children and their families (ENVISION NM). In addition, the two new curricula under development, diabetes prevention and type 2 diabetes in youth, will address obesity prevention since the focus is lifestyle changes with weight loss as the key intervention.

- **Screening Activities.** Prior to SDPI, AI/AN communities had few resources to devote to screening for diabetes and pre-diabetes. In our 2004 SDPI grant program assessment, 95 percent of programs reported that they now screen for type 2 diabetes and 84 percent indicate that they now screen for pre-diabetes. In order to identify individuals who are at high risk to develop diabetes and then to offer a prevention intervention, screening must be done. SDPI programs indicated that they are screening for pre-diabetes in children (70 percent), adolescents (87 percent), adults (95 percent) and elders (93 percent). The newly developed Standards of Care and clinical treatment guidelines for Pre-diabetes and Metabolic Syndrome address issues related to these screening activities at the community level.

- **Best Practices Approach.** Based upon Congressional direction, the IHS developed a consensus-based Indian health "best practices" approach to ensure dissemination of successful community based interventions to the SDPI grant programs. This was accomplished by convening best practices workgroups, consisting of experts from IHS, Tribes, urban Indian organizations, the IHS Model Diabetes Programs, and project coordinators from *SDPI* grant sites. The workgroups developed 14 Best Practice Model approaches for successful diabetes prevention, treatment and education practices in AI/AN communities based on findings from the latest diabetes scientific research, outcomes studies, and their own successful experiences. The best

practice models were used by applicants to identify strengths in diabetes resources and services in their communities, find gaps in diabetes services or programs, establish program priorities, find best practice models that could be applied within their own communities, and to begin a work plan to develop their own local best practice models. To assess use of the consensus-based Best Practice Models for AI/AN communities, IHS Area Chief Medical Officers and Area Diabetes Consultants completed assessments of Best Practice Model use with their review of each grant application. Data were then compiled. In 2003, elements of the Nutrition and Physical Fitness Best Practice Model approach were used by 70 percent of grant programs, the Diabetes Screening Best Practice Model approach was used by 70 percent of grant programs, and the Basic Diabetes Care and Education Best Practice Model approach was used by 55 percent of SDPI grantees.

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

1. Basic diabetes care and education – a systems approach
2. Cardiovascular disease and diabetes – screening, treatment, and follow-up
3. Community Advocacy – winning support for your diabetes program
4. Eye care for people with diabetes – screening, treatment, and follow-up
5. Foot care for people with diabetes – screening, treatment, and follow-up
6. Kidney disease – screening, prevention, treatment, and follow-up
7. Medications for diabetes care
8. Nutrition and physical fitness programs
9. Pregnancy and diabetes – screening, management, and follow-up
10. School health – nutrition and physical activity
11. Diabetes screening programs
12. Diabetes self-management education
13. Type 2 diabetes in youth – prevention and screening
14. Dental care for people with diabetes – screening, management and follow-up

All the Best Practice Models were updated in August 2005 and included the development of 4 new best practices – depression, adult weight management, breastfeeding, and communication.

- **CDC/Native Diabetes Wellness Program (formerly the National Diabetes Prevention Center).** One million dollars of the Balanced Budget Act funds have been allocated yearly to CDC Division of Diabetes for the development of a national focus on diabetes prevention in tribal communities. Originally, these funds were earmarked for the development of a National Diabetes Prevention Center to be located in Gallup, New Mexico. The IHS/CDC agreement was originally awarded to the University of New Mexico (UNM). In 2001, UNM redefined the center's area of impact from that of a national perspective to a southwest regional focus and worked primarily with the Zuni Pueblo and Navajo Nation as a UNM center solely for these southwestern Tribes. Beginning in FY 2002, the IHS and the CDC worked collaboratively to redirect the focus of this funding on the development of a national approach to address diabetes prevention. This led to the expansion of the NDPC, now

known as the Native Diabetes Wellness Program or NDWP. Based on input from SDPI grant programs nationwide, the Tribal Leaders Diabetes Committee, and the IHS, NDWP has focused support for the dissemination of diabetes technical assistance resources including program evaluation, educational materials on diabetes and prevention of diabetes, and other diabetes data. The NDWP has provided support to the American Indian Higher Education Consoritum (AIHEC) to develop a K-12 curriculum on diabetes and science called Diabetes Education in Tribal Schools Project (DETS). Of significance, is the development of a series of 4 children's books called the Eagle Books for use in a variety of settings aimed at diabetes awareness and encouraging healthy lifestyle habits in order to prevent diabetes and obesity. Plans for dissemination are currently underway.

- **Tribal Management of Local Grant Programs.** Eighty-one percent of the *SDPI* non-competitive grant recipients are Tribal programs while ten percent were awarded to urban Indian programs and nine percent to IHS programs. To responsibly manage a health program requires data that supports an assessment of the health needs of the population. To meet this need, Tribal programs were well represented in the IHS 2005 Diabetes Care and Outcomes Audit of AI/AN with diagnosed diabetes and will have the opportunity to participate in the 2006 audit. Data gathered by these audits provides Tribes with information to guide the management of their diabetes programs.

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

- **Joslin Vision Network (JVN) Tele-ophthalmology Project.** The JVN is a telemedicine system that uses low-level illumination and no pupil dilation to remotely diagnose and manage diabetic retinopathy. The acquired retinal image is sent electronically to a reading center using existing IHS networks, and an analysis of the level of diabetic retinopathy and recommended management is returned to the remote site. The IHS has deployed this technology at 32 sites in 14 states. The outcome of this technology has been evaluated and shown to increase both examination rates and treatment rates by 50 percent (Diabetes Care, February 2005, 28:318-322).

  In addition, the IHS Albuquerque Area is developing a strategy for an Area-wide deployment as a coherent public health initiative based on the needs and resources defined with input by the local IHS, tribes and urban Indian health programs. The IHS/JVN National Reading Center has three certified readers who also provide direct clinical care at the Phoenix Indian Medical Center. Work continues on the development of a portable JVN for use in Alaska and sparsely populated sites in the lower 48.

- In addition to the Joslin Vision Network, the IHS is in its 5th year of partnering with the Joslin Diabetes Center, the Veterans Administration and the Department of Defense to deploy a web-based case management system called the Comprehensive

Diabetes Management Program (CDMP). The CDMP is interactive with the IHS health information system (RPMS) and provides the latest patient health information at any location via the web to case managers. With this information and the CDMP case management software, the quality of care for individuals with diabetes can be improved and better coordinated between other diabetes providers. Recent enhancements to the core application in Version 4.1of CDMP includes a behavioral assessment; education needs assessment tool; nutrition assessment (2 levels); basic clinical information, including a patient snapshot, a care planning tool, a medication module and patient education materials. There is also a patient portal (DME), a Study Manager and a JVN Work Manager which is an interface between JVN and CDMP (diagnostic report, images and a reporting tool).

- **NIDDK/IHS/TLDC/AIHEC collaboration to recruit AI/AN Students into biomedical Science Research and Diabetes Careers and DETS (Diabetes Education in Tribal Schools) Project.** Since FY 2001, the IHS and National Institutes of Diabetes Digestive and Kidney Disease (NIDDK) have collaborated on a project to encourage young AI/AN students to consider careers in biomedical research and diabetes. This project also involves the CDC Native Diabetes Wellness Program and the American Indian Higher Education Consortium (AIHEC), which represents the 34 Tribal colleges around the country. This successful program is in its fifth year of working to develop comprehensive science curricula that encourage young AI/AN students to enter the sciences.

- **CDC Division of Diabetes Translation.** IHS and CDC collaborate on projects with American Indian Research and Education Centers at the University of Nevada at Las Vegas and the University of New Mexico on the development of data software programs for collection and analysis, and support for development of an Associate of Science curriculum in diabetes prevention.

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

  The CDC has detailed one full time physician /medical epidemiologist who is board certified in Family Medicine and Preventive Medicine to the IHS DDTP and Epidemiology program from the CDC/CCDPHP/Division of Nutrition and Physical Activity since October 2004. Key elements from the interagency agreement covering this detail include supporting an evaluation of the Boys and Girls Club-based Diabetes Prevention Initiative, providing technical assistance to the IHS on diabetes data quality improvement, initiating a system of surveillance for childhood and adult obesity to guide program implementation and evaluation, providing technical assistance to the IHS and Tribes on best practices for obesity prevention and early intervention, and facilitating collaborations among the IHS, CDC, Tribes, and States around obesity prevention. This interagency agreement was initiated in 2004 and can be renewed annually for 5 years.

- **National Congress of American Indians and Native American Boys and Girls Clubs.** The Indian Health Service (IHS), the National Congress of American Indians (NCAI), the Boys & Girls Clubs of America (BGCA) and Nike, Inc. have partnered to create and implement a program aimed at reducing the onset of diabetes among American Indian youth. The program—On the T.R.A.I.L. (Together Raising Awareness for Indian Life) to Diabetes Prevention—is an innovative combination of physical, educational and nutritional activities that promote healthy lifestyles for children and youth. The program is being piloted in 27 American Indian Boys and Girls Club sites.

- **Head Start Bureau**. The IHS has partnered with the Head Start Bureau to plan and implement obesity prevention activities for the AI/AN Tribal Head Start programs. Activities include coordination of a breastfeeding promotion campaign for Early Head Start, dissemination of best practices for obesity prevention in early childhood, building playgrounds, physical activity and nutrition.

- **Committee on Native American Child Health (CONACH).** The IHS Division of Diabetes Treatment and Prevention continues to collaborate with the American Academy of Pediatrics subcommittee CONACH. DDTP serves on the Childhood Obesity Task Force of CONACH and supports their efforts to address the school health needs of American Indian/Alaska Native children in boarding schools. Planning is underway for the second International Meeting on Inuit and Native American Child Health in 2007. The first conference was held April 29 – May 1, 2005 in Seattle, Washington. Over 750 health care professionals and researchers who work with Inuit, First Nations, American Indian and Alaska Native populations attended to share innovations in clinical care and research, and to work to improve the health of Native children and Native communities.

The IHS collaborates with a number of other federal agencies and organizations to **promote the awareness of diabetes** including the following:

- American Diabetes Association. Staff has served on the ADA Board of Directors, Publications Committee, ADA Youth Projects Design Team and the Awakening the Spirit Native American Outreach Program. The DDTP has collaborated with the ADA to provide key information on Native American community processes, contacts and other links, and methods for dissemination of information.

- American Indian Higher Education Consortium. This is a key partnership to build Tribal college and university capacity to aid AI/AN communities in providing staff and resources to support diabetes prevention and treatment efforts.

- CDC's State Diabetes Control Programs. Sharing skills, resources and training programs at the state level helps to promote increased surveillance of diabetes and its complications, local diabetes care and education quality improvement activities and the dissemination of the latest scientific findings relevant to diabetes treatment and prevention in local Tribal communities.

PERFORMANCE ANALYSIS

In accordance with the "One HHS" 20 Department-wide Objectives, the Indian Health Service is committed to implementing results-oriented management by achieving a 10 percent relative increase in program performance by FY 2007 in LDL (low-density lipoprotein cholesterol – the "bad" cholesterol) screening in patients with diabetes. Low cholesterol levels help to protect patients with diabetes from developing heart disease. Improved control of cholesterol levels reduces the risk of cardiovascular complications by 20 – 50%. In addition, national standards recommend that patients with diabetes keep their LDL cholesterol levels below 100, ideally. The average LDL value for AI/AN's from the IHS Annual Diabetes Care and Outcomes Audit data has decreased from 118 mg/dl in 1998 to 100 mg/dl in 2005.

Besides LDL screening, five other diabetes performance measures are included within the annual Performance Budget of the Indian Health Service. These measures track different aspects of diabetes care, including blood sugar control. This extraordinary number of measures reflects the excessive diabetes disease burden in American Indian/Alaska Native communities. Despite this excessive diabetes disease burden, **the Indian Health Service met all performance targets for FY 2005 from the IHS Annual Diabetes Care and Outcomes.**

Emphasis on diabetes care within IHS' Hospital and Health Clinics budget recognizes the role of diabetes as a major cofactor in morbidity as well as one of the major causes of mortality among AI/AN people. During the FY 2004 budget process, the IHS PART included a review of the IHS Direct Federal Programs and the Hospital and Clinics Budget, where the funding for diabetes care resides. The program received a rating of "Moderately Effective." IHS shared the PART review results with the clinical providers and healthcare facilities of the Indian health system. These improved trends in diabetes care demonstrate the public health impact made possible when local, program, and departmental initiatives are focused on a common outcome. The PART review process has also focused attention on the continued importance of assuring valid and reliable performance data addressing diabetic care at all levels of the Indian health system (IHS, Tribal and Urban) and thus was addressed in both the Urban Indian Health Program and RPMS/IT PART reviews that were part of the FY 2005 budget process.

Diabetes Performance Measure: Ideal Glycemic Control (A1C < 7)
FY 2007 Target: 36 percent for the IHS Diabetes Audit (Maintain FY 2005 Target)

In FY 2005, 36 percent of AI/AN patients with diabetes achieved ideal glycemic control by having an A1C less than 7.0 percent on the 2005 IHS Annual Diabetes Care and Outcomes Audit, which is 2 percent above the rate of 34 percent in the 2004 audit. The 2005 IHS Annual Diabetes Care and Outcomes Audit was conducted in June, July and August 2005 in over 280 Indian health system facilities.

Diabetes Performance Measure: Dyslipidemia Assessment
FY 2007 Target: 76 percent for the IHS Diabetes Audit (Maintain FY 2005 Target)

In FY 2005, 70 percent of clients with diagnosed diabetes were assessed for dyslipidemia by having a low-density lipoprotein (LDL) cholesterol level done. This is 1 percent greater than the level achieved in the 2004 IHS Annual Diabetes Care and Outcomes Audit, representing care to more than 115,000 patients with diabetes seen in over 280 Indian health system facilities.

Address the proportion of patients with diagnosed diabetes that have demonstrated **ideal glycemic control**, i.e., an A1C value less than 7. FY 2005 Target: Maintain the proportion of I/T/U clients with diabetes who have demonstrated ideal glycemic control at the FY 2004 level.	IHS has met this measure based on diabetes audit data since FY 1998. The FY 2005 diabetic audit data showed a 2% increase in the proportion of I/T/U clients with diagnosed diabetes that have demonstrated ideal glycemic control.	Keeping Hemoglobin A1C levels below 7 can slow or prevent the onset and progression of eye, kidney, and nerve disease caused by diabetes. Good blood sugar control also lowers the risk of heart attack and stroke.
Address the proportion of patients with diagnosed diabetes assessed for **dyslipidemia**. FY 2005 Target: Maintain the proportion of I/T/U clients with diabetes who have been assessed for dyslipidemia at the FY 2004 level.	IHS has met this measure based on diabetes audit data since FY 1998. The FY 2005 diabetes audit data showed a 1% increase in the proportion of I/T/U clients with diagnosed diabetes that have been assessed for dyslipidemia by having their LDL cholesterol (or "bad" cholesterol) value checked.	Low cholesterol levels help to protect diabetic patients from developing heart disease. Improved control of cholesterol levels reduces the risk of cardiovascular complications by 20 – 50%. In addition, national standards recommend that patients with diabetes keep their LDL cholesterol levels below 100, ideally. The average LDL value for AI/AN's from the diabetic audit data has decreased from 118 mg/dl in 1998 to 100 mg/dl in 2005.

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

In addition, the IHS DDTP has developed a set of short-term, intermediate and long-term outcomes measures for evaluation of the Special Diabetes Program for Indians (SDPI), using the CDC's Framework for Public Health Evaluation methodology. The December 2004 Interim Report to Congress on the *SDPI* provides data on the accomplishments of IHS thus far on these short-term and intermediate outcomes, and provides a description of the baseline long-term outcomes that will be measured over the next decade. **These activities support the Secretary's 500 Day Plan to transform the Health Care System by using data to evaluate best practices that close the health care gap for American Indians and Alaska Natives.**

FUNDING HISTORY -- Funding for the IHS Special Diabetes Program for Indians during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2002	$100,000,000	0
2003	$100,000,000	0
2004	$150,000,000	0
2005	$150,000,000	0
2006	$150,000,000	0

RATIONALE FOR THE BUDGET

The IHS *Special Diabetes Program for Indians* budget is for the base amount of $150,000,000 as provided in FY 2005, 2006 and 2007.

The programs and activities implemented by the IHS Division of Diabetes Treatment and Prevention provide a strong foundation and new beginning towards a diabetes-free future for AI/AN communities.

The evaluation of the Special Diabetes Program for Indians (SDPI) and diabetes clinical measures suggests that population-level diabetes-related health is better among the AI/AN patients since the implementation of SDPI. The greatest benefit has likely been in a reduction in microvascular complications due to improvement in hyperglycemia (as measured by A1C test) and a reduction in macrovascular disease risk due to improvements in lipid profiles (as measured by LDL and total cholesterol tests). As a reflection of the global effect of quality of care and of resource allocation, these trends demonstrate the public health impact made possible when community, program and congressional initiatives are focused on a common outcome. Further reductions in microvascular and macrovascular complications will require continued efforts to improve glucose, blood pressure and lipid values.

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

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