DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year

2010

Indian Health Service

Justification of Estimates for Appropriations Committees

Introduction

The FY 2010 Congressional Justification is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through the HHS agencies' FY 2010 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS Citizens' Report. These documents are available at http://www.hhs.gov/asrt/ob/docbudget/index.html.

The FY 2010 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2008 Annual Performance Report and FY 2010 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS Citizens' Report summarizes key past and planned performance and financial information.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

I present the Indian Health Service (IHS) fiscal year (FY) 2010 Congressional Justification. This budget request provides our most fully integrated and transparent performance budget to date and supports the Department of Health and Human Services' FY 2007 through 2012 Strategic Plan. Consistent with the Government Performance and Results Act of 1993, this justification includes the FY 2010 Annual Performance Plan and the FY 2008 Annual Performance Report with FY 2009 and FY 2010 performance targets provided.

Performance measurement and reporting continues as a mainstay of IHS performance management, including the quarterly review of critical healthcare data. These data are utilized to enhance the integration of a performance management culture across the Indian health care system. This improved monitoring capacity coupled with an increased awareness and commitment to the IHS mission across the Indian health system are our greatest assets.

For FY 2010, the IHS provides a comprehensive set of performance measures that reflect essential health services with evidence-based linkages to improved health outcomes. The ongoing automated monitoring of these performance measures from the local to the national level provides the IHS and our stakeholders with information to assess ongoing progress towards the following elements of the Departmental and IHS Strategic Plans:

HHS Strategic Objectives:

- 1.2 Increase health care service availability and accessibility.
- 1.3 Improve health care quality, safety, cost, and value.
- 1.4 Recruit, develop, and retain a competent healthcare workforce.
- 2.1 Prevent the spread of infectious diseases.
- 2.2 Protect the public against injuries and environmental threats.
- 2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors, and recovery.
- 2.4 Prepare for and respond to natural and manmade disasters.

IHS Strategic Goals:

- Build and sustain healthy communities.
- Provide accessible, quality health care.
- Foster collaboration and innovation across the Indian Health Network.

Our enhanced performance management processes have resulted in the improved targeting of resources to meet the healthcare needs of American Indian and Alaska Native (AI/AN) people. And while the IHS has succeeded in reducing overall mortality for our population by 28 percent over the past 30 years, this progress is offset by a trend of growing disparities in mortality rates between the AI/AN population and our country's population overall during the same period. Our FY 2010 budget request represents the commitment of the IHS and our stakeholders to the Agency mission by working to meet the healthcare needs of the AI/AN people more efficiently and effectively with unprecedented and significant targeted investments in the Indian Health System.

Robert G. McSwain
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2010 Performance Budget Submission to Congress

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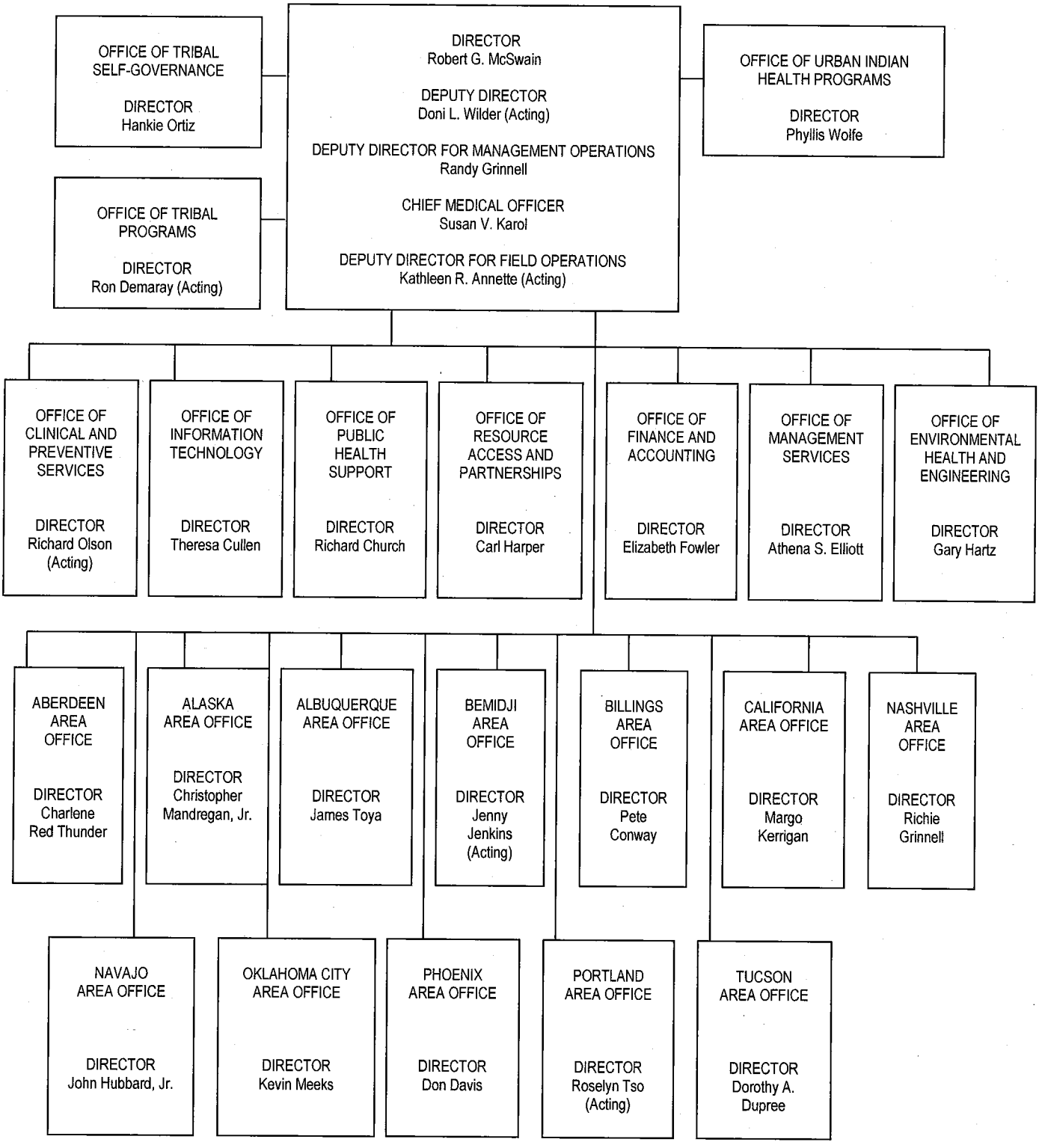
DEPARTMENT OF HEALTH AND HUMAN SERVICES

INDIAN HEALTH SERVICE

Approved:

Date: 4/27/09



EXECUTIVE SUMMARY

Agency Overview

United States Government and Indian Nations

The provision of Federal health services to American Indians and Alaska Natives is based on a special relationship between Indian Tribes and the United States. The Indian Commerce Clause of the United States Constitution, as well as numerous treaties and court decisions, have affirmed this special relationship and the plenary power of Congress to create statutes that benefit Indian people. Principal among these statutes is the Snyder Act of 1921, which provides the basic authority for health services provided by the Federal Government to American Indians and Alaska Natives.

The Indian Health Service and Its Partnership with Tribes

For more than 120 years, Federal responsibility for American Indian and Alaska Native health care passed among different government branches. In 1955, this responsibility was officially transferred to the Public Health Service.

In the 1970s, Federal Indian policy was re-evaluated by the Nixon Administration, which adopted a policy of Indian self-determination. This policy promotes Tribal administration of Federal Indian programs, including health care. Self-Determination does not lessen any Federal obligation, but provides an opportunity for Tribes to assume the responsibility of providing health care for their members.

The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), as amended, and the Indian Health Care Improvement Act of 1976 (IHCIA), as amended, have provided new opportunities for the IHS and Tribes to deliver care. The IHCIA included specific authorizations for providing health care services to urban Indian populations, to administer an Indian health professions program, and the ability to collect from Medicare/Medicaid and other third party insurers for services rendered at IHS or Tribal facilities. Under the ISDEAA, many Tribes have assumed the administrative and program direction roles that were previously carried out by the Federal government. Tribes currently administer over one-half of IHS resources through ISDEAA contracts and compacts. The IHS administers the remaining resources and manages those facilities where Tribes have elected not to contract or compact their health programs.

Vision

The Indian Health Service and the role it plays within the greater Indian health care system is to work in partnership with Tribal governments; American Indian and Alaska Native people; and Federal, State, and local governments, agencies, and organizations to respond in every way possible to preserve and improve our health system for future generations of Indian people. This partnership effort must also include the active participation of patients and the entire Indian health system in our common vision of health care access to “medical homes.” A “medical home” is a patient-centered,

compassionate, comprehensive, and culturally appropriate model of care. See the full text of this Vision at: http://www.ihs.gov/PublicAffairs/DirCorner/index.cfm.

Mission

The mission of the Indian Health Service is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

Overview of Budget Request

The FY 2010 President's Budget request for the Indian Health Service is $4,034,625,000 in discretionary budget authority -- a significant increase of $453,501,000, or 13 percent, over the FY 2009 Omnibus appropriations level. The request includes funds necessary to maintain the current level of services provided as well as funds to expand access to care and address Tribal contract support costs and essential health information technology activities. The following funding increases are included:

Current Services (+$166.7 million)

Federal, Tribal, Urban Pay Costs (+$34.9 million)
The budget request projects a 2.0 percent pay raise for civilian employees and a 2.9 percent pay raise for Commissioned Officers. The $34.9 million requested will fund these pay raises entirely, including commensurate pay raises for Tribal and Urban Indian health program employees.

Population Growth (+$44.6 million)
This request will address the increased cost of health care due to the growth in the American Indian and Alaska Native population. The population is growing at an average rate of 1.5 percent annually and the $44.6 million requested will provide for the additional services needed for these additional patients eligible for care.

Inflation (+$60.3 million)
This request will address the rising costs of providing health care. The $61.5 million is the calculated need to address a 1 percent non-medical inflation rate and a 3.0 percent medical inflation rate.

Staffing and Operating Costs for New/Expanded Facilities (+$26.9 million)
In FY 2010, three newly constructed or one replacement facilities will provide additional staffing. They reflect an investment of more than $36 million in the construction of the facilities to expand access to care in locations where existing capacity is most overextended.

Program Increases (+$297.5 million)

Contract Health Services (+$117 million)
The $117 million for the Contract Health Services (CHS) program is estimated to significantly reduce denials in 2010. From the total amount for this activity, or $47 million, an increase of $17 million will be used to increase the Catastrophic Health Emergency Fund (CHEF). This increase will fund over 700 additional high cost cases that were not previously funded by the CHEF program.

Direct Operations (+$2 million)
These funds are requested to increase the IHS' capacity to perform necessary administrative and management functions. The agency has acquired additional duties and responsibilities to perform without a commensurate increase in funding. As an example, since the 9/11 tragedy numerous personnel and information technology security mandates have been issued for government agencies. The $2 million requested will assist IHS in ensuring such mandates are addressed.

Contract Support Costs (+$104.4 million)
The increase in CSC appropriation for FY 2010 will be allocated to address existing CSC shortfalls associated with ongoing contracts and compacts, and is expected to fund CSC needs; up 14.35 percent. The request for CSC is a significant increase of 38 percent over the FY 2009 Omnibus level to assist tribal programs operate programs.

New Tribes (+$5.6 million)
Funding is identified for New Tribes to be funded in FY 2010. The amounts are projected based on the Mashpee Wampanoag Tribe (1,422 users) and the Tuscarora Tribe (1,201 users).

Indian Health Care Improvement Fund (+$45 million)
The Indian Health Care Improvement Fund was established by Congress to address funding inequities among Indian health care programs. To diminish health care service backlogs, this program increase will be allocated to IHS and Tribal service sites with the greatest deficiencies. Funding will allow highly deficient sites, those funded at less than 45 percent of need, to expand health care services and reduce backlogs for primary care.

Chronic Care Initiative (+$2.5 million)
This request of $2.5 million is for expansion of the agency's Chronic Care Initiative. The expansion will include up to an additional 100 IHS, Tribal and Urban sites thus spreading the improvements in primary care proven to be effective by the initial 38 sites. Area and regional Tribal staff will be trained to support this significant spread effort.

Health Promotion/Disease Prevention (+$.800 million)
The $800,000 requested will support IHS Area Health Promotion/Disease Prevention Coordinator positions to coordinate, plan, and implement effective prevention efforts and strategies in the American Indian/Alaska Native communities.

Health Professions (+$2.9 million)
These funds are requested to offset the health professions education inflation rate. According to the Bureau of Labor Statistics, college tuition costs have increased an average of 7.7 percent annually for each of the last 5 years.

Health Information Technology (+$16.3 million)
IHS' Health Information Technology (HIT) solution (the Resource and Patient Management System) continues to expand to meet additional reporting requirements and provide increased but essential HIT services to patients, providers and communities. Traditionally, HIT is funded primarily from the Hospital and Health Clinics budget. Increasing clinical needs have led to increased spending on HIT to ensure compliance with Federal mandates, increased security needs, improved infrastructure, as well as ongoing and enhanced development and deployment of the electronic health record in over 200 sites. These increases are currently funded from direct clinical care funds. This funding request ensures that these budget needs are supported independent of direct clinical care funds.

Facilities & Environmental Health Support (+$.575 million)
The Facilities & Environmental Health Support (FEHS) provides funding for the overall management of the environmental health and engineering programs, including real property asset management of all, IHS facilities, technical services and support for capital investments, budget formulation, long range planning, national policy development and implementation and liaison with the Department, Congress, Tribes, and other Federal agencies. This funding request will provide additional support for the overall management of the environmental health and engineering program.

Program Decrease (-$10.8 million)

Health Care Facilities Construction (-$10.8 million)
Funding for construction of new health facilities is reduced in this budget request to focus on the provision of health services to American Indian and Alaska Native patients. Funds are provided to continue the construction of the replacement hospital at Barrow, Alaska; and continue the construction of the health centers at San Carlos and Kayenta, Arizona.

All Purpose Table
Indian Health Service

(Dollars in Thousands)

Apr 3, 2009

Program	FY 2008 Appropriation	FY 2009 Appropriation	FY 2009 Recovery Act	FY 2010 Pres. Budget Request
SERVICES				
Hospitals & Health Clinics	1,484,016	1,597,777	85,000	1,751,883
Dental Health	133,637	141,936	0	151,384
Mental Health	63,531	67,748	0	72,786
Alcohol & Substance Abuse	173,243	183,769	0	194,409
Contract Health Services	579,334	634,477	0	779,347
Total, Clinical Services	2,433,762	2,625,707	85,000	2,949,809
Public Health Nursing	55,939	59,885	0	64,071
Health Education	14,991	15,723	0	16,682
Community Health Reps.	54,925	57,796	0	61,628
Immunization AK	1,733	1,823	0	1,934
Total, Preventive Health	127,587	135,227	0	144,315
Urban Health	34,547	36,189	0	38,139
Indian Health Professions	36,291	37,500	0	40,743
Tribal Management	2,490	2,586	0	2,586
Direct Operations	63,624	65,345	0	68,720
Self-Governance	5,836	6,004	0	6,066
Contract Support Costs	267,398	282,398	0	389,490
Total, Other Services	410,184	430,022	0	545,744
TOTAL, SERVICES	2,971,533	3,190,956	85,000	3,639,868
FACILITIES				
Maintenance & Improvement	52,889	53,915	100,000	53,915
Sanitation Facilities Construction	94,253	95,857	68,000	95,857
Health Care Facilities Construction	36,584	40,000	227,000	29,234
Facilities & Environmental Health Support	169,638	178,329	0	193,087
Equipment	21,282	22,067	20,000	22,664
TOTAL, FACILITIES	374,646	390,168	415,000	394,757
TOTAL, BUDGET AUTHORITY	3,346,179	3,581,124	500,000	4,034,625
COLLECTIONS				
Medicare	164,598	166,704	0	166,704
Medicaid	535,940	537,770	0	537,770
Subtotal, M / M	*700,538*	*704,474*	*0*	*704,474*
Private Insurance	94,042	94,042	0	94,042
Total, M / M / PI	*794,580*	*798,516*	*0*	*798,516*
Quarters	6,288	6,288	0	6,288
TOTAL, COLLECTIONS	800,868	804,804	0	804,804
Special Diabetes Program for Indians	150,000	150,000	0	150,000
TOTAL, SDPI	150,000	150,000	0	150,000
TOTAL, PROGRAM LEVEL	4,297,047	4,535,928	500,000	4,989,429

Note: FY 2008 collections revised to include FY 2008 actuals (as of 10-31-08)

INDIAN HEALTH SERVICE
FY 2010 Detail of Change
(Dollars in Thousands)

Sub Sub Activity	FY 2008 Enacted	FY 2009 Recovery Act	FY 2009 Omnibus	CURRENT SERVICES: Pay Costs Fed, 2.0% CS 2.9% CO	Pay Costs Tribal	Population Growth 1.5%	Inflation Non-Medl 1.0%	Inflation Medical 3.0%	Staffing for New Facilities	Current Services Subtotal	PROGRAM INCREASES / DECREASES: CHS	Direct Oper.	CSC	New Tribes	IHCIF	Chronic Care Initiative	HP/DP Initiative	Health Prof.	Health Info.Tech	Health Care Facil. Constr.	Facil. & Envir.Hlth Support	Program Incr/Decr Subtotal	PRESIDENT'S BUDGET REQUEST
SERVICES																							
Hospitals & Health Clinics	1,484,016	85,000	1,597,777	10,701	11,138	23,967	1,240	25,934	12,806	85,786	0	0	0	3,226	45,543	2,500	800	0	16,251	0	0	68,320	1,751,883
Dental Health	133,637	0	141,936	1,419	986	2,129	57	2,009	2,624	9,224	0	0	0	224	0	0	0	0	0	0	0	224	151,384
Mental Health	63,531	0	67,748	545	503	1,016	16	1,083	1,769	4,932	0	0	0	106	0	0	0	0	0	0	0	106	72,786
Alcohol & Substance Abuse	173,243	0	183,769	282	2,538	2,757	25	4,748	0	10,350	0	0	0	290	0	0	0	0	0	0	0	290	194,409
Contract Health Services	579,334	0	634,477	11	0	9,517	3	17,357	0	26,888	117,000	0	0	982	0	0	0	0	0	0	0	117,982	779,347
Total, Clinical Services	2,433,761	85,000	2,625,707	12,958	15,165	39,386	1,341	51,131	17,199	137,180	117,000	0	0	4,828	45,543	2,500	800	0	16,251	0	0	186,922	2,949,809
Public Health Nursing	55,939	0	59,885	547	413	898	28	860	1,183	3,929	0	0	0	257	0	0	0	0	0	0	0	257	64,071
Health Education	14,991	0	15,723	61	174	236	2	351	58	882	0	0	0	77	0	0	0	0	0	0	0	77	16,682
Comm. Health Reps	54,925	0	57,796	9	1,038	867	11	1,617	0	3,542	0	0	0	290	0	0	0	0	0	0	0	290	61,628
Immunization AK	1,733	0	1,823	0	32	27	0	52	0	111	0	0	0	0	0	0	0	0	0	0	0	0	1,934
Total, Preventive Health	127,588	0	135,227	617	1,657	2,028	41	2,880	1,241	8,464	0	0	0	624	0	0	0	0	0	0	0	624	144,315
Urban Health	34,547	0	36,189	47	423	543	23	914	0	1,950	0	0	0	0	0	0	0	0	0	0	0	0	38,139
Indian Health Professions	36,291	0	37,500	42	0	0	347	0	0	389	0	0	0	0	0	0	0	2,854	0	0	0	2,854	40,743
Tribal Management	2,490	0	2,586	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,586
Direct Operations	63,624	0	65,345	934	248	0	50	0	0	1,232	0	2,000	0	143	0	0	0	0	0	0	0	2,143	68,720
Self-Governance	5,836	0	6,004	53	0	0	9	0	0	62	0	0	0	0	0	0	0	0	0	0	0	0	6,066
Contract Support Costs	267,398	0	282,398	0	0	0	2,674	0	0	2,674	0	0	104,418	0	0	0	0	0	0	0	0	104,418	389,490
Total, Other Services	410,186	0	430,022	1,076	671	543	3,103	914	0	6,307	0	2,000	104,418	143	0	0	0	2,854	0	0	0	109,415	545,744
Total, Services	2,971,535	85,000	3,190,956	14,651	17,493	41,957	4,485	54,925	18,440	151,951	117,000	2,000	104,418	5,595	45,543	2,500	800	2,854	16,251	0	0	296,961	3,639,868
FACILITIES																							
Maintenance & Improvement	52,889	100,000	53,915	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	53,915
Sanitation Facilities Constr.	94,253	68,000	95,857	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	95,857
Health Care Facilities Constr.	36,584	227,000	40,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(10,766)	0	(10,766)	29,234
Facil. & Envir. Hlth. Supp.	169,638	0	178,329	1,948	835	2,675	300	0	8,425	14,183	0	0	0	0	0	0	0	0	0	0	575	575	193,087
Equipment	21,282	20,000	22,067	0	0	0	12	585	0	597	0	0	0	0	0	0	0	0	0	0	0	0	22,664
Total, Facilities	374,646	415,000	390,168	1,948	835	2,675	312	585	8,425	14,780	0	0	0	0	0	0	0	0	0	(10,766)	575	(10,191)	394,757
TOTAL, IHS	3,346,181	500,000	3,581,124	16,599	18,328	44,632	4,797	55,510	26,865	166,731	117,000	2,000	104,418	5,595	45,543	2,500	800	2,854	16,251	(10,766)	575	286,770	4,034,625

FY 2010 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
STATEMENT OF PERSONNEL RESOURCES

April 15, 2009

	Total Full-Time Equivalents (Workyears)		
	FY 2008 Enacted	FY 2009 Omnibus	FY 2010 Estimate
Direct:			
Hospitals & Health Clinics	6,366	6,711	6,792
Dental Health	728	767	777
Mental Health	277	292	295
Alcohol & Substance Abuse	160	169	171
Contract Health Services	2	2	2
Total, Clinical Services	7,532	7,940	8,037
Public Health Nursing	243	256	260
Health Education	22	23	23
Community Health Reps	5	5	5
Immunization, AK	0	0	0
Total, Preventive Health	270	284	288
Urban Health	7	7	7
Indian Health Professions	13	14	14
Tribal Management	0	0	0
Direct Operations	330	348	357
Self Governance	11	11	12
Contract Support Costs	0	0	0
Total, SERVICES	8,163	8,605	8,715
Maint. & Improvement	0	0	0
Sanitation Facilities	164	166	166
Hlth Care Facs Construction	0	0	0
Facil. & Envir. Hlth Support	907	916	916
Equipment	0	0	0
Total, FACILITIES	1,071	1,082	1,082
Total, Direct FTE	9,234	9,687	9,797
Reimbursable:			
Buybacks	1,299	1,232	1,232
Medicare	806	764	764
Medicaid	2,956	2,802	2,802
Private Insurance	647	614	614
Quarters	47	45	45
Total, Reimbursable FTE	5,755	5,457	5,457
TOTAL FTE	**14,989**	**15,144**	**15,254**

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Sub Sub Activity	2008 Enacted Budget Authority	2008 Enacted Private Insurance Collections	2008 Enacted Medicare/ Medicaid	2008 Enacted Personnel Quarters	2008 Enacted Total Program Level	2009 Estimate Budget Authority	2009 Estimate Private Insurance Collections	2009 Estimate Medicare/ Medicaid	2009 Estimate Personnel Quarters	2009 Estimate Total Program Level
SERVICES:										
Hospitals & Health Clinics	1,484,016	94,042	700,538 [2/]	0	2,278,596	1,597,777	94,042	704,474 [2/]	0	2,396,293
Dental Health	133,637	0	0	0	133,637	141,936	0	0	0	141,936
Mental Health	63,531	0	0	0	63,531	67,748	0	0	0	67,748
Alcohol & Substance Abuse	173,243	0	0	0	173,243	183,769	0	0	0	183,769
Contract Health Services	579,334	0	0	0	579,334	634,477	0	0	0	634,477
Total, Clinical Services	2,433,762	94,042	700,538	0	3,228,342	2,625,707	94,042	704,474	0	3,424,223
Public Health Nursing	55,939	0	0	0	55,939	59,885	0	0	0	59,885
Health Education	14,991	0	0	0	14,991	15,723	0	0	0	15,723
Comm. Health Reps.	54,925	0	0	0	54,925	57,796	0	0	0	57,796
Immunization AK	1,733	0	0	0	1,733	1,823	0	0	0	1,823
Total, Preventive Health	127,587	0	0	0	127,587	135,227	0	0	0	135,227
Urban Health	34,547	0	0	0	34,547	36,189	0	0	0	36,189
Indian Health Professions	36,291	0	0	0	36,291	37,500	0	0	0	37,500
Tribal Management	2,490	0	0	0	2,490	2,586	0	0	0	2,586
Direct Operations	63,624	0	0	0	63,624	65,345	0	0	0	65,345
Self-Governance	5,836	0	0	0	5,836	6,004	0	0	0	6,004
Contract Support Costs	267,398	0	0	0	267,398	282,398	0	0	0	282,398
TOTAL, SERVICES	2,971,533	94,042	700,538	0	3,766,113	3,190,956	94,042	704,474	0	3,989,472
FACILITIES:										
Maintenance & Improvement	52,889	0	0	6,288	59,177	53,915	0	0	6,288	60,203
Sanitation Facilities Construction	94,253	0	0	0	94,253	95,857	0	0	0	95,857
Health Care Facs. Constr.	36,584	0	0	0	36,584	40,000	0	0	0	40,000
Facil. & Envir. Health Support	169,638	0	0	0	169,638	178,329	0	0	0	178,329
Equipment	21,282	0	0	0	21,282	22,067	0	0	0	22,067
TOTAL, FACILITIES	374,646	0	0	6,288	380,934	390,168	0	0	6,288	396,456
TOTAL, IHS	3,346,179	94,042	700,538	6,288	4,147,047	3,581,124	94,042	704,474	6,288	4,385,928
Special Diabetes Program for Indians [1/]	150,000	0	0	0	150,000	150,000	0	0	0	150,000
GRAND TOTAL	3,496,179	94,042	700,538	6,288	4,297,047	3,731,124	94,042	704,474	6,288	4,535,928

[1/] The Special Diabetes Program for Indians is reauthorized for a total of $150,000,000 in FY 2009.

[2/] Includes $29,203,000 in Medicaid/Medicare for CMS estimates of tribal collections as well as $109,266,000 for tribal direct collection estimates, which began in FY 2002.

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Sub Sub Activity	2010 Request					Increase/Decrease of 2010 Over 2009				
	Budget Authority	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level	Budget Authority	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level
SERVICES:										
Hospitals & Health Clinics	1,751,883	94,042	704,474 [2/]	0	2,550,399	154,106	0	0	0	154,106
Dental Health	151,384	0	0	0	151,384	9,448	0	0	0	9,448
Mental Health	72,786	0	0	0	72,786	5,038	0	0	0	5,038
Alcohol & Substance Abuse	194,409	0	0	0	194,409	10,640	0	0	0	10,640
Contract Health Services	779,347	0	0	0	779,347	144,870	0	0	0	144,870
Total, Clinical Services	2,949,809	94,042	704,474	0	3,748,325	324,102	0	0	0	324,102
Public Health Nursing	64,071	0	0	0	64,071	4,186	0	0	0	4,186
Health Education	16,682	0	0	0	16,682	959	0	0	0	959
Comm. Health Reps.	61,628	0	0	0	61,628	3,832	0	0	0	3,832
Immunization AK	1,934	0	0	0	1,934	111	0	0	0	111
Total, Preventive Health	144,315	0	0	0	144,315	9,088	0	0	0	9,088
Urban Health	38,139	0	0	0	38,139	1,950	0	0	0	1,950
Indian Health Professions	40,743	0	0	0	40,743	3,243	0	0	0	3,243
Tribal Management	2,586	0	0	0	2,586	0	0	0	0	0
Direct Operations	68,720	0	0	0	68,720	3,375	0	0	0	3,375
Self-Governance	6,066	0	0	0	6,066	62	0	0	0	62
Contract Support Costs	389,490	0	0	0	389,490	107,092	0	0	0	107,092
Total, Other Services	545,744	0	0	0	545,744	115,722	0	0	0	115,722
TOTAL, SERVICES	3,639,868	94,042	704,474	0	4,438,384	448,912	0	0	0	448,912
FACILITIES:										
Maintenance & Improvement	53,915	0	0	6,288	60,203	0	0	0	0	0
Sanitation Facilities Construction	95,857	0	0	0	95,857	0	0	0	0	0
Health Care Facs. Constr.	29,234	0	0	0	29,234	(10,766)	0	0	0	(10,766)
Facil. & Envir. Health Support	193,087	0	0	0	193,087	14,758	0	0	0	14,758
Equipment	22,664	0	0	0	22,664	597	0	0	0	597
TOTAL, FACILITIES	394,757	0	0	6,288	401,045	4,589	0	0	0	4,589
TOTAL, IHS	4,034,625	94,042	704,474	6,288	4,839,429	453,501	0	0	0	453,501
Special Diabetes Program for Indians [1/]	150,000	0	0	0	150,000	0	0	0	0	0
GRAND TOTAL	4,184,625	94,042	704,474	6,288	4,989,429	453,501	0	0	0	453,501

[1/] The Special Diabetes Program for Indians is reauthorized for a total of $150,000,000 in FY 2010.

[2/] Includes $29,203,000 in Medicaid/Medicare for CMS estimates of tribal collections as well as $109,266,000 for tribal direct collection estimates, which began in FY 2002.

INDIAN HEALTH SERVICE
STAFFING AND OPERATING COSTS FOR NEW / EXPANDED FACILITIES
FY 2010 Requirements

(Dollars in Thousands)

rev Mar 12, 2009

	Little Axe, OK Absentee Shawnee Health Center Joint Venture		Santee, NE Santee Health Center Joint Venture		Ada, OK Carl Albert Hospital Replacement Joint Venture		Lakeport, CA Lake County Tribal Health Center Joint Venture		TOTAL	
Opening Date:	July 2010		Oct 2009		Jan 2010		Jun 2010			
Sub Sub Activity	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	Positions	Amount
Hospitals & Health Clinics	21	$1,777	23	$1,553	115	$8,789	10	$687	168	$12,806
Dental Health	5	481	4	293	23	1,781	1	69	33	2,624
Mental Health	3	254	2	127	17	1,264	2	125	23	1,769
Total, Clinical Services	29	2,512	29	1,973	155	11,833	13	882	225	17,200
Public Health Nursing	2	157	3	254	9	689	1	83	14	1,183
Health Education	0	0	0	0	1	58	0	0	1	58
Total, Preventive Health	2	157	3	254	10	747	1	83	15	1,241
Total, Services	30	2,669	32	2,227	164	12,580	14	965	240	18,440
Facilities Support	1	245	4	1,306	8	6,294	1	491	14	8,336
Environmental Health Support	0	0	1	89	0	0	0	0	1	89
Total, FEHS	1	245	5	1,395	8	6,294	1	491	15	8,425
Total, Facilities	1	245	5	1,395	8	6,294	1	491	15	8,425
Grand Total [1]	**31**	**$2,914**	**37**	**$3,622**	**173**	**$18,874**	**15**	**$1,456**	**256**	**$26,865**

[1] Includes utilities

FY 2008 Crosswalk
Budget Authority
Actual Distribution
(Dollars in Thousands)

	Federal Health Administration								Tribal Health Administration								
Sub Activity	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	FY 2008 Enacted
SERVICES																	
Hospitals & Health Clinics	772,217	0	0	0	0	0	0	772,217	711,799	0	0	0	0	0	0	711,799	1,484,016
Dental Health	77,838	0	0	0	0	0	0	77,838	55,799	0	0	0	0	0	0	55,799	133,637
Mental Health	32,911	0	0	0	0	0	0	32,911	30,620	0	0	0	0	0	0	30,620	63,531
Alcohol & Substance Abuse	27,474	0	0	0	0	0	0	27,474	145,769	0	0	0	0	0	0	145,769	173,243
Contract Health Services	289,264	0	0	0	0	0	0	289,264	290,070	0	0	0	0	0	0	290,070	579,334
Subtotal (CS)	1,199,704	0	0	0	0	0	0	1,199,704	1,234,057	0	0	0	0	0	0	1,234,057	2,433,761
Public Health Nursing	0	0	31,785	0	0	0	0	31,785	0	24,153	0	0	0	0	0	24,153	55,938
Health Education	0	0	3,900	0	0	0	0	3,900	0	11,091	0	0	0	0	0	11,091	14,991
Community Health Repr.	0	0	1,200	0	0	0	0	1,200	0	53,725	0	0	0	0	0	53,725	54,925
Immunization AK	0	0	0	0	0	0	0	0	0	1,733	0	0	0	0	0	1,733	1,733
Subtotal (PH)	0	0	36,885	0	0	0	0	36,885	0	90,702	0	0	0	0	0	90,702	127,587
Urban Health Project	0	11,442	0	0	0	0	0	11,442	0	0	23,105	0	0	0	0	23,105	34,547
Indian Health Professions	0	0	0	36,291	0	0	0	36,291	0	0	0	0	0	0	0	0	36,291
Tribal Management	0	0	0	76	0	0	0	76	0	0	0	2,414	0	0	0	2,414	2,490
Direct Operations	0	0	0	0	48,084	0	0	48,084	0	0	0	15,540	0	0	0	15,540	63,624
Self-Governance	0	0	0	0	0	3,354	0	3,354	0	0	0	0	2,481	0	0	2,481	5,835
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	267,398	0	267,398	267,398
Subtotal (OS)	0	11,442	0	36,367	48,084	3,354	0	99,247	0	0	23,105	17,954	2,481	267,398	0	310,938	410,185
Total, Services	1,199,704	11,442	36,885	36,367	48,084	3,354	0	1,335,837	1,234,057	90,702	23,105	17,954	2,481	267,398	0	1,635,696	2,971,533
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	19,905	19,905	0	0	0	0	0	0	32,984	32,984	52,889
Sanitation Facilities Constr.	0	0	0	0	0	0	32,989	32,989	0	0	0	0	0	0	61,264	61,264	94,253
Health Care Facs. Constr.	0	0	0	0	0	0	21,420	21,420	0	0	0	0	0	0	15,164	15,164	36,584
Facs. & Env. Health Sup	0	0	0	0	0	0	123,006	123,006	0	0	0	0	0	0	46,632	46,632	169,638
Equipment	0	0	0	0	0	0	7,434	7,434	0	0	0	0	0	0	13,848	13,848	21,282
Total, Facilities	0	0	0	0	0	0	204,755	204,754	0	0	0	0	0	0	169,893	169,893	374,646
TOTAL, IHS	1,199,704	11,442	36,885	36,367	48,084	3,354	204,755	1,540,590	1,234,057	90,702	23,105	17,954	2,481	267,398	169,893	1,805,589	3,346,179

FY 2009 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2009 Omnibus
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																	
Hospitals & Health Clinics	835,434	0	0	0	0	0	0	835,434	762,343	0	0	0	0	0	0	762,343	1,597,777
Dental Health	82,151	0	0	0	0	0	0	82,151	59,785	0	0	0	0	0	0	59,785	141,936
Mental Health	34,765	0	0	0	0	0	0	34,765	32,983	0	0	0	0	0	0	32,983	67,748
Alcohol & Substance Abuse	31,133	0	0	0	0	0	0	31,133	152,636	0	0	0	0	0	0	152,636	183,769
Contract Health Services	316,808	0	0	0	0	0	0	316,808	317,669	0	0	0	0	0	0	317,669	634,477
Subtotal (CS)	1,300,291	0	0	0	0	0	0	1,300,291	1,325,416	0	0	0	0	0	0	1,325,416	2,625,707
Public Health Nursing	0	0	33,887	0	0	0	0	33,887	0	25,998	0	0	0	0	0	25,998	59,885
Health Education	0	0	4,081	0	0	0	0	4,081	0	11,642	0	0	0	0	0	11,642	15,723
Community Health Repr.	0	0	1,242	0	0	0	0	1,242	0	56,554	0	0	0	0	0	56,554	57,796
Immunization AK	0	0	0	0	0	0	0	0	0	1,823	0	0	0	0	0	1,823	1,823
Subtotal (PH)	0	0	39,210	0	0	0	0	39,210	0	96,017	0	0	0	0	0	96,017	135,227
Urban Health Project	0	11,801	0	0	0	0	0	11,801	0	0	24,388	0	0	0	0	24,388	36,189
Indian Health Professions	0	0	0	37,500	0	0	0	37,500	0	0	0	0	0	0	0	0	37,500
Tribal Management	0	0	0	79	0	0	0	79	0	0	0	2,507	0	0	0	2,507	2,586
Direct Operations	0	0	0	0	49,373	0	0	49,373	0	0	0	15,972	0	0	0	15,972	65,345
Self-Governance	0	0	0	0	0	3,463	0	3,463	0	0	0	0	2,541	0	0	2,541	6,004
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	282,398	0	282,398	282,398
Subtotal (OS)	0	11,801	0	37,579	49,373	3,463	0	102,217	0	0	24,388	18,479	2,541	282,398	0	327,805	430,022
Total, Services	1,300,291	11,801	39,210	37,579	49,373	3,463	0	1,441,718	1,325,416	96,017	24,388	18,479	2,541	282,398	0	1,749,238	3,190,956
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	20,931	20,931	0	0	0	0	0	0	32,984	32,984	53,915
Sanitation Facilities Constr.	0	0	0	0	0	0	33,550	33,550	0	0	0	0	0	0	62,307	62,307	95,857
Health Care Facs. Constr.	0	0	0	0	0	0	22,000	22,000	0	0	0	0	0	0	18,000	18,000	40,000
Facs. & Env. Health Sup	0	0	0	0	0	0	127,556	127,556	0	0	0	0	0	0	50,773	50,773	178,329
Equipment	0	0	0	0	0	0	8,023	8,023	0	0	0	0	0	0	14,044	14,044	22,067
Total, Facilities	0	0	0	0	0	0	212,061	212,060	0	0	0	0	0	0	178,108	178,108	390,168
TOTAL, IHS	1,300,291	11,801	39,210	37,579	49,373	3,463	212,061	1,653,778	1,325,416	96,017	24,388	18,479	2,541	282,398	178,108	1,927,346	3,581,124

FY 2010 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2010 Estimate
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Administration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Administration	
SERVICES																	
Hospitals & Health Clinics	919,238	0	0	0	0	0	0	919,238	832,645	0	0	0	0	0	0	832,645	1,751,883
Dental Health	86,238	0	0	0	0	0	0	86,238	65,146	0	0	0	0	0	0	65,146	151,384
Mental Health	36,511	0	0	0	0	0	0	36,511	36,275	0	0	0	0	0	0	36,275	72,786
Alcohol & Substance Abuse	32,899	0	0	0	0	0	0	32,899	161,510	0	0	0	0	0	0	161,510	194,409
Contract Health Services	389,640	0	0	0	0	0	0	389,640	389,707	0	0	0	0	0	0	389,707	779,347
Subtotal (CS)	1,464,526	0	0	0	0	0	0	1,464,526	1,485,283	0	0	0	0	0	0	1,485,283	2,949,809
Public Health Nursing	0	0	35,706	0	0	0	0	35,706	0	28,365	0	0	0	0	0	28,365	64,071
Health Education	0	0	4,372	0	0	0	0	4,372	0	12,310	0	0	0	0	0	12,310	16,682
Community Health Repr.	0	0	1,595	0	0	0	0	1,595	0	60,033	0	0	0	0	0	60,033	61,628
Immunization AK	0	0	0	0	0	0	0	0	0	1,934	0	0	0	0	0	1,934	1,934
Subtotal (PH)	0	0	41,674	0	0	0	0	41,674	0	102,641	0	0	0	0	0	102,641	144,315
Urban Health Project	0	12,338	0	0	0	0	0	12,338	0	0	25,801	0	0	0	0	25,801	38,139
Indian Health Professions	0	0	0	40,743	0	0	0	40,743	0	0	0	0	0	0	0	0	40,743
Tribal Management	0	0	0	79	0	0	0	79	0	0	0	2,507	0	0	0	2,507	2,586
Direct Operations	0	0	0	0	52,488	0	0	52,488	0	0	0	16,232	0	0	0	16,232	68,720
Self-Governance	0	0	0	0	0	3,521	0	3,521	0	0	0	0	2,545	0	0	2,545	6,066
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	389,490	0	389,490	389,490
Subtotal (OS)	0	12,338	0	40,822	52,488	3,521	0	109,170	0	0	25,801	18,739	2,545	389,490	0	436,574	545,744
Total, Services	1,464,526	12,338	41,674	40,822	52,488	3,521	0	1,615,370	1,485,283	102,641	25,801	18,739	2,545	389,490	0	2,024,498	3,639,868
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	20,931	20,931	0	0	0	0	0	0	32,984	32,984	53,915
Sanitation Facilities Constr.	0	0	0	0	0	0	33,550	33,550	0	0	0	0	0	0	62,307	62,307	95,857
Health Care Facs. Constr.	0	0	0	0	0	0	7,234	7,234	0	0	0	0	0	0	22,000	22,000	29,234
Facs. & Env. Health Sup	0	0	0	0	0	0	130,543	130,543	0	0	0	0	0	0	62,544	62,544	193,087
Equipment	0	0	0	0	0	0	8,620	8,620	0	0	0	0	0	0	14,044	14,044	22,664
Total, Facilities	0	0	0	0	0	0	200,879	200,878	0	0	0	0	0	0	193,879	193,879	394,757
TOTAL, IHS	1,464,526	12,338	41,674	40,822	52,488	3,521	200,879	1,816,248	1,485,283	102,641	25,801	18,739	2,545	389,490	193,879	2,218,377	4,034,625

INDIAN HEALTH SERVICE

Federal Funds

General and Special Funds:

INDIAN HEALTH SERVICES

For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination Act, the Indian Health Care Improvement Act, and titles II and III of the Public Health Service Act with respect to the Indian Health Service, **[**$3,190,956,000**]** *$3,639,868,000*, together with payments received during the fiscal year pursuant to 42 U.S.C. 238(b*)* and 238b for services furnished by the Indian Health Service: *Provided*, That funds made available to tribes and tribal organizations through contracts, grant agreements, or any other agreements or compacts authorized by the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), shall be deemed to be obligated at the time of the grant or contract award and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: *Provided further, That $18,251,000 is provided for Headquarters operations and information technology activities and, notwithstanding any other provision of law, the amount available under this proviso shall be allocated at the discretion of the Director of the Indian Health Service:* [1] *Provided further*, That **[**$634,477,000**]** *$779,347,000* for contract medical care, including **[**$31,000,000**]** *$48,000,000* for the Indian Catastrophic Health Emergency Fund, shall remain available until expended: *Provided further*, That no less than **[**$36,189,000**]** *$38,139,000* is provided for maintaining operations of the urban Indian health program: *Provided further*, That of the funds provided, up to $32,000,000 shall remain available until expended for implementation of the loan repayment program under section 108 of the Indian Health Care Improvement Act: *Provided further,* That $16,391,000 is provided for a methamphetamine and suicide prevention and treatment initiative and $7,500,000 is provided for the domestic violence prevention initiative and, notwithstanding any other provision of law, the amounts available under this proviso shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended: *Provided further,* That funds provided in this Act may be used for one-year contracts and grants which are to be

performed in two fiscal years, so long as the total obligation is recorded in the year for which the funds are appropriated: *Provided further*, That the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act shall remain available until expended for the purpose of achieving compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act (exclusive of planning, design, or construction of new facilities): *Provided further*, That funding contained herein, and in any earlier appropriations Acts for scholarship programs under the Indian Health Care Improvement Act (25 U.S.C. 1613) shall remain available until expended: *Provided further*, That amounts received by tribes and tribal organizations under title IV of the Indian Health Care Improvement Act shall be reported and accounted for and available to the receiving tribes and tribal organizations until expended: *Provided further*, That, notwithstanding any other provision of law, of the amounts provided herein, not to exceed **[**$282,398,000**]** *$389,490,000* shall be for payments to tribes and tribal organizations for contract or grant support costs associated with contracts or grants support costs associated with contracts, grants, self-governance compacts, or annual funding agreements between the Indian Health Service and a tribe or tribal organization pursuant to the Indian Self-Determination Act of 1975, as amended, prior to or during fiscal year **[**2009**]** *2010*, of which not to exceed $5,000,000 may be used for contract support costs associated with new or expanded self-determination contracts, grants, self-governance compacts or annual funding agreements: *Provided further*, That the Bureau of Indian Affairs may collect from the Indian Health Service, tribes and tribal organizations operating health facilities pursuant to Public Law 93-638, such individually identifiable health information relating to disabled children as may be necessary for the purpose of carrying out its functions under the Individuals with Disabilities Education Act, (20 U.S.C. 1400, et seq.): *Provided further*, That the Indian Health Care Improvement Fund may be used, as needed, to carry out activities typically funded under the Indian Health Facilities account. (Omnibus Appropriations Act, 2009, Division E -- Department of the Interior)

INDIAN HEALTH FACILITIES

For construction, repair, maintenance, improvement, and equipment of health and related auxiliary facilities, including quarters for personnel; preparation of plans, specifications, and drawings; acquisition of sites, purchase and erection of modular buildings, and purchases of trailers; and for provision of domestic and community sanitation facilities for Indians, as authorized by section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), the Indian Self-Determination Act, and the Indian Health Care Improvement Act, and for expenses necessary to carry out such Acts and titles II and III of the Public Health Service Act with respect to environmental health and facilities support activities of the Indian Health Service, **[**$390,168,000**]** *$394,757,000*, to remain available until expended: *Provided*, That notwithstanding any other provision of law, funds appropriated for the planning, design, construction or renovation of health facilities for the benefit of Indian tribe or tribes may be used to purchase land for sites to construct, improve, or enlarge health or related facilities: *Provided further*, That not to exceed $500,000 shall be used by the Indian Health Service to purchase TRANSAM equipment from the Department of Defense for distribution to the Indian Health Service and tribal facilities: *Provided further*, That none of the funds appropriated to the Indian Health Service may be used for sanitation facilities construction for new homes funded with grants by the housing programs of the United States Department of Housing and Urban Development: *Provided further*, That not to exceed $2,700,000 from this account and the ``Indian Health Services" account shall be used by the Indian Health Service to obtain ambulances and tribal facilities in conjunction with an existing interagency agreement between the Indian Health Service and the General Services Administration: *Provided further*, That not to exceed $500,000 shall be placed in a Demolition Fund, available until expended, to be used by the Indian Health Service for demolition of Federal buildings. (Omnibus Appropriations Act, 2009, Division E -- Department of the Interior)

ADMINISTRATIVE PROVISIONS, INDIAN HEALTH SERVICE

Appropriations in this Act to the Indian Health Service shall be available for services as authorized by 5 U.S.C. 3109 but at rates not to exceed the per diem rate

equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. 5376; hire of passenger motor vehicles and aircraft; purchase of medical equipment; purchase of reprints; purchase, renovation and erection of modular buildings and renovation of existing facilities; payments for telephone service in private residences in the field, when authorized under regulations approved by the Secretary; and for uniforms or allowances therefor as authorized by 5 U.S.C. 5901-5902; and for expenses of attendance at meetings that relate to the functions or activities for which the appropriation is made or otherwise contribute to improved conduct, supervision, or management of those functions or activities.

In accordance with the provisions of the Indian Health Care Improvement Act, non-Indian patients may be extended health care at all tribally administered or Indian Health Service facilities, subject to charges, and the proceeds along with funds recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2651-2653) shall be credited to the account of the facility providing the service and shall be available without fiscal year limitation.

Notwithstanding any other law or regulation, funds transferred from the Department of Housing and Urban Development to the Indian Health Service shall be administered under Public Law 86-121, the Indian Sanitation Facilities Act and Public Law 93-638, as amended.

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

[None of the funds made available to the Indian Health Service in this Act shall be used for any assessments or charges by the Department of Health and Human Services unless identified in the budget justification and provided in this Act, or approved by the House and Senate Committees on Appropriations through the reprogramming process.**]** [2]

Notwithstanding any other provision of law, funds previously or herein made available to a tribe or tribal organization through a contract, grant, or agreement authorized by title I or title V of the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), may be deobligated and reobligated to a self-determination contract under title I, or a self-governance agreement under title V of such Act and

thereafter shall remain available to the tribe or tribal organization without fiscal year limitation.

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

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

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

The appropriation structure for the Indian Health Service may not be altered without advance notification to the House and Senate Committees on Appropriations. (Omnibus Appropriations Act, 2009, Division E -- Department of the Interior)

SEC. 409. Notwithstanding any other provision of law, amounts appropriated to or otherwise designated in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, 108-447, 109-54, 109-289, division B and Continuing Appropriations Resolution, 2007 (division B of Public Law 109-289, as amended by Public Law 110-5 and 110-28), Public Laws *110-92, 110-116, 110-137, 110-149,* 110-161, *110-329, 111-6 and 111-8* [4] for payments for contract support costs associated with self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded by such Acts, are the total amounts available for fiscal years 1994 through **[**2008**]** *2009* for such purposes, except that for the Bureau of Indian Affairs, *federally recognized* [5] tribes and tribal organizations may use their tribal priority allocations for unmet contract support costs of ongoing contracts, grants, self-governance compacts or annual funding agreements.

Language Analysis

Language Provision	Explanation
SERVICES	
[1] *Provided further, That $18,251,000 is provided for Headquarters operations and information technology activities and, notwithstanding any other provision of law, the amount available under this proviso shall be allocated at the discretion of the Director of the Indian Health Service:*	Language needed to ensure funds are used for necessary administrative and management functions associated with IHS residual. The IHS residual, i.e., amount of funding identified with those functions which cannot legally be delegated to Indian Tribes, has increased since initial Tribal shares tables were established in the mid-1990s. For example, new mandates for personnel and IT security have been issued for Federal government agencies since that time. This language will ensure that the total amount is used for these functions.
FACILITIES	
[2] *Provided*, That notwithstanding any other provision of law, funds appropriated for the planning, design, construction or renovation of health facilities for the benefit of ~~an~~ *a federally-recognized* Indian tribe or tribes may be used to purchase land for sites to construct, improve, or enlarge health or related facilities:	Added to make language more accurate in clarifying which tribes are eligible for IHS services.
ADMINISTRATIVE PROVISIONS	
[3] ~~None of the funds made available to the Indian Health Service in this Act shall be used for any assessments or charges by the Department of Health and Human Services unless identified in the budget justification and provided in this Act, or approved by the House and Senate Committees on Appropriations through the reprogramming process.~~	Language restricts Department's flexibility in managing overall resources for the Agency.
GENERAL PROVISIONS	
[4, 5] SEC. 409. Notwithstanding any other provision of law, amounts appropriated to or otherwise designated in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, 108-447, 109-54, 109-289, division B and Continuing	

Appropriations Resolution, 2007 (division B of Public Law 109-289, as amended by Public Law 110-5 and 110-28), ~~and~~ Public Laws *110-92, 110-116, 110-137, 110-149,* 110-161, *110-329, 111-6 and 111-8* [4] for payments for contract support costs associated with self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded by such Acts, are the total amounts available for fiscal years 1994 through **[**2008**]** *2009* for such purposes, except that for the Bureau of Indian Affairs, *federally recognized* [5] tribes and tribal organizations may use their tribal priority allocations for unmet contract support costs of ongoing contracts, grants, self-governance compacts or annual funding agreements.	Added to continue provision to limit payments for Contract Support Costs in past years (FY 1994 through 2009) to the funds available in law and accompanying the report language in those years for the Bureau of Indian Affairs and Indian Health Service. Added to make language more accurate in clarifying which tribes are eligible for IHS services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
SERVICES

Amounts Available for Obligations

	FY 2008	FY 2009	FY 2010
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$3,018,624,000	$3,190,586,000	$3,639,868,000
Across-the-board reductions (Interior)	($47,091,000)	$0	$0
Subtotal, Appropriation (Interior)	$2,971,533,000	$3,190,586,000	$3,639,868,000
Supplemental, Recovery Act	$0	$85,000,000	$0
Subtotal, adjusted appropriation	$2,971,533,000	$3,275,586,000	$3,639,868,000
Mandatory Appropriation:			
Appropriation	$150,000,000	$150,000,000	$150,000,000
Offsetting Collections:			
Federal sources	$223,000,000	$455,000,000	$455,000,000
Non-federal sources	$713,000,000	$485,000,000	$485,000,000
Subtotal	$936,000,000	$940,000,000	$940,000,000
Unobligated Balance, Start of Year	183,000,000	351,000,000	409,000,000
Unobligated Balance End of Year	351,000,000	409,000,000	382,000,000
Total Obligations	$3,739,533,000	$4,157,586,000	$4,606,868,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FACILITIES

Amounts Available for Obligations

	FY 2008	FY 2009	FY 2010
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$380,583,000	$390,168,000	$394,757,000
Across-the-board reductions (Interior)	($5,937,000)	$0	$0
Subtotal, Appropriation (Interior)	$374,646,000	$390,168,000	$394,757,000
Supplemental, Recovery Act	$0	$415,000,000	$0
Subtotal, adjusted appropriation	$374,646,000	$805,168,000	$394,757,000
Offsetting Collections:			
Federal sources	$1,000,000	$1,000,000	$1,000,000
Subtotal	$1,000,000	$1,000,000	$1,000,000
Unobligated Balance, Start of Year	247,000,000	307,000,000	721,000,000
Unobligated Balance End of Year	307,000,000	721,000,000	720,000,000
Total Obligations	$315,646,000	$392,168,000	$396,757,000

INDIAN HEALTH SERVICE
SERVICES
Summary of Changes

FY 2009	$3,190,956,000
Total estimated budget authority	3,190,956,000
Less Obligations	(3,190,956,000)
FY 2010 President's Budget	3,639,868,000
Less Obligations	(3,639,868,000)
Net Change	448,912,000
Less Obligations	(448,912,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$42,000
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	$14,609,000
3	Tribal Pay Cost	--	n/a	--	$17,493,000
4	Within Grade Increase	--	n/a	--	$0
5	Two Days Pay	--	n/a	--	$0
6	Increased Cost of Travel	--	40,776,000	--	$873,000
7	Increased Cost of Transportation & Things	--	9,791,000	--	$89,000
8	Increased Cost of Printing	--	543,000	--	$5,000
9	Increased Cost of Rents, Communications, & Utilities	--	30,883,000	--	$287,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	511,694,000	--	$11,491,000
11	Increased Cost of Supplies	--	93,803,000	--	$2,358,000
12	Increased Cost of Medical or other Equipment	--	9,414,000	--	$117,000
13	Increased Cost of Land & Structure	--	10,000	--	$0
14	Increased Cost of Grants	--	1,820,792,000	--	$44,188,000
15	Increased Cost of Insurance / Indemnities	--	211,000	--	$1,000
16	Increased Cost of Interest / Dividends	--	116,000	--	$1,000
17	Population Growth	--	n/a	--	$41,957,000
	Subtotal, Built-In	--	2,518,033,000	--	133,511,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	n/a	240	18,440,000
C. Base Adjustment:		--	0	--	0
D. Prorgram Increases		--	25,000,000	--	296,961,000
TOTAL INCREASES		--	2,518,033,000	240	448,912,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Program Decreases:		--	0	--	0
TOTAL DECREASES		--	0	--	0
NET CHANGE		--	**$2,518,033,000**	--	**$448,912,000**

INDIAN HEALTH SERVICE
Clinical Services
Summary of Changes

FY 2009	$2,625,707,000
Total estimated budget authority	$2,625,707,000
Less Obligations	(2,625,707,000)
FY 2010 President's Budget	2,949,809,000
Less Obligations	(2,949,809,000)
Net Change	324,102,000
Less Obligations	(324,102,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	$12,958,000
3	Tribal Pay Cost	--	n/a	--	$15,165,000
4	Within Grade Increase	--	n/a	--	$0
5	Two Days Pay	--	n/a	--	$0
6	Increased Cost of Travel	--	38,019,000	--	$848,000
7	Increased Cost of Transportation & Things	--	8,377,000	--	$76,000
8	Increased Cost of Printing	--	525,000	--	$5,000
9	Increased Cost of Rents, Communications, & Utilities	--	30,187,000	--	$273,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	490,895,000	--	$11,335,000
11	Increased Cost of Supplies	--	92,720,000	--	$2,344,000
12	Increased Cost of Medical or other Equipment	--	8,755,000	--	$111,000
13	Increased Cost of Land & Structure	--	10,000	--	$0
14	Increased Cost of Grants	--	1,360,943,000	--	$37,478,000
15	Increased Cost of Insurance / Indemnities	--	201,000	--	$1,000
16	Increased Cost of Interest / Dividends	--	116,000	--	$1,000
17	Population Growth	--	n/a	--	$39,386,000
	Subtotal, Built-In	--	2,030,748,000	--	119,981,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	225	17,200,000
C. Base Adjustment:		--	0	0	0
D. Indian Health Care Improvement Fund		--	15,000,000	0	45,543,000
D. New Tribes		--	0	0	4,828,000
F. Chronic Care Initiative		--	0	0	2,500,000
G. Health Information Technology		--	2,500,000	0	16,251,000
H. Domestice Violence		--	7,500,000	0	0
I. Health Promotion and Disease Prevention		--	0	0	800,000
J. CHS Increase		--	0	0	117,000,000
TOTAL INCREASES		--	2,055,748,000	225	324,102,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
TOTAL DECREASES		--	0	--	0
NET CHANGE		--	**$2,055,748,000**	--	**$324,102,000**

INDIAN HEALTH SERVICE
Hospitals & Health Clinics
Summary of Changes

FY 2009	$1,597,777,000
Total estimated budget authority	1,597,777,000
Less Obligations	(1,597,777,000)
FY 2010 President's Budget	1,751,883,000
Less Obligations	(1,751,883,000)
Net Change	154,106,000
Less Obligations	(154,106,000)

	FY 2009 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2 2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	10,701,000
3 Tribal Pay Cost	--	n/a	--	11,138,000
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	0
6 Increased Cost of Travel	--	10,304,000	--	93,000
7 Increased Cost of Transportation & Things	--	7,310,000	--	66,000
8 Increased Cost of Printing	--	509,000	--	5,000
9 Increased Cost of Rents, Communications, & Utilities	--	29,745,000	--	269,000
10 Increased Cost of Health Care Provided under Contracts & Grants	--	174,659,000	--	3,226,000
11 Increased Cost of Supplies	--	79,093,000	--	1,983,000
12 Increased Cost of Medical or other Equipment	--	6,434,000	--	73,000
13 Increased Cost of Land & Structure	--	10,000	--	0
14 Increased Cost of Grants	--	793,935,000	--	21,458,000
15 Increased Cost of Insurance / Indemnities	--	144,000	--	1,000
16 Increased Cost of Interest / Dividends	--	1,000	--	0
17 Population Growth	--	n/a	--	23,967,000
Subtotal, Built-In	--	1,102,144,000	--	72,980,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	168	12,806,000
C. Base adjustment:	--	0	0	0
D. New Tribes	--	0	0	3,226,000
E. Indian Health Care Improvement Fund	--	15,000,000	0	45,543,000
F. Chronic Care Initiative	--	0	0	2,500,000
G. Health IT Telemed	--	2,500,000	0	16,251,000
H. Domestice Violence	--	7,500,000	0	0
I. Health Promotion and Disease Prevention	--	0	0	800,000
TOTAL INCREASES	--	1,127,144,000	168	154,106,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	0
TOTAL DECREASES	--	0	0	0
NET CHANGE	--	**$1,127,144,000**	**168**	**$154,106,000**

INDIAN HEALTH SERVICE
Dental Health
Summary of Changes

FY 2009	$141,936,000
Total estimated budget authority	141,936,000
Less Obligations	(141,936,000)
FY 2010 President's Budget	151,384,000
Less Obligations	(151,384,000)
Net Change	9,448,000
Less Obligations	(9,448,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	1,419,000
3	Tribal Pay Cost	--	n/a	--	986,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	997,000	--	9,000
7	Increased Cost of Transportation & Things	--	508,000	--	5,000
8	Increased Cost of Printing	--	12,000	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	109,000	--	1,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	12,242,000	--	267,000
11	Increased Cost of Supplies	--	4,415,000	--	111,000
12	Increased Cost of Medical or other Equipment	--	1,229,000	--	14,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	61,589,000	--	1,659,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	n/a	--	2,129,000
	Subtotal, Built-In	--	81,101,000	--	6,600,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	33	2,624,000
C. Base Adjustment:		--	0	0	0
D. New Tribes		--	0	0	224,000
TOTAL INCREASES		--	81,101,000	33	9,448,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	0
TOTAL DECREASES		--	0	0	0
NET CHANGE		--	**$81,101,000**	**33**	**$9,448,000**

INDIAN HEALTH SERVICE
Mental Health
Summary of Changes

FY 2009	$67,748,000
Total estimated budget authority	67,748,000
Less Obligations	(67,748,000)
FY 2010 President's Budget	72,786,000
Less Obligations	(72,786,000)
Net Change	5,038,000
Less Obligations	(5,038,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	545,000
3	Tribal Pay Cost	--	n/a	--	503,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	508,000	--	5,000
7	Increased Cost of Transportation & Things	--	429,000	--	4,000
8	Increased Cost of Printing	--	2,000	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	24,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	6,724,000	--	174,000
11	Increased Cost of Supplies	--	363,000	--	4,000
12	Increased Cost of Medical or other Equipment	--	197,000	--	2,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	33,727,000	--	910,000
15	Increased Cost of Insurance / Indemnities	--	46,000	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	n/a	--	1,016,000
	Subtotal, Built-In	--	42,020,000	--	3,163,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	23	1,769,000
C. Base Adjustment:		--	0	0	0
D. New Tribes		--	0	0	106,000
TOTAL INCREASES		--	42,020,000	23	5,038,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	0
TOTAL DECREASES		--	0	0	0
NET CHANGE		--	**$42,020,000**	**23**	**$5,038,000**

INDIAN HEALTH SERVICE
Alcohol & Substance Abuse
Summary of Changes

FY 2009	$183,769,000
Total estimated budget authority	183,769,000
Less Obligations	(183,769,000)
FY 2010 President's Budget	194,409,000
Less Obligations	(194,409,000)
Net Change	10,640,000
Less Obligations	(10,640,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	282,000
3	Tribal Pay Cost	--	n/a	--	2,538,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	322,000	--	3,000
7	Increased Cost of Transportation & Things	--	128,000	--	1,000
8	Increased Cost of Printing	--	2,000	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	329,000	--	3,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	10,485,000	--	196,000
11	Increased Cost of Supplies	--	1,070,000	--	24,000
12	Increased Cost of Medical or other Equipment	--	185,000	--	2,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	158,904,000	--	4,544,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	n/a	--	2,757,000
	Subtotal, Built-In	--	171,425,000	0	10,350,000
B. New Tribes		--	0	0	290,000
	TOTAL INCREASES	--	171,425,000	0	10,640,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	0
B. Base Adjustment:		--	0	0	0
	TOTAL DECREASES	--	0	0	0
NET CHANGE		--	**$171,425,000**	**0**	**$10,640,000**

INDIAN HEALTH SERVICE
Contract Health Services
Summary of Changes

FY 2009	$634,477,000
Total estimated budget authority	634,477,000
Less Obligations	(634,477,000)
FY 2010 President's Budget	779,347,000
Less Obligations	(779,347,000)
Net Change	144,870,000
Less Obligations	(144,870,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	11,000
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	25,888,000	--	738,000
7	Increased Cost of Transportation & Things	--	2,000	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	(20,000)	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	286,785,000	--	7,472,000
11	Increased Cost of Supplies	--	7,779,000	--	222,000
12	Increased Cost of Medical or other Equipment	--	710,000	--	20,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	312,788,000	--	8,907,000
15	Increased Cost of Insurance / Indemnities	--	11,000	--	0
16	Increased Cost of Interest / Dividends	--	115,000	--	1,000
17	Population Growth	--	n/a	--	9,517,000
	Subtotal, Built-In	--	634,058,000	--	26,888,000
B. Base Adjustment:		--	0	--	0
C. CHS Increase		--	0	--	117,000,000
D. New Tribes		--	0	--	982,000
TOTAL INCREASES		--	634,058,000	--	144,870,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
TOTAL DECREASES		--	0	--	0
NET CHANGE		--	**$634,058,000**	--	**$144,870,000**

INDIAN HEALTH SERVICE
Preventive Health
Summary of Changes

FY 2009	$135,227,000
Total estimated budget authority	135,227,000
Less Obligations	(135,227,000)
FY 2010 President's Budget	144,315,000
Less Obligations	(144,315,000)
Net Change	9,088,000
Less Obligations	(9,088,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	$617,000
3	Tribal Pay Cost	--	n/a	--	$1,657,000
4	Within Grade Increase	--	n/a	--	$0
5	Two Days Pay	--	n/a	--	$0
6	Increased Cost of Travel	--	624,000	--	$6,000
7	Increased Cost of Transportation & Things	--	1,154,000	--	$11,000
8	Increased Cost of Printing	--	11,000	--	$0
9	Increased Cost of Rents, Communications, & Utilities	--	384,000	--	$9,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	3,770,000	--	$85,000
11	Increased Cost of Supplies	--	1,187,000	--	$12,000
12	Increased Cost of Medical or other Equipment	--	464,000	--	$4,000
13	Increased Cost of Land & Structure	--	0	--	$0
14	Increased Cost of Grants	--	99,099,000	--	$2,794,000
15	Increased Cost of Insurance / Indemnities	--	0	--	$0
16	Increased Cost of Interest / Dividends	--	0	--	$0
17	Population Growth	--	n/a	--	$2,028,000
	Subtotal, Built-In	--	106,693,000	0	7,223,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	15	1,241,000
C. Base Adjustment:		--	0	0	0
D. New Tribes		--	0	0	624,000
TOTAL INCREASES		--	106,693,000	15	9,088,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	0
TOTAL DECREASES		--	0	0	0
NET CHANGE		--	**$106,693,000**	**15**	**$9,088,000**

INDIAN HEALTH SERVICE
Public Health Nursing
Summary of Changes

FY 2009	$59,885,000
Total estimated budget authority	59,885,000
Less Obligations	(59,885,000)
FY 2010 President's Budget	64,071,000
Less Obligations	(64,071,000)
Net Change	4,186,000
Less Obligations	(4,186,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	547,000
3	Tribal Pay Cost	--	n/a	--	413,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	430,000	--	4,000
7	Increased Cost of Transportation & Things	--	1,075,000	--	10,000
8	Increased Cost of Printing	--	3,000	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	344,000	--	4,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	2,644,000	--	63,000
11	Increased Cost of Supplies	--	714,000	--	7,000
12	Increased Cost of Medical or other Equipment	--	326,000	--	3,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	29,000,000	--	797,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	n/a	--	898,000
	Subtotal, Built-In	--	34,536,000	0	2,746,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	14	1,183,000
C. Base Adjustment:		--	0	0	0
D. New Tribes		--	0	0	257,000
TOTAL INCREASES		--	34,536,000	14	4,186,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	0
TOTAL DECREASES		--	0	0	0
NET CHANGE		--	**$34,536,000**	**14**	**$4,186,000**

INDIAN HEALTH SERVICE
Health Education
Summary of Changes

FY 2009	$15,723,000
Total estimated budget authority	15,723,000
Less Obligations	(15,723,000)
FY 2010 President's Budget	16,682,000
Less Obligations	(16,682,000)
Net Change	959,000
Less Obligations	(959,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	61,000
3	Tribal Pay Cost	--	n/a	--	174,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	118,000	--	1,000
7	Increased Cost of Transportation & Things	--	57,000	--	1,000
8	Increased Cost of Printing	--	8,000	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	2,000	--	5,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	299,000	--	11,000
11	Increased Cost of Supplies	--	396,000	--	3,000
12	Increased Cost of Medical or other Equipment	--	115,000	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	11,732,000	--	332,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	n/a	--	236,000
	Subtotal, Built-In	--	12,727,000	0	824,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	1	58,000
B. Base Adjustment:		--	0	0	0
C. New Tribes		--	0	0	77,000
TOTAL INCREASES		--	12,727,000	0	959,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	0
TOTAL DECREASES		--	0	--	0
NET CHANGE		--	**$12,727,000**	--	**$959,000**

INDIAN HEALTH SERVICE
Community Health Representatives
Summary of Changes

FY 2009	$57,796,000
Total estimated budget authority	57,796,000
Less Obligations	(57,796,000)
FY 2010 President's Budget	61,628,000
Less Obligations	(61,628,000)
Net Change	3,832,000
Less Obligations	(3,832,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	9,000
3	Tribal Pay Cost	--	n/a	--	1,038,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	76,000	--	1,000
7	Increased Cost of Transportation & Things	--	22,000	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	38,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	827,000	--	11,000
11	Increased Cost of Supplies	--	77,000	--	2,000
12	Increased Cost of Medical or other Equipment	--	23,000	--	1,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	56,544,000	--	1,613,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	n/a	--	867,000
	Subtotal, Built-In	--	57,607,000	0	3,542,000
B. Base Adjustment:		--	0	0	0
C. New Tribes		--	0	0	290,000
	TOTAL INCREASES	--	57,607,000	0	3,832,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$57,607,000**	--	**$3,832,000**

INDIAN HEALTH SERVICE
Immunization AK
Summary of Changes

FY 2009	$1,823,000
Total estimated budget authority	1,823,000
Less Obligations	(1,823,000)
FY 2010 President's Budget	1,934,000
Less Obligations	(1,934,000)
Net Change	111,000
Less Obligations	(111,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	32,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
11	Increased Cost of Supplies	--	0	--	0
12	Increased Cost of Medical or other Equipment	--	0	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	1,823,000	--	52,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	n/a	--	27,000
	Subtotal, Built-In	--	1,823,000	0	111,000
C. Base Adjustment:		--	0	0	0
	TOTAL INCREASES	--	1,823,000	0	111,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	0
	TOTAL DECREASES	--	0	0	0
NET CHANGE		--	**$1,823,000**	--	**$111,000**

INDIAN HEALTH SERVICE
Other
Summary of Changes

FY 2009	$430,022,000
Total estimated budget authority	430,022,000
Less Obligations	(430,022,000)
FY 2010 President's Budget	545,744,000
Less Obligations	(545,744,000)
Net Change	115,722,000
Less Obligations	(115,722,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$42,000
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	$1,034,000
3	Tribal Pay Cost	--	n/a	--	$671,000
4	Within Grade Increase	--	n/a	--	$0
5	Two Days Pay	--	n/a	--	$0
6	Increased Cost of Travel	--	2,133,000	--	$19,000
7	Increased Cost of Transportation & Things	--	260,000	--	$2,000
8	Increased Cost of Printing	--	7,000	--	$0
9	Increased Cost of Rents, Communications, & Utilities	--	312,000	--	$5,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	17,029,000	--	$71,000
11	Increased Cost of Supplies	--	(104,000)	--	$2,000
12	Increased Cost of Medical or other Equipment	--	195,000	--	$2,000
13	Increased Cost of Land & Structure	--	0	--	$0
14	Increased Cost of Grants	--	360,750,000	--	$3,916,000
15	Increased Cost of Insurance / Indemnities	--	10,000	--	$0
16	Increased Cost of Interest / Dividends	--	0	--	$0
18	Population Growth	--	n/a	--	$543,000
	Subtotal, Built-In	--	380,592,000	--	6,307,000
B. Base Adjustment:		--	0	--	0
B. Indian Health Professions		--	0	--	2,854,000
C. Direct Operations		--	0	--	2,000,000
D. New Tribes		--	0	--	143,000
C. Contract Support Costs		--	0	--	104,418,000
TOTAL INCREASES		--	380,592,000	--	115,722,000
DECREASES					
A. Built-In					
Absorption of Built-In Increases		--	0	--	0
B. Program Decreases:		--	0	--	0
TOTAL DECREASES		--	0	--	0
NET CHANGE		--	**$380,592,000**	--	**$115,722,000**

INDIAN HEALTH SERVICE
Urban Indian Health
Summary of Changes

FY 2009	$36,189,000
Total estimated budget authority	36,189,000
Less Obligations	(36,189,000)
FY 2010 President's Budget	38,139,000
Less Obligations	(38,139,000)
Net Change	1,950,000
Less Obligations	(1,950,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	47,000
3	Tribal Pay Cost	--	n/a	--	423,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	170,000	--	2,000
7	Increased Cost of Transportation & Things	--	12,000	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	(267,000)	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	2,543,000	--	34,000
11	Increased Cost of Supplies	--	59,000	--	1,000
12	Increased Cost of Medical or other Equipment	--	32,000	--	1,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	31,738,000	--	899,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	0	--	543,000
	Subtotal, Built-In	--	34,287,000	--	1,950,000
	TOTAL INCREASES	--	34,287,000	--	1,950,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Program Decreases:					
	Urban Indian Health Program	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$34,287,000**	--	**$1,950,000**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2009	$37,500,000
Total estimated budget authority	37,500,000
Less Obligations	(37,500,000)
FY 2010 President's Budget	40,743,000
Less Obligations	(40,743,000)
Net Change	3,243,000
Less Obligations	(3,243,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$42,000
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	28,000	--	0
7	Increased Cost of Transportation & Things	--	6,000	--	0
8	Increased Cost of Printing	--	1,000	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	3,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	934,000	--	3,000
11	Increased Cost of Supplies	--	1,000	--	1,000
12	Increased Cost of Medical or other Equipment	--	1,000	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	34,991,000	--	343,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	0	--	0
	Subtotal, Built-In	--	35,965,000	--	389,000
B. Base Adjustment:		--	0	--	0
C. Indian Health Professions		--	0	--	2,854,000
	TOTAL INCREASES	--	35,965,000	0	3,243,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Program Decrease		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$35,965,000**	--	**$3,243,000**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2009	$2,586,000
Total estimated budget authority	2,586,000
Less Obligations	(2,586,000)
FY 2010 President's Budget	2,586,000
Less Obligations	(2,586,000)
Net Change	0
Less Obligations	0

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	14,000	--	0
7	Increased Cost of Transportation & Things	--	1,000	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	6,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	49,000	--	0
11	Increased Cost of Supplies	--	1,000	--	0
12	Increased Cost of Medical or other Equipment	--	1,000	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	2,514,000	--	0
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	0	--	0
	Subtotal, Built-In	--	2,586,000	--	0
B. Base Adjustment:		--	0	--	0
	TOTAL INCREASES	--	2,586,000	--	0
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$2,586,000**	--	**$0**

INDIAN HEALTH SERVICE
Direct Operations
Summary of Changes

FY 2009	$65,345,000
Total estimated budget authority	65,345,000
Less Obligations	(65,345,000)
FY 2010 President's Budget	68,720,000
Less Obligations	(68,720,000)
Net Change	3,375,000
Less Obligations	(3,375,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	934,000
3	Tribal Pay Cost	--	n/a	--	248,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	1,783,000	--	16,000
7	Increased Cost of Transportation & Things	--	238,000	--	2,000
8	Increased Cost of Printing	--	6,000	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	559,000	--	5,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	3,059,000	--	26,000
11	Increased Cost of Supplies	--	(178,000)	--	0
12	Increased Cost of Medical or other Equipment	--	159,000	--	1,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	16,218,000	--	0
15	Increased Cost of Insurance / Indemnities	--	10,000	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	21,854,000	--	1,232,000
B. Base Adjustment:		--	0	--	0
C. Direct Operations		--	0	--	2,000,000
D. New Tribes		--	0	--	143,000
TOTAL INCREASES		--	21,854,000	--	3,375,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Base Adjustment:		--	0	--	0
TOTAL DECREASES		--	0	--	0
NET CHANGE		--	**$21,854,000**	--	**$3,375,000**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2009	$6,004,000
Total estimated budget authority	6,004,000
Less Obligations	(6,004,000)
FY 2010 President's Budget	6,066,000
Less Obligations	(6,066,000)
Net Change	62,000
Less Obligations	(62,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	53,000
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	138,000	--	1,000
7	Increased Cost of Transportation & Things	--	3,000	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	11,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	848,000	--	8,000
11	Increased Cost of Supplies	--	13,000	--	0
12	Increased Cost of Medical or other Equipment	--	2,000	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	2,487,000	--	0
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	0	--	0
	Subtotal, Built-In	--	3,502,000	--	62,000
B. Base Adjustment:		--	0	--	0
	TOTAL INCREASES	--	3,502,000	--	62,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$3,502,000**	--	**$62,000**

INDIAN HEALTH SERVICE
Contract Support Costs
Summary of Changes

FY 2009	$282,398,000
Total estimated budget authority	282,398,000
Less Obligations	(282,398,000)
FY 2010 President's Budget	389,490,000
Less Obligations	(389,490,000)
Net Change	107,092,000
Less Obligations	(107,092,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annual of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3mos.)	--	n/a	--	$0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	9,596,000	--	0
11	Increased Cost of Supplies	--	0	--	0
12	Increased Cost of Medical or other Equipment	--	0	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	272,802,000	--	2,674,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	282,398,000	--	2,674,000
B. Base Adjustment:		--	0	--	0
C. Contract Support Costs		--	0	--	104,418,000
	TOTAL INCREASES	--	282,398,000	--	107,092,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$282,398,000**	--	**$107,092,000**

INDIAN HEALTH SERVICE
FACILITIES
Summary of Changes

FY 2009	$390,168,000
Total estimated budget authority	390,168,000
Less Obligations	(390,168,000)
FY 2010 President's Budget	394,757,000
Less Obligations	(394,757,000)
Net Change	4,589,000
Less Obligations	(4,589,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of 2009 Pay Raise at 3.5% (3 mos.)	--	n/a	--	0
2	2010 Pay Raise at 2.9% civilians and 3.4% CO (9 mos.)	--	n/a	--	1,948,000
3	Tribal Pay Cost	--	n/a	--	835,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	4,128,000	--	37,000
7	Increased Cost of Transportation & Things	--	2,144,000	--	18,000
8	Increased Cost of Printing	--	28,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	19,728,000	--	175,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	101,811,000	--	36,000
11	Increased Cost of Supplies	--	8,882,000	--	35,000
12	Increased Cost of Medical or other Equipment	--	7,086,000	--	171,000
13	Increased Cost of Land & Structure	--	8,022,000	--	1,000
14	Increased Cost of Grants	--	150,684,000	--	(10,342,000)
15	Increased Cost of Insurance / Indemnities	--	10,000	--	0
16	Increased Cost of Interest / Dividends	--	6,000	--	0
17	Increased Cost of Service & Supply Fund	--	53,915,000	--	0
18	Population Growth	--	n/a	--	2,675,000
	Subtotal, Built-In	--	356,444,000	--	(4,411,000)
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	15	8,425,000
	TOTAL INCREASES	--	356,444,000	15	4,014,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		**--**	**$356,444,000**	**--**	**$4,014,000**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2009	$53,915,000
Total estimated budget authority	53,915,000
Less Obligations	(53,915,000)
FY 2010 President's Budget	53,915,000
Less Obligations	(53,915,000)
Net Change	0
Less Obligations	0

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3 mos)	--	n/a	--	0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	45,000	--	0
7	Increased Cost of Transportation & Things	--	18,000	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	251,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	11,556,000	--	0
11	Increased Cost of Supplies	--	4,985,000	--	0
12	Increased Cost of Medical or other Equipment	--	378,000	--	0
13	Increased Cost of Land & Structure	--	2,808,000	--	0
14	Increased Cost of Grants	--	33,874,000	--	0
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
	Subtotal, Built-In	--	53,915,000	--	0
C. Base Adjustment:		--	0	--	0
	TOTAL INCREASES	--	53,915,000	--	0
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		**--**	**$53,915,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Sanitation Facilities Construction
Summary of Changes

FY 2009	$95,857,000
Total estimated budget authority	95,857,000
Less Obligations	(95,857,000)
FY 2010 President's Budget	95,857,000
Less Obligations	(95,857,000)
Net Change	0
Less Obligations	0

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3 mos.)	--	n/a	--	0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	45,000	--	0
7	Increased Cost of Transportation & Things	--	29,000	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	1,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	77,699,000	--	0
11	Increased Cost of Supplies	--	11,000	--	0
12	Increased Cost of Medical or other Equipment	--	0	--	0
13	Increased Cost of Land & Structure	--	4,818,000	--	0
14	Increased Cost of Grants	--	7,868,000	--	0
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	90,471,000	--	0
	TOTAL INCREASES	--	90,471,000	--	0
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		**--**	**$90,471,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2009	$40,000,000
Total estimated budget authority	40,000,000
Less Obligations	(40,000,000)
FY 2010 President's Budget	29,234,000
Less Obligations	(29,234,000)
Net Change	(10,766,000)
Less Obligations	10,766,000

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3 mos.)	--	n/a	--	0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	0	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	84,000	--	0
11	Increased Cost of Supplies	--	0	--	0
12	Increased Cost of Medical or other Equipment	--	18,000	--	0
13	Increased Cost of Land & Structure	--	323,000	--	0
14	Increased Cost of Grants	--	39,508,000	--	(10,766,000)
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	39,933,000	--	(10,766,000)
	TOTAL INCREASES	--	39,933,000	--	(10,766,000)
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	10,766,000
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	10,766,000
NET CHANGE		**--**	**$39,933,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Facilities & Environmental Health Support
Summary of Changes

FY 2009	$178,329,000
Total estimated budget authority	178,329,000
Less Obligations	(178,329,000)
FY 2010 President's Budget	193,087,000
Less Obligations	(193,087,000)
Net Change	14,758,000
Less Obligations	(14,758,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3 mos.)	--	n/a	--	0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	1,948,000
3	Tribal Pay Cost	--	n/a	--	835,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	4,038,000	--	37,000
7	Increased Cost of Transportation & Things	--	2,006,000	--	18,000
8	Increased Cost of Printing	--	28,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	19,439,000	--	175,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	11,025,000	--	27,000
11	Increased Cost of Supplies	--	3,600,000	--	32,000
12	Increased Cost of Medical or other Equipment	--	1,140,000	--	10,000
13	Increased Cost of Land & Structure	--	71,000	--	1,000
14	Increased Cost of Grants	--	54,780,000	--	0
15	Increased Cost of Insurance / Indemnities	--	10,000	--	0
16	Increased Cost of Interest / Dividends	--	6,000	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	n/a	--	2,675,000
	Subtotal, Built-In	--	96,143,000	--	5,758,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	15	8,425,000
C. OEHE		--	0	--	575,000
	TOTAL INCREASES	--	96,143,000	--	14,758,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Base Adjustment:		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		**--**	**$96,143,000**	**15**	**$14,758,000**

INDIAN HEALTH SERVICE
F&EHS - Facilities Health Support
Summary of Changes

FY 2009	$96,038,000
Total estimated budget authority	96,038,000
Less Obligations	(96,038,000)
FY 2010 President's Budget	108,831,000
Less Obligations	(108,831,000)
Net Change	12,793,000
Less Obligations	(12,793,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3 mos.)	--	n/a	--	0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	1,948,000
3	Tribal Pay Cost	--	n/a	--	835,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	761,000	--	7,000
7	Increased Cost of Transportation & Things	--	702,000	--	6,000
8	Increased Cost of Printing	--	2,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	18,777,000	--	169,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	4,829,000	--	12,000
11	Increased Cost of Supplies	--	2,984,000	--	27,000
12	Increased Cost of Medical or other Equipment	--	707,000	--	6,000
13	Increased Cost of Land & Structure	--	71,000	--	1,000
14	Increased Cost of Grants	--	26,825,000	--	0
15	Increased Cost of Insurance / Indemnities	--	8,000	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	n/a	--	1,446,000
	Subtotal, Built-In	--	55,666,000	--	4,457,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	14	8,336,000
TOTAL INCREASES		--	55,666,000	--	12,793,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Base Adjustment:		--	0	--	0
TOTAL DECREASES		--	0	--	0
NET CHANGE		**--**	**$55,666,000**	**--**	**$12,793,000**

INDIAN HEALTH SERVICE
F&EHS - Environmental Health Support
Summary of Changes

FY 2009	$67,022,000
Total estimated budget authority	67,020,000
Less Obligations	(67,020,000)
FY 2010 President's Budget	68,142,000
Less Obligations	(68,142,000)
Net Change	1,120,000
Less Obligations	(1,120,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3 mos.)	--	n/a	--	0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	1,840,000	--	17,000
7	Increased Cost of Transportation & Things	--	1,210,000	--	11,000
8	Increased Cost of Printing	--	14,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	519,000	--	4,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	3,614,000	--	3,000
11	Increased Cost of Supplies	--	460,000	--	4,000
12	Increased Cost of Medical or other Equipment	--	346,000	--	3,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	26,276,000	--	0
15	Increased Cost of Insurance / Indemnities	--	2,000	--	0
16	Increased Cost of Interest / Dividends	--	6,000	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	n/a	--	989,000
	Subtotal, Built-In	--	34,287,000	--	1,031,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	1	89,000
	TOTAL INCREASES	--	34,287,000	--	1,120,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Base Adjustment:		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		**--**	**$34,287,000**	**--**	**$1,120,000**

INDIAN HEALTH SERVICE
F&EHS - OEHE Health Support
Summary of Changes

FY 2009	$15,269,000
Total estimated budget authority	15,269,000
Less Obligations	(15,269,000)
FY 2010 President's Budget	16,114,000
Less Obligations	(16,114,000)
Net Change	845,000
Less Obligations	(845,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3 mos.)	--	n/a	--	0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	1,437,000	--	13,000
7	Increased Cost of Transportation & Things	--	94,000	--	1,000
8	Increased Cost of Printing	--	12,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	143,000	--	2,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	2,582,000	--	12,000
11	Increased Cost of Supplies	--	156,000	--	1,000
12	Increased Cost of Medical or other Equipment	--	87,000	--	1,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	1,679,000	--	0
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	na	--	240,000
	Subtotal, Built-In	--	6,190,000	--	270,000
C. Environmental Health Support		--	0	--	575,000
	TOTAL INCREASES	--	6,190,000	--	845,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Base Adjustment:		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		**--**	**$6,190,000**	**--**	**$845,000**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2009	$22,067,000
Total estimated budget authority	22,067,000
Less Obligations	(22,067,000)
FY 2010 President's Budget	22,664,000
Less Obligations	(22,664,000)
Net Change	597,000
Less Obligations	(597,000)

		FY 2009 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of 2009 Pay Raise @ 2.9% CS and 3.4% CO (3 mos.)	--	n/a	--	0
2	2010 Pay Raise at 2.9% civilian and 2.0% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	91,000	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	37,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	1,447,000	--	9,000
11	Increased Cost of Supplies	--	286,000	--	3,000
12	Increased Cost of Medical or other Equipment	--	5,550,000	--	161,000
13	Increased Cost of Land & Structure	--	2,000	--	0
14	Increased Cost of Grants	--	14,654,000	--	424,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	22,067,000	--	597,000
	TOTAL INCREASES	--	22,067,000	--	597,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		**--**	**$22,067,000**	**--**	**$597,000**

INDIAN HEALTH SERVICE

Budget Authority by Activity

(Dollars in Thousands)

	2008 Actual		2009 Omnibus		2010 Estimate	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES:						
Hospitals & Health Clinics	6,366	$1,484,016	6,711	$1,597,777	6,792	$1,751,883
Dental Services	728	133,637	767	141,936	777	151,384
Mental Health	277	63,531	292	67,748	295	72,786
Alcohol & Substance Abuse	160	173,243	169	183,769	171	194,409
Contract Health Services	2	579,334	2	634,477	2	779,347
Total Clinical Services	7,532	2,433,761	7,940	2,625,707	8,037	2,949,809
Public Health Nursing	243	55,939	256	59,885	260	64,071
Health Education	22	14,991	23	15,723	23	16,682
Comm. Health Reps.	5	54,925	5	57,796	5	61,628
Immunization AK	0	1,733	0	1,823	0	1,934
Total Preventive Health	270	127,588	284	135,227	288	144,315
Urban Health	7	34,547	7	36,189	7	38,139
Indian Health Professions	13	36,291	14	37,500	14	40,743
Tribal Management	0	2,490	0	2,586	0	2,586
Direct Operations	330	63,624	348	65,345	357	68,720
Self-Governance	11	5,836	11	6,004	12	6,066
Contract Support Costs	0	267,398	0	282,398	0	389,490
Total Services	8,163	2,971,535	8,605	3,190,956	8,715	3,639,868
FACILITIES:						
Maintenance & Improvement	0	52,889	0	53,915	0	53,915
Sanitation Facilities Constr.	164	94,253	166	95,857	166	95,857
Health Care Facs. Constr.	0	36,584	0	40,000	0	29,234
Facil. & Envir. Health Supp.	907	169,638	916	178,329	916	193,087
Equipment		21,282	0	22,067	0	22,664
Total Facilities	1,071	$374,646	1,082	$390,168	1,082	394,757
Total IHS	9,234	$3,346,181	9,687	$3,581,124	9,797	4,034,625

INDIAN HEALTH SERVICE

Authorizing Legislation

(Dollars in Thousands)

Apr 19, 2010

	FY 2009		FY 2010	
	Amount Authorized	Enacted	Amount Authorized	President's Budget
1. Services Appropriation: 25 U.S.C. 13, Act and P.L. 83-568, Transfer Act, 42 U.S.C. 2001. Snyder Act, Title V, P.L. 94-437, Indian Health Care Improvement Act (IHCIA), as amended. Title I, Indian Health Manpower. Indian Self Determination and Education Assistance Act, P.L. 93-638, as amended, Sections 103(b)(2) and 103(e). Titles III & V, Self Governance Demonstration Program, Indian Self Determination Act, as amended. P.L. 100-472 Section 106(a)(2) A&B P.L. 106-260 Tribal Self Governance Amendment of 2000.	3,190,956	3,190,956	3,639,868	3,639,868
2. Facilities Appropriation: Indian Sanitation Facilities Act P.L. 86-121, 42 U.S.C. 2004a Section 301 of the IHCIA P.L. 103-413, P.L. 102-573 P.L. 98-473, Quarters Return Funds	390,168 6,288	390,168 6,288	394,757 6,288	394,757 6,288
3. Public and Private Collections: Economy Act 31 U.S.C. 1535, P.L. 94-437, Title V of IHCIA.	798,516	798,516	798,516	798,516
4. Special Diabetes Program for Indians: 111 STAT. 574 (P.L. 105-33) 114.2763A-525, (P.L. 106-554, Sec. 432) 123 STAT. 2494 (P.L. 110-275, Sec. 303)	150,000	150,000	150,000	150,000
5. American Recovery & Reinvestment Act 123 STAT. 1150. (P.L. 111-5)	*500*	*500*	*0*	*0*
Unfunded authorizations:	0	0	0	0
Total appropriations:	4,535,928	4,535,928	4,989,429	4,989,429
Total appropriations against Definite authorizations:	4,535,928	4,535,928	4,989,429	4,989,429

INDIAN HEALTH SERVICE
Appropriation History Table
Services

Apr 14, 2009

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2001	$2,271,055,000	$2,106,178,000	$2,184,421,000	$2,240,658,000
Supplemental (PL 106-554)				$30,000,000
Rescission (PL 106-554)	-	-	-	($4,995,000)
2002	$2,387,014,000	$2,390,014,000	$2,388,614,000	$2,389,614,000
Rescission (PL 107-206)	-	-	-	($1,009,000)
2003	$2,513,668,000	$2,508,756,000	$2,466,280,000	$2,492,115,000
Rescission (PL 108-7)	-	-	-	($16,199,000)
2004	$2,502,393,000	$2,556,082,000	$2,546,524,000	$2,561,932,000
Rescission (PL 108-108)	-	-	-	($16,550,000)
Rescission (PL 108-199)	-	-	-	($15,018,000)
2005	$2,612,824,000	$2,627,918,000	$2,633,624,000	$2,632,667,000
Rescission (PL 108-447, Sec. 501)				($15,638,000)
Rescission (PL 108-447, Sec. 122)				($20,936,000)
2006	$2,732,298,000	$2,732,298,000	$2,732,323,000	$2,732,298,000
Rescission (PL 109-54)				($13,006,000)
Rescission (PL 109-148)				($27,192,000)
2007	$2,822,449,000	$2,830,085,000	$2,835,493,000	$2,818,871,000
2008	$2,931,530,000	$3,023,532,000	$2,991,924,000	$3,018,624,000
Rescission (PL 110-161)				($47,091,000)
2009 Omnibus	$2,971,533,000	-	-	$3,190,956,000
2009 ARRA (PL 111-5)	-	-	-	$85,000,000
2010	$3,639,868,000			

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

	FY 2008	FY 2009		FY 2010	FY 2010
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	+/- FY 2009 Omnibus
BA	$2,433,761,000	$2,625,707,000	$85,000,000	$2,949,809,000	+$324,102,000
FTE	7,532	7,940	0	8,042	+102

SUMMARY OF PROGRAM

The FY 2010 budget request for Clinical Services is $2,949,809,000, an increase of $324,102,000 over the FY 2009 Omnibus level. This change represents $137,180,000 for increases in pay, inflation, population growth and staffing 4 new facilities and $186,922,000 in program increases.

- $1.752 billion for **Hospitals & Health Clinics** reflects an increase of $85,786,000 for pay, inflation, population growth and staffing new facilities and $68,320,000 for program increases over FY 2009 Omnibus level. These funds are necessary to support 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/community health initiatives targeting health conditions disproportionately affecting AI/AN 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.

  The health information system for IHS, the Resource and Patient Management System (RPMS), is supported from this fund. RPMS consists of more than 60 software applications and is used at approximately 400 IHS, tribal and urban (I/T/U) locations. The certified Electronic Health Record (EHR) of RPMS is in use in a meaningful way at over 200 of these facilities, with continued deployment activities underway. RPMS applications support direct clinical care in both medical and behavioral health settings, case management, population and public health, and clinical quality reporting. RPMS includes practice management and revenue cycle capabilities. RPMS-EHR is a critical component to the success of the chronic care initiative, as well as the health promotion/ disease prevention and behavioral health initiatives.

- $151 million for **Dental Health** reflects an increase of $9,448,000 over the FY 2009 Omnibus level. These funds are necessary to provide preventive and basic care, and over 90 percent of the dental services provided are basic and emergency care. Basic services are prioritized over more complex rehabilitative care such as root canals, crown and bridge, dentures, and surgical extractions. The demand for dental treatment remains high due to the high dental caries rate in the AI/AN children; however, a continuing emphasis on community oral health promotion/disease prevention is essential to long-term improvement of the oral health of AI/AN people.

- $73 million for **Mental Health** reflects an increase of $5,038,000 over the FY 2009 Omnibus level. These funds are necessary to provide a community-oriented clinical and preventive mental health service program that provides outpatient mental health and related services, crisis triage, case management, prevention programming and outreach services. Mental Health is crucial for the well being of AI/AN individuals and their communities; it must be considered integral in the healing process.

- $194 million for **Alcohol & Substance Abuse** reflects an increase of $10,640,000 over the FY 2009 Omnibus level. These funds are necessary to provide preventive and treatment services at both the community and clinic levels. These programs provide alcohol and substance abuse treatment and prevention services within rural and urban communities, with a focus on holistic and culturally-based approaches. The Alcohol and Substance Abuse Program (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.

- $779 million for **Contract Health Services** reflects an increase of $144,870,000 over the FY 2009 Omnibus level. These funds are necessary to purchase essential healthcare services not available in IHS/Tribal facilities including inpatient and outpatient care, routine and emergency ambulatory care, transportation, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, and physical therapy, etc. The demand for CHS remains high as the cost of medical care increases and gas prices continue to rise. The CHS program continues to emphasize adherence to Medical Priorities, enrolling patients in alternate resources available to them and negotiating discounted rates with medical providers.

The bulk of clinical services funds are provided to 12 Area (regional) Offices which in turn provide resource distribution, program monitoring and evaluation activities, and administrative and technical support to 163 Federal and Tribal service units (local level) for over 600 health care facilities providing care to 1.9 million AI/AN primarily in services areas that are rural, isolated and underserved.

Performance Summary Table -- The following table displays performance measures that are considered over-arching because all of the programs in this section contribute toward the achievement of targets.

OUTCOMES

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
31: Childhood Weight Control: Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher. IHS - All *(Outcome)*	24% (Target Met)	N/A	24%	N/A
31: Tribally Operated Health Programs *(Outcome)*	25% (Target Met)	N/A	25%	N/A
TOHP-2: Number of designated annual clinical performance goals met. *(Outcome)*	14/17 (Target Met)	14/17	16/17	+2
28: Unintentional Injury Rates: Unintentional mortality rate in AI/AN population.[1]	2003 94.8 (Target Not Met)	94.8 (2016)	94.8 (2016)	N/A
FAA-3: Unintentional Injury Rates: Unintentional mortality rate in AI/AN population.[2]	2003 92.2 (Target Not Met)	92.2 (2016)	92.2 (2016)	N/A
Program Level Funding ($ in millions)	**$4,297.0**	**$4,535.9**	**$4,989.4**	**+$454.0**
ARRA Level Funding ($ in millions)	**$0**	**$85.0**	**$0**	**$0**

[1] *Long Term Measure; reportable in 2016.*
[2] *Long Term Measure; reportable in 2016.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
HOSPITALS AND HEALTH CLINICS

	FY 2008	FY 2009		FY 2010	FY 2010
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	+/- FY 2009 Omnibus
BA	$1,484,016,000	$1,597,777,000	$85,000,000	$1,751,883,000	+$154,106,000
Epi Ctrs	*$4,548,361*	*$4,548,361*	*$0*	*$5,089,392*	*+$541,031*
HIT	*$112,006,000*	*$114,506,000*	*$85,000,000*	*$129,418,000*	*+$16,251,000*
FTE	**6,366**	**6,711**	**0**	**6,792**	**+85**

Authorizing Legislation .....25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001

FY 2010 Authorization .....Expired 2000

Allocation Method.....Direct Federal; P.L. 93-638 contracts and compacts with Tribal nations and Tribal consortia; competitive grants; interagency agreements; commercial contracts.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Hospitals and Health Clinics (H&HC) is by far the largest activity within the Indian Health Service (IHS) budget, amounting to nearly one-half of the IHS budget authority. It supports essential personal health services for American Indians and Alaska Natives (AI/AN) 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/community health initiatives targeting health conditions disproportionately affecting AI/AN 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. The IHS system of care is unique in that personal health care services are integrated with public health services. Collecting, analyzing, and interpreting health information is done through a network of Tribally-operated epidemiology centers in collaboration with a national IHS coordinating center leading to the identification of health conditions as well as promoting interventions. Information technology that supports both personal health services (including the electronic health record) and public health initiatives is primarily funded through the Hospitals and Health Clinics budget.

One-half of the H&HC budget is transferred under P.L. 93-638 contracts or compacts to Tribal governments or Tribal organizations which provide these individual and community health services for the Federal Government. This is reflected in the outputs

table which shows that approximately 58 percent of the outpatient workload and 38 percent of the inpatient workload is performed by Tribally managed hospitals and clinics. Most of the remainder is managed by direct Federal programs providing health care at the local level. A small percentage of the funds (<0.5 percent) is distributed to Tribes via many small competitive grant programs; examples include eldercare, children and youth, women's health, and health promotion and disease prevention grants.

Although the health status of AI/AN has increased significantly in the past 50 years since the inception of the IHS, the average life expectancy at birth is 74.4 years compared to the U.S. all races life expectancy of 76.9 and the U.S. white of 77.4.[1] The IHS and Tribes primarily serve small, rural populations with mainly primary medical care and community-health services, relying on the private sector for much of the secondary and all of the tertiary medical care needs. A few of our hospitals do provide secondary medical services such as ophthalmology, orthopedics, etc. Of 45 IHS or Tribal hospitals, only one has an average daily census of >45 patients. Nineteen of 45 hospitals have operating rooms; the majority do not. This speaks to their focus on primary and community based care, not on secondary or tertiary care.

The following are brief descriptions of several specific activities funded through H&HC:

Emergency Services – The IHS' Emergency Services staff office establishes emergency management goals and objectives consistent with those of the Department of Health and Human Services, Department of Homeland Security, and other Federal agencies in addressing mission critical elements, strategic plans, policies, procedures, continuity of operations (COOP), deployment, physical security, and public health infrastructure. IHS is:

(1) building capacity in public health infrastructure and emergency preparedness through linkages among its hospitals and clinics with local, county, Tribal and State agencies and non-governmental organizations throughout the country;
(2) working to assure that the needs of Tribal communities are addressed by States which have received targeted funding for emergency preparedness and response;
(3) working with and expanding the capacity of 91 Tribal and 3 IHS local emergency medical services (EMS) by providing technical assistance to enhance their ability to provide optimum emergency medical access, response and care in Indian Country;
(4) enhancing IHS' ability to deploy staff for national and international emergencies as was done for the response to hurricanes Gustav and Ike, suicide clusters in Tribal communities, wild fires in southern California, and flooding in the Grand Canyon, Northwest, and the Dakotas.
(5) preparing its hospitals and clinics to diagnose and treat victims of a bioterrorism or other mass casualty situations such as pandemic influenza;
(6) measuring the effectiveness of IHS critical infrastructure protection programs though a systematic effort of inspection and review; and

[1] Pappalardo, JG, Freidman, A, et. al. "Life Expectancy Data Years: 1999-2001." Rockville, Maryland: Indian Health Service. 2007.

(7) participating in numerous local, regional, and national exercises to test response capabilities and enhance linkages with public safety elements at all levels.

IHS has developed a comprehensive emergency management program that focuses on strengthening an all-hazards response capability in the Agency as well as in AI/AN communities. This program has participated with other Federal Agencies involved in emergency response in Tribal communities to enhance information sharing and provide a common operating picture of Tribal community needs after an emergency to provide an integrated response. A satellite communications system and emergency notification system are maintained to provide backup communications with the 12 Area Offices and provide a quick, reliable method of notification of an emergency. All of these efforts are in support of DHHS' role in enhancing the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges.

Alcohol Screening and Brief Intervention – The IHS has initiated a major alcohol intervention (funded through the H&HC budget activity), the Alcohol Screening and Brief Intervention (ASBI) program, to address alcohol abuse and injury prevention, very serious inter-related issues in Indian Country. It is aimed at breaking the alcohol–injury cycle by taking advantage of the "teachable moment" when an injured patient presents at an IHS or Tribal hospital emergency department as a result of possible alcohol or other drug intoxication. The ASBI program is being implemented system-wide in all IHS and Tribal hospitals.

The ASBI is similar to the Screening, Brief Intervention, Referral, and Treatment (SBIRT) program of SAMHSA with which IHS collaborates. We are also working with the American College of Surgeons and level I and II referral trauma centers and their SBIRT programs. In FY 2007, IHS conducted six ASBI train-the-trainer conferences around the country and has trained over 200 physicians, nurses, behavioral and allied health professionals in this intervention methodology. In FY 2008, IHS broadened the scope of the ASBI program to include IHS-Tribal primary care and behavioral health clinics. A performance measure is being developed to determine how well our hospital emergency departments and ambulatory clinics are screening for hazardous alcohol use in injured individuals in the 15 – 34 age range and providing a brief counseling intervention to decrease future injuries or death.

Managing High Cost Pharmaceuticals – The IHS minimizes and avoids costs, through negotiated rates for purchased services, medical products, and pharmaceuticals. In FY 2008, the IHS and Tribes spent approximately $280 million on pharmaceuticals. While the rate of cost increase has been dramatically reduced over the last 2 years (due to a number of high cost medications becoming available as generic products and negotiated discounts through the Department of Veterans Affairs (VA) Pharmaceutical Prime Vendor program), pharmaceutical costs for the Indian Health Service and our Tribal partners has increased an average of 6.6 percent per year for the last five fiscal years. The interventions to control costs include greater use of bulk purchasing methods through the pharmaceutical prime vendor (about 90 percent of all purchases) and the 340B program, increased use of a limited but more efficacious formulary, and education of

providers about specific pharmacoeconomic strategies. These activities are closely linked to 5 of 6 diabetes GPRA performance measures which are based on effective lifestyle and pharmaceutical management. The effort to manage high cost pharmaceuticals was enhanced by IHS pharmacy residency activities. The residency programs now operate in 12 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 – Continuation of the Health Promotion/Disease Prevention program in FY 2010 is contingent on results of an independent program evaluation conducted in FY 2008 to ensure IHS is investing its resources in the most effective health promotion and disease prevention efforts. The IHS is increasing access to preventive and curative services (secondary and tertiary prevention) for Indian communities by 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 and for acute and chronic diseases. The IHS recognizes that clinical approaches alone will not reduce the ongoing disparity in health among AI/AN communities.

Since its inception in 2005, the Health Promotion/Disease Prevention Initiative has focused on promoting primary prevention among AI/AN communities to reduce the leading causes of preventable death such as behaviors related to poor nutrition, physical inactivity, commercial tobacco use, and excessive and underage alcohol consumption. Through integration of the HP/DP program with the other two agency initiatives on Behavioral Health and Chronic Care, the IHS has become the model health system in integrating individual and community health, emphasizing both clinical and community-based prevention efforts.

Accomplishments specific to the HP/DP program include:

- Providing 33 competitive grants to AI/AN communities to enhance and expand prevention efforts focusing on behavioral risk factors that contribute to cancer, obesity, diabetes, and cardiovascular disease. The HP/DP program is evaluating these 33 grantees to ensure IHS is investing its resources in the most effective health promotion and disease prevention efforts.
- Implementing the Healthy Native Communities Fellowship program that has graduated over 200 fellows from across the country. This is an intense year-long program that develops Tribal, IHS, and urban Indian health leaders to be catalysts for making positive changes in their communities.
- Partnering with the National Indian Health Board to promote and expand *Just Move It* physical activity campaign to get 1 million American Indian and Alaska Native people moving. Currently, there are over 29,000 participants from 337 partnering organizations and communities.
- Conducting Community Champion Forums in all 12 IHS Areas. Over 500 individuals have participated in these on-going Forums across the 12 IHS Areas.

- Partnering with Mothers Against Drunk Driving (MADD) to train youth to address underage drinking, revising the Youth in Action manual for the American Indian population, and providing *Protecting You/Protecting Me* training to over 100 individuals in 6 of the 12 IHS Areas.
- Partnering with the University of New Mexico Prevention Research Center to develop the "Across the Life Span Physical Activity Kit" to encourage increased physical activity in schools, worksites, and communities. National training and dissemination will be held in May 2009.
- Building local capacity by implementing the Youth Leadership Program to engage youth and their adult mentors to address local issues and coordinating a youth summit in 2 IHS Areas with over 800 participants to expand best and promising strategies.

Additional strategies include:

- Focusing on those traditional practices and values of Indian communities which have a strong role in promoting wellness.
- Promoting and implementing effective programs in schools and communities.
- Engaging youth and strengthening families to make healthy lifestyle choices. The agency is working closely with national youth organizations such as Boys and Girls Clubs of America and United National Indian Tribal Youth, Inc. (UNITY) to promote healthy lifestyles for AI/AN children and youth.
- Engaging professional HP/DP experts, as well as Federal, Tribal, and community leaders through the Prevention Task Force and Policy Advisory Committee to guide this initiative to eliminate health disparities.

Chronic Care Initiative (CCI) – The IHS has a long and successful history of addressing public health challenges and acute, infectious diseases. Today, however, increasing chronic disease burdens are challenging the Indian health system. Addressing this challenge is an agency priority that requires a redesign of the delivery of primary care services to advance reliable and evidence-based care, to better integrate all of the health programs available to patients, and to put them at the center of their care.

Fourteen pilot sites began work in FY 2007 in the CCI and showed improvements in clinical prevention (screening for elevated blood pressure, depression, intimate partner violence, alcohol misuse, tobacco abuse, and obesity); in cancer screening (colorectal, breast, and cervical cancer); in chronic disease treatment (control of blood pressure), and in patient experience of care (patients who would recommend their healthcare facility to friends and relatives). This work continued in FY 2008; these original 14 sites laid the foundation for changes that will lead the Indian health system to make needed improvement in our primary care model.

In FY 2009 the CCI added an additional 24 IHS, Tribal, and Urban Indian health programs and these 38 programs collectively provide services to over 400,000 AI/AN people. The CCI pilot sites work together within a "collaborative," utilizing peer-to-peer learning with faculty guidance that is increasingly provided by natural leaders who have emerged in the early phases of the initiative. The sharing of knowledge and experience within this collaborative structure accelerates learning and improvement. The

collaborative uses virtual meeting technology, allowing us to reach larger numbers of professionals in a cost-efficient way and to open the health care improvement process to greater involvement by community members and Tribal leadership.

The changes that the CCI pilot sites are using are conceptually organized by the Care Model which was developed at the MacColl Institute for Healthcare Innovation and tested and implemented widely in the U.S. and abroad. These changes crosswalk closely with published concepts of the "medical home" and rely on the full optimization of the IHS clinical information system. A broad and comprehensive measurement plan guides improvement in the four domains of clinical prevention, care of chronic conditions, patient experience of care, and the cost of care.

In the next year these health care programs will leverage changes in the delivery of health care and the use of the clinical information system to improve patient self-management skills and to create patient care teams with increased efficiency, effectiveness, and continuity of care. This will provide local sites with the skills and tools to support ongoing health care system improvement. Participating programs will share learning and experience in a collaborative fashion to increase their chances of success and speed of change.

Outcome evaluation of clinical system changes will be based upon existing performance measures. As the number of sites joining the CCI in this effort expands, the effect on the majority of H&HC performance measures will increase. Because of the emphasis on clinical screening as well as chronic disease management, the CCI will directly impact most of the H&HC measures such as the 6 diabetes measures, the 3 cancer screening measures, the 3 immunization measures, etc. In addition, new measurements will be developed as appropriate.

Area and regional Tribal staff are being trained to support a significant spread effort in FY 2010. In that fiscal year, the work will be made available to an additional 100 IHS, Tribal, and Urban sites spreading the improvements in primary care proven to be effective by the initial sites.

FUNDING HISTORY

Fiscal Year	Amount	
2005	$1,289,418,000	
2006	$1,339,488,000	
2007	$1,411,336,000	
2008	$1,484,016,000	
2009 Recovery Act	$85,000,000*	Health IT, P.L. 111-5
2009 Omnibus	$1,597,777,000	

* see HIT narrative (separate)

BUDGET REQUEST

The FY 2010 budget request for Hospitals and Health Clinics is $1,751,883,000, an increase of $154,106,000 over the FY 2009 Omnibus level. This increase represents

$85,786,000 for pay increases, inflation, population growth and staffing new facilities and $68,320,000 for program increases.

Hospitals and Health Clinics funding will provide personal health care services for acute, chronic, and emergency conditions as well as clinical preventive services for approximately 1.9 million people; public/community health initiatives targeting health conditions affecting AI/AN; health promotion and disease prevention; emergency preparedness and response; and complex health information technology that supports both personal health services and public health initiatives.

Program increases:

- $3.226 million for 2 newly Federally recognized Tribes to begin providing health services.
- $45.543 million for the Indian Health Care Improvement Act Fund (IHCIF). The IHCIF methodology compares the current funding of health care delivery sites relative to a benchmark cost for a standard benefits package. The formula allocates funds to sites with the lowest scores. The benchmark considers site user counts, population health status, prevailing health care costs, and an estimate for Medicare and Medicaid funding. In FY 2010, the IHS will conduct a thorough evaluation of the methodology and data sources utilized to distribute the IHCIF and will take action to improve and refine the formula if necessary.
- $2.5 million for expansion of the agency's Chronic Care Initiative: The expansion will include up to an additional 100 IHS, Tribal, and Urban sites thus spreading the improvements in primary care proven to be effective by the initial 38 sites. Area and regional Tribal staff will be trained to support this significant spread effort.
- $0.8 million for expansion of the agency's Health Promotion/Disease Prevention Initiative.

The Recovery Act will enable IHS to create and acquire new enhancements.

Funding distribution:

- Approximately $919 million to be distributed to Federally-administered hospitals and clinics.
- Approximately $832 million to be distributed to Tribally operated hospitals and clinics through P.L. 93-638 compacts and contracts to provide similar services that the IHS would provide if these programs were directly Federally administered.
- Hospitals and Health Clinics funding for staffing of new facilities opening in FY 2010:

Staff for New Facility	Amount	Tribal Positions
Absentee Shawnee Health Center (JV), Little Axe, OK	$1,777,000	21
Santee Health Center (JV), Santee, NE	$1,553,000	23
Carl Albert Hospital, Replacement (JV), Ada, OK	$8,789,000	115
Lake County Tribal Health Center (JV), Lakeport, CA	$687,000	10
Grand Total:	**$12,806,000**	**168**

OUTCOMES

Twenty-one Government Performance and Results Act (GPRA) key performance measures are directly related to the H&HC budget. These measures include a variety of clinical measures such as prenatal HIV screening, pap smear and mammography screening, domestic violence screening, immunization rates, community-based cardiovascular disease and obesity prevention, depression screening, and reducing tobacco usage. Although the IHS has many more clinical measures, these 17 are the only ones being reported as national performance measures and only evaluate the performance of a portion of the clinical care program, as all aspects of primary and some secondary clinical care of individuals, involving thousands of disease states, are provided through the H&HC budget. Each of the approximately 1.9 million individuals cared for in the Indian Health System is unique and requires individual attention and care, so that each individual is a unique "output." Assessing performance data from the most current reported data demonstrates effective H&HC outcomes. In FY 2008, the IHS met or exceeded 12 H&HC performance measures, whereas two were not met, establishment of baseline rates and the TOHP sub-components are not included in this count . Those not met were each only 1 percent under the goal; e.g. the target for controlled blood pressure in diabetic patients was 39 percent but only 38 percent was achieved. Some of these performance measures are very resource intensive. The level of performance measure achievement is similar to that for the past several years.

Two of the 21 key GPRA results of programs funded through H&HC will be discussed. These are just examples from the key measures and are not necessarily any more important than the other 17 measures. Most of these measures relate to direct clinical care and are all important for the agency to meet its mission of elevating the health of Indian people to the highest level.

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. Of particular concern, the incidence of the disease is increasing rapidly in youth and young adults.

Supplemental funding, key Tribal involvement, collaboration with other Federal agencies, and community emphasis all contributed to the IHS meeting or exceeding four of six diabetes performance measures. Ongoing interventions include more effective pharmaceuticals, more aggressive screening for the secondary effects of diabetes, earlier intervention when complications are identified, and emphasizing 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 developed 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. Six of these are reported as GPRA indicators. Over two-thirds of Tribal communities have programs in place for

community-wide prevention of diabetes, and 83 percent of Tribal communities offer primary prevention programs for children and youth.

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 through screening for protein in the urine (proteinuria) helps prevent or delay the need for dialysis or renal transplant. Proteinuria is also an independent predictor of cardiovascular disease, the number one killer of AI/AN adults. In conjunction with other diabetes standards of care (blood sugar control and blood pressure control), this GPRA performance measure is intended to increase screening of diabetic patients for nephropathy in order to prevent or delay kidney failure by use of angiotensin-converting enzyme (ACE) inhibitors, medications proven to delay or prevent the onset of kidney failure. IHS use of ACE inhibitors has been steadily increasing since 1993. And since 1996 the rate of new cases of kidney failure in AI/AN patients with diabetes has been *decreasing*, while the rates continue to rise in African American and Caucasian diabetic populations. For FY 2007, this measure was changed to require quantitative testing in addition to or instead of the previous qualitative screening method, and a new baseline was established at 40%. The change in the measure was done in order to encourage a better assessment of diabetes related kidney damage. In FY 2008 IHS exceeded the target of 40 percent by an additional 10 percent of patients assessed.

Accreditation/Certification –The Joint Commission (JC), the Accreditation Association for Ambulatory Health Care (AAAHC), and the Centers for Medicare and Medicaid Services (CMS) regularly conduct in-depth quality reviews of IHS and Tribal hospitals and clinics. The average accreditation status levels are consistent with the average levels for all U.S. hospitals. The most frequently cited area for improvement is Life Safety Code Compliance because some IHS facilities are old and cannot be maintained adequately for the current array of services. The average age of IHS facilities is greater than 30 years.

IHS met this performance measure in FY 2008 as four IHS hospitals were evaluated by either the JC or CMS; all remain accredited or certified. The four hospitals surveyed in FY 2008 were Sells, in the Tucson Area, Hopi Health Center, Phoenix Indian Medical Center, and San Carlos in the Phoenix Area. IHS also achieved its goal of 100 percent accreditation of ambulatory facilities. Accreditation contributes both directly and indirectly to improve clinical safety and is essential for maximizing third-party collections. 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. Measuring accreditation and certification is a very important performance element because these periodic external review processes help monitor that basic policies and procedures, staffing, and patient care outcomes monitoring mechanisms are in place to ensure that consistent high quality patient care is being provided safely. In FY 2010, the IHS expects to maintain 100% accreditation or certification of its facilities.

Federally Administered Activities and Tribally operated programs have also participated in program assessments. Both programs have been successful in performance reporting, utilizing subsets of national GPRA measures to demonstrate achievement in addressing the major health disparities facing the AI/AN population. For example, IHS recently developed and released a 40-page guidance document with specific clinical strategies based on childhood obesity prevention and treatment for provider use. IHS is utilizing the most current recommendations to prevent increases in the Childhood Weight Control measure.

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
5: **Diabetes: Nephropathy Assessment:** Proportion of patients with diagnosed diabetes assessed for nephropathy. IHS-All	FY 2008: 50% (Target Exceeded)	47%	51%	+ 4%
5: Tribally Operated Health Programs	FY 2008: 35% (Target Exceeded)	33%	36%	+ 3 %
20: **Accreditation**: Percent of hospitals and outpatient clinics accredited (excluding tribal and urban facilities)	FY 2008: 100% (Target Met)	100%	100%	Maintain
6: **Diabetic Retinopathy:** Proportion of patients with diagnosed diabetes who receive an annual retinal examination. IHS-All	FY 2008: 50% (Target Exceeded)	47%	51%	+ 4%
6: Tribally Operated Health Programs	FY 2008: 48% (Target Met)	46%	49%	+ 3%
7: **Pap Smear Rates:** Proportion of eligible women who have had a Pap screen within the previous three years. IHS-All	FY 2008: 59% (Target Met)	59%	60%	+ 1%
7: Tribally Operated Health Programs	FY 2008: 60% (Target Not Met)	60%	61%	+ 1%
8: **Mammogram Rates:** Proportion of eligible women who have had mammography screening within the previous two years. IHS-All	FY 2008: 45% (Target Exceeded)	45%	47%	+2%
8: Tribally Operated Health Programs	FY 2008: 47% (Target Exceeded)	47%	49%	+2%
9: **Colorectal Cancer Screening Rates**: Proportion of eligible patients who have had appropriate colorectal cancer screening. IHS-All	FY 2008: 29% (Target Exceeded)	29%	32%	+3%
9: Tribally Operated Health Programs	FY 2008: 32% (Target Exceeded)	32%	35%	+3%
TOHP-4: Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) populations served by tribal health programs (Outcome)	2003 62.5 (Baseline)	55.3 (2015)	55.3 (2015)	N/A
FAA-2: Years of Potential Life Lost in American Indian/Alaska Native population *(Outcome)*	2003 79.2 (Baseline)	62.3 (2015)	62.3 (2015)	N/A
24: **Combined (4:3:1:3:3) Childhood Immunization rates:** AI/AN children patients aged 19-35 months. In 2010 this measure will add the Varicella vaccine to the basic series that is required. IHS - All *(Outcome)* IHS-All	FY 2008: 78% (Target Met)	78%	79%	+1%
24: Tribally Operated Health Programs	FY 2008: 72% (Target Met)	72%	73%	+1%
FAA-E: Hospital Admissions per 100,000 service population for long term complications of diabetes in federally administered facilities. *(Efficiency)*	FY 2006: 171.3 (Target Not Met)	167.9	167.9	Maintain
FAA-1: Children ages 2-5 years with a BMI at the 95th percentile or higher.	FY 2008: 23.9% (Target Not Met)	23.2%	24%	N/A

TOHP-3: Percentage of AI/AN patients with diagnosed diabetes served by tribal health programs that achieve ideal blood sugar control[1]	FY 2008: 34%	N/A	N/A	N/A
16: **Domestic (Intimate Partner) Violence Screening:** Proportion of women who are screened for domestic violence at health care facilities. IHS-All	FY 2008: 42% (Target Exceeded)	42%	47%	+5%
16: Tribally Operated Health Programs	FY 2008: 36% (Target Exceeded)	36%	41%	+5%
25: **Adult Immunizations: Influenza:** Influenza vaccination rates among adult patients aged 65 years and older. IHS-All	FY 2008: 62% (Target Exceeded)	62%	63%	+1%
25: Tribally Operated Health Programs	FY 2008: 57% (Target Exceeded)	57%	58%	+1%
26: **Adult Immunizations: Pneumovax**: Pneumococcal vaccination rates among adult patients aged 65 years and older. IHS-All	FY 2008: 82% (Target Exceeded)	82%	83%	+ 1%
26: Tribally Operated Health Programs	FY 2008: 77% (Target Exceeded)	77%	78%	+ 1%
33: **HIV Screening**: Proportion of pregnant women screened for HIV	FY 2008: 75% (Target Exceeded)	75%	76%	+1%
FAA-4: **Breastfeeding Rates**: Proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed.	FY 2008: 28% (Baseline)	28%	33%	+5%
Program Level Funding ($ in millions)	**$1,484.0**	**$1,597.8**	**$1,751.9**	**+$154.1**
ARRA Level Funding ($ in millions)	**$0**	**$85.0**	**$0**	**$0**

[1]*No annual targets; this is a long term measure with a target of 40% in 2014.*

OUTPUTS

Measure	Most Recent Result (FY 2008)	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Inpatient Admissions - IHS Direct	34,849	35,800	37,600	+1,800
Inpatient Admissions - Tribal Direct	21,809	22,600	23,800	+1,200
Total Admissions	**56,658**	**58,400**	**61,400**	**+3,000**
Outpatient Visits - IHS Direct	4,549,675	4,718,000	4,961,500	+243,500
Outpatient Visits - Tribal Direct	6,162,250	6,390,300	6,720,000	+329,700
Total Outpatient Visits	**10,711,925**	**11,108,300**	**11,681,500**	**+573,200**
Program Level Funding ($ in millions)	**$1,484.0**	**$1,597.8**	**$1,751.9**	**+$154.1**
ARRA Level Funding ($ in millions)	**$0**	**$85.0**	**$0**	**$0**

GRANTS AWARDS FUNDED BY HOSPITALS AND HEALTH CLINIC: A small percentage of the funds (<0.5 percent) is distributed to Tribes via many small competitive grant programs; examples include eldercare, children and youth, women's health, and health promotion and disease prevention grants.

	FY 2008	FY 2009	FY 2010
Number of Awards	48	48	91
Average Award	$135,300	$135,300	$257,100
Range of Awards	$11,800 - $1,040,000	$11,800 - $1,040,000	$11,800 - $1,040,000
Total Awards	$6,495,205	$6,495,205	$10,815,205

AREA ALLOCATION – Hospitals & Health Clinics

Discretionary SERVICES	**FY 2008 Actual**	**FY 2009 Omnibus**	**FY 2010 Estimate**	**FY 2010 +/- FY 2009**
Aberdeen	$132,215,800	$144,842,286	$159,220,379	+$16,644,403
Alaska	238,929,395	254,332,786	276,731,198	+26,387,734
Albuquerque	67,335,175	71,673,346	77,988,493	+7,436,601
Bemidji	76,305,674	81,221,783	88,378,245	+8,427,317
Billings	59,257,689	63,075,456	68,633,042	+6,544,511
California	58,633,369	62,410,914	68,624,826	+7,190,439
Nashville	48,830,002	51,975,949	56,555,556	+5,392,861
Navajo	208,063,351	221,468,150	240,981,736	+22,978,840
Oklahoma	252,732,122	276,869,678	312,259,474	+39,721,903
Phoenix	140,328,921	155,557,645	169,263,848	+16,140,173
Portland	65,292,212	69,498,763	75,622,307	+7,210,973
Tucson	18,149,901	19,319,236	21,021,457	+2,004,503
Headquarters	117,942,389	125,541,007	136,602,440	+13,025,741
Total, H&HC	$1,484,016,000	$1,597,777,000	$1,751,883,000	+$179,106,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
HOSPITALS AND HEALTH CLINICS
Epidemiology Centers

	FY 2008	FY 2009		FY 2010	FY 2010
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	+/- FY 2009 Omnibus
BA	$1,484,016,000	$1,597,777,000	$85,000,000	$1,751,293,000	+$153,516,000
Epi Ctrs	*$4,548,361*	*$4,548,361***	*$0*	*$5,080,295*	*+$531,934*
FTE	13	13	0	13	0

**FY 2009 Budget estimated
Note: *Italicized* dollar amounts and FTE are non-add; FY 2008 Enacted updated to reflect the FY 2007 "Actual."

Authorizing Legislation..... 25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001 Section 214(a) (1) Public Law 94-437, Indian Health Care Improvement Act, as amended

FY 2010 Authorization .....expired 2000

Allocation Method.....Cooperative Agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Congress authorized the innovative Indian Health Service (IHS) Tribal Epidemiology Center (TEC) program in FY 1996. The intent was to develop Epidemiology Centers and public health infrastructure by augmenting existing tribal organizations with expertise in epidemiology and support.

Epidemiology provides the foundation for all public health activities. Tribal governments and health facilities as well as IHS direct-service sites already deliver public health services such as immunization and cancer prevention and control programs to American Indian and Alaska Native (AI/AN) communities throughout the country. More efficient service delivery and development of effective interventions to improve health requires in-depth knowledge of the causes of illness and mortality among the population and epidemiology provides that knowledge.

The IHS Division of Epidemiology and Disease Prevention (DEDP) is the national coordinating center and collaborates with the 12 TECs to collect, analyze, interpret, and disseminate health information critical to identifying diseases to target, suggesting strategies for successful interventions and testing the effectiveness of health interventions that have been implemented.

Initially, four TECs competed and received recommendations from an objective review panel. They received funding of up to $155,000 each through cooperative agreements with Tribes and Tribal organizations, such as Indian health boards.

In FY 2000, the four original TECs plus two new centers received funding for five years. Three new TECs were added in FY 2005 and in FY 2006, after the most recent competitive 5-year cooperative agreement award process, the IHS TEC program was expanded to include 11 TECs. In FY 2008, IHS continued to fund 11 Tribal epidemiology centers, the IHS national coordinating center in Albuquerque and additionally, one new TEC in California was recognized and funded by the IHS Director's office. All 12 existing TECs now serve a major portion of the AI/AN population in 12 regions comparable to the IHS Areas.

In FY 2010, the IHS 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 IHS will also continue to support the TEC program in their efforts to provide technical training in public health practice and prevention-oriented research and promoting public health career pathways for tribal communities and members. In FY 2010, this will be the final year of the 5-year cooperative agreement. Activities will be finalized and summarized among the TECs. Preparations will be made for competing and issuing a new cycle of funding through the cooperative agreement process.

Operating from within Tribal organizations, TECs are unique in their position to provide support to local disease surveillance and control programs, and in assessing the effectiveness of public health programs. In addition, TECs work to improve data needed for GPRA reporting and monitoring of the Healthy People 2010 objectives. All TECs monitor the health status of tribes in their region, producing reports annually or biannually for constituent tribes. Following standardization of these reports across all TECs in FY 2008, the IHS National Coordinating Center will produce a composite picture of Indian health.

TECs provide critical support to Tribes who self-govern their health programs. Data generated locally and analyzed by TECs 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 also can lead to improvements in Indian health data overall.

IHS health priorities, as determined by Tribal recommendations, often might be a direct result of the work of TECs. All TECs strive to monitor health status of tribes in their region, producing reports annually or biannually for constituent tribes.

About 90 percent of the TECs budget is distributed through Cooperative Agreements. A fully staffed TEC would be composed of at least one physician or doctoral-level

epidemiologist, two Masters-level epidemiologists, one statistician, and support staff. Funding for each TEC is authorized up to $1,000,000.

FY 2010 Tribal Epidemiology Centers Allocation (Estimate)			
1	Alaska Native Tribal Health Consortium	Anchorage, AK	$475,000
2	Albuquerque American Indian Health Board	Albuquerque, NM	475,000
3	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI	400,000
4	Inter Tribal Council of Arizona	Phoenix, AZ	400,000
5	Montana/Wyoming Tribal Leaders Council	Billings, MT	400,000
6	Navajo Nation Division of Health	Window Rock, AZ	400,000
7	Northern Plains – Aberdeen Area	Rapid City, SD	400,000
8	Northwest Portland Area Indian Health Board	Portland, OR	400,000
9	Oklahoma City Area Inter-Tribal Health Board	Oklahoma City, OK	300,000
10	Seattle Indian Health Board	Seattle, WA	300,000
11	United South and Eastern Tribes, Inc.	Nashville, TN	300,000
12	California Rural Indian Health Board - NEW	Sacramento, CA	350,000
13	IHS Division of Epidemiology (DEDP)	Albuquerque, NM	480,295
	TOTAL		**$5,080,295**

FUNDING HISTORY

Fiscal Year	Amount
2005 *	*$4,526,369*
2006 *	*$4,525,802*
2007 *	*$4,549,669*
2008	*$4,548,361*
2009 Recovery Act	*$0*
2009 Omnibus	*$4,548,361 (est.)*

* FY funding amounts were updated to reflect "Actual" *non-add* budget data

BUDGET REQUEST

The FY 2010 budget request for Epidemiology Centers under Hospitals and Health Clinics is $5,080,295 to maintain current service levels (FY 2009 amount increased by 4% for medical and non-medical inflation). This request also includes $350,000 to fund the California Rural Indian Health Board TEC.

OUTCOMES

No specific national-level outcomes have been set for this project because each TEC sets goals and determines outcomes independently as directed by their constituent tribes and health boards.

OUTPUTS TABLE

In the expanding environment of Tribally-operated health programs, epidemiology centers 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.

The TEC 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. Efforts to supplement the TEC programs are coordinated with the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) to optimize federal resource utilization, create stronger interagency partnerships, and prevent costly duplication of effort. ***This program continues to promote HHS Goal 4 to enhance the capacity and productivity of the Nation's health science research enterprise.***

OUTPUTS

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Health Status & Monitoring **Measured by surveys, assessments, reports* Provides regional health profiles	11 of 11 TECs 11 of 11 TECs	11 of 11 TECs 11 of 11 TECs	12 of 12 TECs 12 of 12 TECs	+1 +1
Develop & Implement disease control & prevention programs Contribute to national measures, i.e., GPRA/ Healthy People 2010	11 of 11 TECs 11 of 11 TECs	11 of 11 TECs 11 of 11 TECs	12 of 12 TECs 12 of 12 TECs	+1 +1
Support tribal communities through technical training in public health practice	11 of 11 TECs	11 of 11 TECs	12 of 12 TECs	+1
Program Level Funding ($ in millions)	**$4.5**	**$4.5**	**$5.1**	**+$0.5**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

GRANTS AWARDS

Cooperative Agreements	FY 2008	FY 2009	FY 2010
Number of Awards	11*	11 + 1*=12	12**
Average Award	$379,030	$379,030	$390,792
Range of Awards	$290,000-$530,000	$315,000-$530,000	$300,000-$475,000
IHS Director's Office Funds	$350,000	$350,000	

* IHS Director's Office Funds - In FY 2008, IHS continued to fund 11 Tribal epidemiology centers, the IHS national coordinating center in Albuquerque and additionally, one new TEC in California was recognized and funded by the IHS Director's office.

** The IHS national coordinating center in Albuquerque is included in average.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
HOSPITALS AND HEALTH CLINICS
Health Information Technology

	FY 2008	FY 2009		FY 2010	FY 2010
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	+/- FY 2009 Omnibus
BA	$1,484,016,000	$1,597,777,000	$85,000,000	$1,751,293,000	+$153,516,000
HIT	*$112,006,000*	*$114,506,000**	*$85,000,000*	*$130,757,000*	*+$16,251,000*
FTE	*313*	*511*	*0*	*511*	*0*

* Estimate as of April 2009.

Authorizing Legislation..... 25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001, Section 214(a) (1) Public Law 94-437, Indian Health Care Improvement Act, as amended

Allocation Method.....Direct Federal; Cooperative Agreements, HIT services and products comprise the large majority of allocations to 12 Area Offices within the IHS.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Health Information Technology (HIT) - Health care is information intensive and dependent on technology to assure that appropriate health information is available whenever and wherever the data is needed. Information technology is essential to effective health care delivery and efficient resource management in the IHS. The IHS HIT is based on an architecture that incorporates government and industry standards for the collection, processing and transmission of information. IHS HIT is managed as strategic investments by senior management, fully integrated with the agency's programs, and critical to improving service delivery as reflected in this and other budget activity narratives and displayed in the accompanying budget exhibits. The IHS has a long history of successfully integrating health information technology and health service delivery. The Resource and Patient Management System (RPMS) is the IHS enterprise health information system. RPMS consists of more than 60 software applications and is used at approximately 400 IHS, tribal and urban (I/T/U) locations. The RPMS Certified Electronic Health Record (EHR) is in use in a meaningful way at over 200 of these facilities, with continued deployment activities underway. RPMS applications support direct clinical care in both medical and behavioral health settings, case management, population and public health, and clinical quality reporting; the suite also include practice management and revenue cycle capabilities. RPMS-EHR is a critical component to the success of the chronic care initiative, as well as the health promotion/ disease prevention and behavioral health initiatives.

Costs of the IHS IT infrastructure (development, support, licensing, contracts, bandwidth, training of staff, and others) have risen dramatically in the past decade. Information technology helps ensure that IHS is able to meet these needs. The RPMS application suite is considered a leading HIT system in many areas, including wellness, population and public health, chronic care management and electronic clinical quality reporting. The IHS works closely with the Office of the National Coordinator for Health Information Technology, Centers for Medicare and Medicaid Services, Agency for Healthcare Research and Quality, Veterans Health Administration, Department of Defense, and other Federal entities on IT initiatives to ensure that the direction of our HIT system is consistent with other Federal agencies. In addition, IHS has routinely shared HIT artifacts (design and requirement documents, clinical quality logic, etc.) with both public and private organizations.

IHS has also continued to expand its support for telehealth. Telehealth enables a "best practice" model of specialist health care delivery. Such a model of enhanced access, improved clinical quality, and organizational cost-efficiency is possible through the emerging tools of expert tele-consultation and home monitoring/care coordination.

Many telehealth clinical tools were initially developed to support acute illness care; telehealth expansion within Indian Health Service specifically targets chronic care and a comprehensive approach to integrated specialty service delivery. Clinical problems and chronic conditions targeted for enhanced service delivery include diabetes care, cardiovascular care, and mental health care. Ongoing federal investments in telehealth include items such as the Alaska Federal Health Care Access Network (AFHCAN) enterprise telemedicine solution and the IHS Joslin Vision Network program. The telehealth program closely integrates its planning, implementation, and evaluation activities with three of the Agency's health initiatives on chronic care, behavioral health, and health promotion/disease prevention.

Finally, IHS strives to improve its HIT infrastructure to support Presidential, Secretarial and IHS goals and priorities. This infrastructure is fundamental to HIT and health care operations. The current emphasis on health information technology emphasizes the use of a certified electronic health record in a meaningful way. Indian Health Service is committed to meeting this charge, recognizing that HIT holds the potential for improved clinical quality and safety and health information interoperability for all citizens.

The RPMS Program underwent a program assessment in 2003. The assessment cited progress in achieving the majority of long-term performance goals and a clear commitment to provide accurate, timely, and comprehensive information to IHS providers and program managers as strong attributes of the program. The RPMS program continues to take actions to develop the capability to track how system improvements impact health outcomes, to develop budget requests that are explicitly tied to the accomplishment of annual and long-term performance goals and to analyze alternatives to provide a valid cost accounting link to health outcomes.

American Recovery and Reinvestment Act (ARRA) – Health Information Technology (HIT)

Recovery Act funds enable IHS to modernize and extend its electronic health care information tools, improving access, quality, safety and overall health status of American Indian/Alaska Native patients and populations. Approximately 60% of the funds will be obligated in FY 2009 and 40% in FY 2010.

Approximately 95% of Recovery Act funded activities will be carried out through existing or new commercial contracts. IHS will use up to 5% of the funds for administrative costs, project management, and Recovery Act transparency reporting.

- New competition:
  - Approximately 20% will be used for new hardware acquisitions for the purpose of infrastructure modernization relating to security, networking, communications, and health information technology. These purchases will be completed through new contracts competed among vendors offering products that meet the government's requirements. In addition, acquisitions for software development and related services will be awarded via appropriate contract vehicles and through existing Tribal contracts as appropriate.
  - In addition, approximately 25% will be used for a number of new acquisitions anticipated for software development and related services including requirements identification and management, design, development, testing, quality assurance, release management, and deployment. These new acquisitions will also be awarded via appropriate government contract vehicles, as well as through existing Tribal contracts as appropriate.

- Supplements to former competition: The remaining 50% will be awarded through several existing GSA contracts that will be accelerated to expedite Recovery Act funded activities for the EHR. The IHS has several existing GSA-awarded contract vehicles that will be accelerated to accommodate the immediate opportunity afforded by the ARRA funding; this will enable us to rapidly expand our activities in the near term, addressing known requirements that were previously unfunded. Existing contracts will be used wherever the proposed work is consistent with the original contract scope; the vendors are prepared to add staff as necessary to meet the government's need.

Objectives -- Consistent with the intent of ARRA and the HITECH portion of the Act, as well as with its own mission, IHS has identified activities to improve access, quality, safety, and overall health status of American Indian/Alaska Native patients and populations. These include:

- Meaningful use of a qualified Electronic Health Record –
  - Comprehensive Health Information – Improving capabilities across the RPMS suite, such as clinical care, support services, and practice management, including

activities to increase the ease of implementation, support, and usability of the system.
    - Provider Order Entry – Continued improvements to applications that support the communication of orders and consultations, including electronic prescribing, among members of the health care team both on-site and remotely.
    - Clinical Decision Support – Creating and acquiring clinical decision support tools that build additional intelligence into RPMS, supporting quality of care and patient safety.
    - Quality and Performance Reporting – Expanding existing quality and performance reporting capabilities and ensuring that quality and performance data are transparent and accessible to consumers of IHS health care services.
    - Health Information Exchange – Activities to ensure that RPMS meets national interoperability standards and that facilities using RPMS are positioned to participate in exchanges such as the Nationwide Health Information Network.
    - Certification – Ensuring that RPMS receives national certification as a qualified EHR for inpatient use and for behavioral health settings and continued certification as an outpatient EHR solution.
    - Deployment – Intensive support for the deployment of RPMS EHR in all Federal and Tribal inpatient facilities and optimization of implementation in outpatient settings as well.
- Personal Health Record Adoption – Development and collaborations to create truly consumer-oriented tools for management and portability of personal health information.
- Telehealth and Network Infrastructure – Increasing the capability of the IHS technology infrastructure to support a broad range of new telehealth initiatives.

This investment in health information technology within IHS will directly benefit the economy through the expenditure of funds in the private sector for goods and services. Planned activities will contribute to the revitalization of the American economy because these activities will require a significant expansion in the use of IT service companies and will also support substantial acquisition of hardware from U.S. based information technology companies.

FUNDING HISTORY

Fiscal Year	Amount *
2005	*$80,147,000*
2006	*$76,192,000*
2007	*$98,243,000*
2008	*$112,006,000*
2009 Recovery Act	*$85,000,000*
2009 Omnibus	*$114,506,000*

*This represents the total cost of HIT within IHS. The vast majority is from the Hospital & Health Clinics budget line with a small amount from Direct Operations for federal personnel and travel.

BUDGET REQUEST

The FY 2010 budget request for Information Technology under Hospitals and Health Clinics is $130,757,000, an increase of $16,251,000 over the FY 2009 Omnibus level.

IHS has information technology professionals working throughout the U.S. in clinics, hospitals, Area Offices, and two Headquarters locations. The consolidation of the HHS investment resulted in a detailed data call throughout IHS facilities. The increase in the OMB A-11 exhibit 300 for the IHS Infrastructure investment from FY 2009 to FY 2010 reflects the additional personnel, and their salaries, identified during this process and is a more accurate picture of what is spent in HIT.

IHS' HIT solution (RPMS – Resource and Patient Management System) continues to expand to meet additional reporting requirements and provide increased but essential HIT services to patients, providers and communities. Traditionally, HIT is funded primarily from the Hospital and Health Clinics budget. Increasing clinical needs have led to increased spending on HIT to ensure compliance with federal mandates, increased security needs, improved infrastructure, as well as ongoing and enhanced development and deployment of the electronic health record in over 200 sites. These increases are currently funded from direct clinical care funds. The current budget request ensures that these budget needs are independent of direct clinical care funds.

The current IT budget request supports the functionality, interoperability and evolution of the IHS health IT system.

OUTCOMES

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
RPMS-E1 and E2: Average days in accounts receivable for hospitals and average days in accounts receivable for small ambulatory clinics. *(Efficiency)*		Baseline	TBD	N/A
RPMS-2: Derive all clinical measures from RPMS and integrate with EHR (Clinical Measures/Areas) (RPMS Program Assessment)	FY 2008: 59/12 (Target Met)	61/12	63/12	2/maintain
RPMS-7: Number of patients with clinical images captured or displayed for use in the RPMS Electronic Health Record (RPMS Program Assessment)		Baseline	10% increase	+10%
Program Level Funding ($ in millions)	**$112.0**	**$114.5**	**$129.3**	**+$16.3**
ARRA Level Funding ($ in millions)	**$0**	**$85.0**	**$0**	**$0**

GRANTS AWARDS -- IHS does not use grants for health information technology.

AREA ALLOCATION -- Area funding of health information technology is handled similarly to the national level; the funding is from other budget line items, not specified as a line item for HIT.

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

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$133,637,000	$141,936,000	$0	$151,384,000	+$9,448,000
FTE	728	767	0	777	+10

Authorizing Legislation .....25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001

FY 2010 Authorization .....Expired 2000

Allocation Method..... Direct Federal; P.L. 93-638 Self-Determination Contracts, Grants, and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Dental Program has been in existence since the inception of the IHS in 1955. The Dental Program raises the oral health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level through the provision of quality preventive and treatment services at both the community and clinic levels. The Dental Program is oriented toward preventive and basic care and over 90 percent of the dental services provided are basic and emergency care. More complex rehabilitative care (i.e., root canals, crown and bridge, dentures and surgical extractions) are provided where resources allow. The demand for dental treatment remains high due to the high dental caries rate in the AI/AN children; however, a continuing emphasis on community oral health promotion/disease prevention is essential to long-term improvement of the oral health of AI/AN people.

The dental program maintains data and tracking of the three Government Performance and Results Act key program objectives – dental sealant, dental access, and topical fluorides. During the most recently completed Government Performance and Result Act (GPRA) data collection period, the dental program met the access to care target, exceeded the topical fluoride objective by 12 percent, and narrowly missed meeting the sealant objective by 1.7 percent.

In FY 2008, the dental program utilized field dental programs in conjunction with the Dental Clinical and Preventive Support Centers to achieve the program performance targets. The target for the topical fluoride measure was surpassed, resulting in a 12% increase in the number of topical fluoride applications over the previous fiscal year. The Dental access to care target was met, with 25% of the patient population receiving dental

services. The dental sealant objective met 98% of its target. The dental program has reported that most patients in the age cohorts targeted for sealants have already have had sealants placed on their teeth and that there are fewer new patients eligible for sealants each year. As a result, targets based on historical performance may continue to be difficult to achieve for this measure. The collaborative efforts between the field dental programs and the Dental Clinical and Preventive Support Centers have resulted an increase in the number of topical fluorides applications, meeting the target for dental access, and a decrease in the number of teeth eligible for dental sealants. The Dental Clinical and Preventive Support Centers were designed and implemented in FY 2000 to help augment the dental public health infrastructure necessary to best meet the oral health need of the AI/AN community. The primary purpose of a Dental Clinical and Preventive Support Center is to provide technical support, training, and assistance in clinical and preventive aspects of dental programs providing care to the AI/AN community. Each of the support centers approaches the target based on the assessed needs of their Area but all strive towards providing the technical support, training and assistance needed for the improvement of access of care and quality of care provided to the AI/AN population. The current support centers continue to develop and implement the unique and innovative programs to address the needs of the AI/AN community. The FY 2008 activities of the Support Center include but not limited to:

- Coordinated the dental referral and recall appointments for expectant mothers, caregivers, infants and preschoolers.
- Increased Tribal infrastructure to deliver community-based primary prevention and oral health education programs.
- Conducted ongoing oral health assessments in Tribal communities where prevention programs are in place.
- Conducted fluoridation advocacy for area communities that do not have fluoridated water.
- Increased access through partnership with public/private organization to provide dental care.

	Support Center	**States**	**Area**
1	AK Native Tribal Health Consortium	AK	Alaska
2	All Indian Pueblo Council	NM	Albuquerque
3	Intertribal Council of Arizona	AZ, UT, CO	Phoenix/Tucson
4	Northwest Portland Area Indian Health Board	OR, WA, ID	Portland
5	Salish & Kootenai Tribes of Flathead	MT, WY	Billings
6	CA Rural Indian Health Board	CA	California
7	Aberdeen Area Tribal Chairmen's Health Board	ND, SD, NE	Aberdeen
8	Nashville Area Dental Support Center	TN	Nashville

For FY 2008, the Dental Program placed approximately a quarter of a million sealants to the teeth of roughly 90,000 patients. One of the challenges that the program will face is that many adolescents already experience a higher prevalence of dental sealants, making it increasingly difficult to maintain current levels of sealant placement production. This represents a significant victory for IHS Dental Program, as greater percentages of eligible tooth surfaces have been protected by dental sealants.

FUNDING HISTORY

Fiscal Year	Amount
2005	$109,023,000
2006	$117,731,000
2007	$125,396,000
2008	$133,637,000
2009 Recovery Act	$0
2009 Omnibus	$141,936,000

BUDGET REQUEST

The FY 2010 budget request for Dental Health is $151,384,000, an increase of $9,448,000 over the FY 2009 Omnibus level. This increase represents $9,224,000 for pay increases, inflation, population growth and staffing new facilities and $224,000 to provide health care to members of Tribes that have recently become eligible for IHS services.

Staff for New Facility	Amount	Tribal Positions
Absentee Shawnee Health Center (JV), Little Axe, OK	$481,000	5
Santee Health Center (JV), Santee, NE	$293,000	4
Carl Albert Hospital Replacement (JV), Ada, OK	$1,781,000	23
Lake County Tribal Health Center (JV), Lakeport, CA	$69,000	1
TOTAL	**$2,624,000**	**33**

The plans for FY 2010 are to increase emphasis on the oral health promotion and disease prevention programs with activities such as school-based dental sealant programs, community water fluoridation programs and periodontal treatment programs for high-risk patients; increased collaboration with the funded Dental Clinical and Preventive Support Centers to increase awareness and education with community-based and school-based prevention programs; and to expand the collaboration with the American Dental Association (ADA) on oral health promotion and disease prevention initiatives identified at the recent oral health summit held jointly between the ADA, IHS, and AI/AN community members. Faced with an on-going critical vacancy rate, the program plans continued targeting of high-risk patients and collaborative efforts within and outside of IHS as strategies to meet ambitious targets set forth in FY 2010. The specific examples of the utilization of the support centers to achieve the goals for FY 2010 included but not limited to:

- Provide biannual comprehensive dental program reviews, with emphasis on improving the efficiency and effectiveness of the dental programs to each of the eight IHS and tribal dental programs in the Billings Area.
- Increase access to dental care to Diabetic patients in the Phoenix Area by establishing two periodontal treatment programs for diabetics.
- Provide training and technical assistance in sealant application to at least two staff members at 18 dental clinics in the Aberdeen Area.

- Maintain the original 5 pilot sites of Healthy Start Programs currently using Xylitol gum in their classrooms in the Aberdeen Area. Plans to increase Xylitol gum programs to all sites in the Aberdeen Area.
- Maintaining the 43 (out of 55) fluoridated community water systems in the Aberdeen Area.
- Conduct fluoridated advocacy for communities who do not have fluoridated water in the Oklahoma Area.
- Increase access through partnership with the public/private organization to provide care in a mobile dental clinic in the Oklahoma Area.
- Provide programs about the effect of tobacco on the oral health.

The IHS expects to continue the implementation of the Electronic Dental Record (EDR) in FY 2009 to:

- Increase patient safety
- Reduce medical/dental errors
- Increase patient visits through improved scheduling and diagnostic capabilities.
- Increase third party revenues through more effective and efficient billing practices
- Improving patient tracking and clinical functionality.

OUTCOMES

Measure	FY 2008	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
12: **Topical Fluorides:** Number of American Indian and Alaska Native patients receiving at least one topical fluoride application.	FY 2008: 120,754 (Target Exceeded)	114,716	114,900	+184
13: **Dental Access:** Percent of patients who receive dental services.	FY 2008: 25% (Target Met)	24%	26%	+2%
14: **Dental Sealants:** Number of sealants placed per year in AI/AN patients.	FY 2008: 241,207 (Target Unmet)	229,147	230,000	+853
Program Level Funding ($ in millions)	**$133.6**	**$142.0**	**$151.4**	**+$9.4**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	FT 2008	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Dental Vacancy Rates	26%	26%	26%	0%
Patient Visits	987,502	1,018,700	1,053,300	+34,600
# of Services	3,009,000	3,104,100	3,209,600	+105,500
Program Level Funding ($ in millions)	**$133.6**	**$142.0**	**$151.4**	**+$9.4**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

GRANTS AWARDS – Support Centers

	FY 2008	FY 2009	FY 2010
Number of Awards	4	4	4
Average Award	$249,998	$249,998	$249,998
Range of Awards	$249,996 – 250,000	$249,996 – 250,000	$249,996 – 250,000

AREA ALLOCATION – Dental Services

Discretionary SERVICES	**FY 2008 Actual**	**FY 2009 Omnibus**	**FY 2010 Estimate**	**FY 2010 +/- FY 2009**
Aberdeen	$12,881,047	$13,469,979	$14,410,654	+$940,675
Alaska	17,629,038	18,435,053	19,320,868	+885,816
Albuquerque	7,799,291	8,155,881	8,547,777	+391,895
Bemidji	3,826,713	4,001,673	4,193,956	+192,283
Billings	6,942,394	7,259,807	7,608,645	+348,838
California	1,408,052	1,472,429	1,612,282	+139,853
Nashville	2,301,775	2,407,014	2,522,673	+115,659
Navajo	27,862,863	29,136,777	30,536,817	+1,400,040
Oklahoma	27,377,384	29,418,101	33,097,011	+3,678,910
Phoenix	10,941,534	12,841,790	13,458,846	+617,056
Portland	7,106,948	7,431,884	7,788,991	+357,107
Tucson	1,690,187	1,767,464	1,852,392	+84,928
Headquarters	5,869,775	6,138,146	6,433,088	+294,942
Total, Dental	**$133,637,000**	**$141,936,000**	**$151,384,000**	**+$9,448,000**

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

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$63,531,000	$67,748,000	$0	$72,786,000	+$5,038,000
FTE	277	292	0	295	+3

Authorizing Legislation.....25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001

FY 2010 Authorization.....Expired 2000

Allocation Method..... Direct Federal; P.L. 93-638 Self-Determination compacts and contracts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

In partnership with American Indian and Alaska Natives (AI/AN), the purpose of the Mental Health/Social Service (MH/SS) program is to raise their physical, mental, social and spiritual health to the highest possible level. We strive to support AI/AN communities in eliminating behavioral health diseases and conditions by: 1) maximizing positive behavioral health and resiliency in individuals, families and communities; 2) improving the overall health care of AI/AN; 3) reducing the prevalence and incidence of behavioral health diseases; 4) supporting the efforts of AI/AN communities toward achieving excellence in holistic behavioral health treatment, rehabilitation, and prevention services for individuals and their families; 5) advocating for and supporting Tribal behavioral treatment and prevention efforts; 6) promoting the capacity for self-determination and self-governance; and 7) advocating for AI/AN and service providers by actively participating in professional, regulatory, educational, and community organizations at the National, State, Urban and Tribal levels.

The MH/SS program is a community-oriented clinical and preventive mental health service program that provides primarily outpatient mental health and related services, crisis triage, case management, prevention programming, and outreach services. The MH/SS program provides general executive direction 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 163 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 1.9 million AI/AN. Mental Health is crucial for the well-being of AI/AN communities.

The most common MH/SS program model is an acute, crisis-oriented outpatient service staffed by one or more mental health professionals. Over half of the federally recognized Tribes have administrative control over and delivery of the majority of mental health and substance abuse programs through tribal contracts and compacts. Such local programs are community based and have direct knowledge of their population and what interventions can be effectively implemented. Many of the IHS, Tribal and Urban (I/T/U) mental health programs that provide services in times of crises do not have enough staff to operate 24/7. Therefore, when an emergency occurs, the clinic and service units will often have to contract out to non-IHS hospitals and crisis centers. Inpatient services are often purchased from non-IHS hospitals or provided by State or County mental health hospitals. 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.

IHS has developed a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion. The suicide surveillance tool captures data related to a specific incident of suicide, such as date and location of act, method, contributing factors, and other useful epidemiological information. Local and national reports can be sorted by a number of different variables including the number of suicide events by sex, age, community, tribe, and others. The suicide surveillance measure has evolved from the FY 2004 target of deploying a suicide reporting form into the behavioral health package to integrating the form into the Resource Patient Management System (RPMS) in FY 2005 to setting a baseline level of use in FY 2006. The FY 2008 target for the use of the suicide surveillance form was not met. The target was to increase the completion of suicidal behavior reporting forms from 1,674 in FY 2007 to 1,758 in FY 2008. The number of forms completed dropped to 1,598. While the Behavioral Health-Management Information System was deployed widely in FY 2007, there were few additional sites added in FY 2008. Moreover, because this measure tracks forms completed, it is difficult to tell whether a decrease reflects lower usage of a form, or fewer events to record. The FY 2008 target was increased based on the FY 2007 performance results; however, targets for this measure are difficult to set, as it is also contingent on broader trends within AI/AN communities. In addition, the suicide surveillance form is currently underutilized by medical and behavioral health providers. To increase the utilization of the suicide surveillance reporting form, IHS will increase and improve awareness of the form and the importance of suicide surveillance activities among providers, facility and Area managers, and administrators. Similarly, RPMS Site Managers and Electronic Health Record (EHR) Clinical Application Coordinators (CAC) must also be aware of the suicide surveillance reporting form component and the appropriate application set-up and exporting processes. The FY 2009 target is to increase 5 percent over the FY 2008 result to 1,678 forms completed.

IHS has been assessing the depression screening rate since FY 2006, when a baseline rate of 15 percent was established. In FY 2004 and FY 2005, the measure tracked the number of programs reporting certain behavioral health-related data. In FY 2007 the target for this measure was exceeded by 9 percentage points. In FY 2008 the targets for this

measure were met and exceeded. In FY 2008, 35 percent of patients age 18 and older were screened for depression, an increase of 11 percentage points over the FY 2007 rate of 24 percent. This measure has seen significant increases in results from the baseline result of 15 percent in FY 2006. Higher screening rates reflect increasing provider awareness of the importance of universal screening for depression among adults. The FY 2009 target is to maintain the screening rate at the FY 2008 results of 35 percent. The FY 2010 target is to increase the screening rate to 44 percent. This is a lower-cost screening measure with potential high return on investment. Depression is often an underlying component contributing to suicide, accidents, domestic/intimate partner violence, and alcohol and substance abuse. Early identification of depression will contribute to reducing their incidence, as well as allow providers to plan interventions and treatment to improve the mental health and well-being of AI/AN people who experience depression.

Director's Behavioral Health Initiative: Behavioral Health is an integral part in the treatment and prevention of diseases. Many health conditions are linked to life-long behavior patterns, and therefore can be prevented by a change in lifestyle. By focusing on effective behavioral health techniques and integrating Tribal traditions and customs, we can bring proven behavioral health strategies and specific health promotion and disease prevention programs to AI/AN communities. Significant disparities exist within the AI/AN communities that can lead to behavioral health problems. Issues such as substance abuse, domestic violence, forced cultural change, education, poverty, lack of economic opportunity, and isolation can lead to physical and psychological problems.

The objective of the Director's Behavioral Health Initiative is to improve the physical, mental, social, and spiritual well-being of AI/AN people by implementing strategies that will integrate and adapt various types of behavioral health techniques on a Federal, Urban and Tribal level, by focusing on the following areas:

- ***Methamphetamine Abuse Reduction***: Methamphetamine use in Indian country can be described in a single word: "Crisis." It is a crisis for individuals, families, communities, agencies and tribal governments. Most of the services for methamphetamine prevention programs are at the Tribal community level. The IHS is supporting Tribal programs through funding, national networking, training, and educational services. In the IHS system, clinical services are provided.

- ***Suicide Prevention***: The Center for Disease Control and Prevention reports that from 1999-2004, the suicide rate for American Indians/Alaska Natives (AI/AN) was 10.84 per 100,000, higher than the overall US rate of 10.75. Suicide clustering is also a phenomenon known to occur in Indian country, affecting entire communities. Most of the suicide prevention programs are at the Tribal community level. The Division of Behavioral Health focuses efforts in the areas of emergency preparedness, training, national networking and educational services.

- ***Child/Family Protection***: Domestic violence affects all communities, but AI/AN women and children are particularly vulnerable to abuse: In 2003, AI/AN children had the highest rate of victimization; 21.3 children per 1000 *(National Data Analysis*

- ***BH Management Information System (MIS)***: Used to provide direct clinical services, as well as sharing patient care documents and electronic charts across wide geographic areas in real-time (in accordance with the Health Insurance Portability and Accountability Act regulations). In 2006, a GPRA indicator for Depression Screening was implemented in order to screen for depression, potential suicide risk and suicide clustering, providing clinicians with more accurate data and documentation tools in order to develop a comprehensive treatment plan and intervention.

- ***Wellness:*** Several area offices have been focusing on the promotion of wellness and the treatment and prevention of chronic diseases through creative and alternative treatments that are culturally competent.

Current and Recent Activities -- IHS has several programs that target suicide, such as:

A. The IHS National Suicide Prevention Initiative -- The Director established the Suicide Prevention Initiative which is directly related to the Health and Human Services (HHS) National Strategy for Suicide Prevention and includes the following activities:

IHS established the Suicide Prevention Committee (SPC), which provides recommendations and guidance to the Indian health system regarding suicide prevention, intervention and post-prevention in Indian Country. Membership of the SPC is interdisciplinary and represents a broad geographic distribution within and outside the Indian health system. In December 2008, the SPC submitted the "5-Year Indian Health System Suicide Prevention Strategic Plan."

The IHS Community Suicide Prevention website provides AI/AN communities with culturally appropriate information about best/promising suicide prevention and early intervention programs and training opportunities. Further information and resources can be found at the following address: http://www.ihs.gov/NonMedicalPrograms/nspn/

A Memorandum of Understanding between Health Canada and the United States Department of Health and Human Services was signed to raise the health status of First Nations people in Canada and American Indians/Alaska Natives in the U.S. An Ad Hoc Working Group on Suicide Prevention was established to share knowledge. As part of this work, the Honouring Life Network, which is a project of the National Aboriginal Health Organization, developed a website that offers culturally relevant information and resources on suicide prevention for Aboriginal people in Canada. Further information and resources can be found at the following address: http://www.honouringlife.ca/

Tele-behavioral health technology is increasingly adopted to improve access to behavioral health services. Currently, over 30 IHS and Tribal facilities in 8 IHS Areas are augmenting on-site behavioral health services with tele-behavioral health services. This type of system capacity building supports not only distance psychiatric services to remote communities where such services are not available now but can also be used to share resources more efficiently in urban and semi-urban areas.

IHS supports changing the paradigm of mental health services from being specialty and disease focused to being a part of primary care and the "Medical Home." This offers new opportunities for interventions that identify high-risk individuals before their actions or behavior becomes more clinically significant. Such interventions offer the promise of reducing traumatic experiences and losses dramatically in AI/AN communities. One primary care based behavioral health intervention is the Alcohol Screening Brief Intervention, which our agency is broadly promoting as an integral part of a primary care based behavioral health program. The agency, through our Chronic Disease Collaborative and Innovations in Primary Care project, is also supporting efforts to integrate behavioral health providers directly into primary care settings.

B. The Emergency Medical Services/Preparedness Division -- The IHS Emergency Medical Services/Preparedness Division is supporting AI/AN communities by utilizing the IHS Emergency Response to Suicide Model to assess communities with high incidence of suicide, coordinate a response to the affected community, and augment existing staff, with the goal of mitigating the emergency and stabilizing the community. For example, in FY 2008, the IHS Emergency Services staff on behalf of HHS and Intergovernmental Affairs managed the deployment of Public Health Service mental health clinicians through the Office of Force Readiness and Deployment (OFRD) to one Tribal community from January - May 2008 to respond to a suicide "cluster" in that community.

C. Inter-Agency and Other Collaborations -- IHS collaborates with Tribes and Tribal organizations, Urban Indian programs, Federal (e.g., SAMHSA, CDC, NIMH), State, and local agencies, as well as public and private organizations (e.g. Suicide Prevention Resource Center, National Suicide Prevention Lifeline) to formulate long term strategic approaches to address the issue of suicide in Indian Country more effectively. Some of these collaborations included: the Joint IHS & SAMHSA National Behavioral Health Conference which provided training on a variety of behavioral health topics, including co-occurring disorders, methamphetamine and suicide prevention/intervention training. The 2008 Conference was held in Billings, Montana in August. There was an expansion of the collaboration efforts last year with the inclusion of the Bureau of Indian Affairs and Department of Justice, Housing and Urban Development. These Federal partners convened a Tribal Justice, Safety and Wellness Conference, with the IHS/SAMHSA conference included within. There was an estimated participation of over 600 trainees. The 2009 Conference is scheduled to be held in August 2009 in the Minneapolis, Minnesota area. We have been working in collaboration with the National Suicide Prevention Lifeline (1-800-SUICIDE crises line) and the Suicide Prevention Resource Center to develop and disseminate culturally appropriate information and resources for

suicide prevention in Indian Country, both of which are funded by SAMHSA. The IHS established a National Behavioral Health Workgroup in 2007; and established the National Tribal Advisory Committee on Behavioral Health in 2008. Through an Intra-Agency Agreement, the IHS and the Administration for Children and Families (ACF) have collaborated in the planning, development and administration of an expanded training project that will provide five regional training sessions for I/T/U mental health and service providers who work in the area of child abuse and neglect (CAAN). The IHS and ACF have a long history of collaboration on this project to provide this needed training. This year's training will be expanded to include technical assistance to mental health and service providers who serve AI/AN children who have experienced physical, sexual abuse and related trauma.

D. Resource Patient Management System (RPMS) -- IHS has made substantial efforts over the last several years to improve the documentation of behavioral health services by enhancing behavioral health functionality in the Agency's health information system, Resource and Patient Management System (RPMS). Behavioral health information is integrated with primary care and other clinical information supporting coordinated care and improved health outcomes.

IHS is developing an IHS-wide Behavioral Health "data mart" to provide IHS leadership with up-to-date information on suicidal events including suicide completions. The application will include a number of available reports and will provide the ability to identify "cluster" events to assist in the mobilization and deployment of available resources.

IHS has developed a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion. This tool is part of the RPMS health information system and is available to all providers. The Suicide Reporting Database is beginning to provide a more detailed picture of who is committing or attempting suicide and identifies salient factors contributing to the events. Accurate and timely data captured at the point of care provides important clinical and epidemiological information that can be used to inform intervention and prevention efforts.

IHS GPRA measures now include screening for depression of adults ages 18 and over in primary care settings as best practice in order to assist in identifying patients at risk for developing suicidal ideation. Tools have been selected to assess depression, monitor response, track such response over time, and are incorporated into the IHS Electronic Health Record. IHS has consistently met or exceeded target goals for this GPRA depression screening measure. The system is now deployed and in operation in over 250 clinical sites across the country. Depression screening improves detection, referral, and treatment of mental health needs.

FUNDING HISTORY

Fiscal Year	Amount
2005	$55,060,000
2006	$58,455,000

2007	$60,882,000
2008	$63,531,000
2009 Recovery Act	$0
2009 Omnibus	$67,748,000

BUDGET REQUEST

The FY 2010 budget request for Mental Health is $72,786,000, an increase of $5,038,000 over the FY 2009 Omnibus level. This increase represents $1,048,000 for Federal and Tribal pay increases; $1,016,000 for population growth at 1.5 percent; $16,000 for non-medical inflation at 1.0 percent; $1,083,000 medical inflation at 3.0 percent; $1,769,000 for staffing new facilities; and $106,000 for program increases for 2 new tribes, the Mashpee Wampanoag Tribe and the Tuscarora Tribe under the Nashville Area Office.

Staffing for New Facilities	Amount	Tribal Positions
Absentee Shawnee Health Center (JV), Little Axe, OK	$254,000	3
Santee Health Center (JV), Santee, NE	$127,000	2
Carl Albert Hospital Replacement (JV), Ada, OK	$1,264,000	17
Lake County Tribal Health Center (JV), Lakeport, CA	$125,000	2
TOTAL	**$1,769,000**	**23**

Funding distribution: approximately 50 percent is distributed to Federally administered programs and 50 percent to Tribally administered programs.

OUTCOMES

Measure	FY 2008	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
29. **Suicide Surveillance:** Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals.	1,598 (Target Unmet)	1,678	1,700	+22
18. **Behavioral Health:** Proportion of adults ages 18 and over who are screened for depression. IHS-All	35% (Target Exceeded)	35%	44%	+9%
18. Tribally Operated Health Programs	29% (Target Exceeded)	29%	35%	+6%
Program Level Funding ($ in millions)	**$63.5**	**$67.7**	**$72.7**	**+$5.0**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

The FY 2010 target is to increase 1.3 percent over the FY 2009 result to 1,700 forms completed. The increased target for FY 2010 is based on the assumption that increased use of the reporting form will result in an increased number of forms completed. Completion of forms should provide more complete information about the incidence of suicidal ideation and attempts as well as completions, which will provide far more accurate data to national policy makers and will allow interventions to be evaluated for effectiveness in ways not previously possible.

GRANT AWARDS

There were no grant awards from Mental Health in FY 2008, or anticipated for FY 2009 or FY 2010.

AREA ALLOCATION – Mental Health

Discretionary SERVICES	**FY 2008 Actual**	**FY 2009 Omnibus**	**FY 2010 Estimate**	**FY 2010 +/- FY 2009**
Aberdeen	$8,279,604	$8,661,583	$9,206,272	+$544,689
Alaska	5,826,677	6,095,491	6,389,322	+293,832
Albuquerque	4,051,805	4,238,735	4,443,062	+204,327
Bemidji	2,053,713	2,148,461	2,252,027	+103,566
Billings	3,605,893	3,772,251	3,954,092	+181,841
California	1,353,269	1,415,702	1,609,102	+193,401
Nashville	1,476,841	1,544,975	1,619,450	+74,475
Navajo	13,516,746	14,140,340	14,821,973	+681,632
Oklahoma	9,356,724	10,168,396	12,178,467	+2,010,071
Phoenix	6,060,902	7,246,522	7,595,839	+349,317
Portland	3,869,404	4,047,919	4,243,048	+195,129
Tucson	1,354,336	1,416,818	1,485,115	+68,297
Headquarters	2,725,086	2,850,808	2,988,230	+137,423
Total, Mental Health	**$63,531,000**	**$67,748,000**	**$72,786,000**	**+$5,038,000**

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

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$173,243,000	$183,769,000	$0	$194,409,000	+$10,640,000
FTE	160	169	0	171	+2

Authorizing Legislation.....25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001

FY 2010 Authorization.....Expired 2000

Allocation Method..... Direct Federal; P.L. 93-638 Self-Determination contracts and compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The purpose of the Indian Health Service (IHS) Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral health status of American Indians/Alaska Natives (AI/ANs) to the highest possible level through the provision of preventive and treatment services at both the community and clinic levels. These programs provide alcohol and substance abuse treatment and prevention services within rural and urban communities, with a focus on holistic and culturally-based approaches. The ASAP exists as part of an integrated behavioral health team 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 and Urban staff comprising 95 percent. The reported certified counselor and professional licensure rates continue at 85 percent. Two ways in which the ASAP measures its ability to raise the behavioral health status of AI/AN are by ensuring that Youth Residential Treatment Centers (YRTC) are licensed and/or accredited and that mothers to-be receive the appropriate screenings for Fetal Alcohol Spectrum Disorders (FASD).

The 12 youth residential treatment centers (YRTCs) provide substance abuse and co-occurring mental health treatment services to AI/ANs. Presently there are 11 operating YRTCs and 1 adult treatment center. Congress authorized the construction of YRTCs in each IHS Area but some Tribes have elected to run their own programs. Some IHS areas such as Alaska and Navajo, divide their funds to provide residential services for two programs. The YRTCs that are congressionally authorized for the California Area IHS are in the implementation stage, e.g., land purchase, building construction, with program justification documents approved by IHS Headquarters.

Past trending results for this program show consistent achievement of a 100 percent accreditation rate for YRTCs in operation 18 months or longer. In FY 2007 and FY 2008, this measure was not met since one facility was not accredited resulting in an accreditation rate of 91 percent. This facility continues to work toward the goal of accreditation by State certification, Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF). The anticipated timeframe is estimated to be within twelve months. In FY 2009, the target is to assist all YRTCs in their goal of achieving and maintaining the 100 percent accreditation rate.

- Reasons for Performance Result: One facility failed accreditation in FY 2008, which resulted in a 91 percent accreditation rate for the YRTCs. IHS continues to collaborate with programs regarding licensure and accreditation issues. Strong recommendations to continue with the accreditation process, including State certification, are always a top priority within the program.
- Steps Being Taken to Better Match Targets with Program Performance: The FY 2009 and 2010 targets for this measure are to reach a 100 percent accreditation rate.
- Impact of Results: These programs provide alcohol and substance abuse treatment and prevention services within rural and urban communities, with a focus on holistic and culturally-based approaches. The program 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.

In addition to the RTCs, many of the approximately 300 Tribal and Urban alcohol programs are State-licensed/certified and/or accredited. There are more than a dozen Tribally-operated AI/AN alcohol and substance abuse adult residential treatment centers, including two serving pregnant women and/or women with children.

Alcohol & Substance Abuse - Youth and Adult Regional Treatment Centers				
	Name	**Town**	**State**	**IHS Area**
1	Graf-Healing Place	Fairbanks	AK	Alaska
2	Raven's Way	Sitka	AK	Alaska
3	Desert Visions *	Sacaton	AZ	Phoenix
4	Hayool K'aal Hooghan Adult TC	Chinle	AZ	Navajo
5	Unity *	Cherokee	NC	Nashville
6	New Sunrise *	San Fidel	NM	Albuquerque
7	Shiprock Adolescent TC	Shiprock	NM	Navajo
8	Jack Brown	Tahlequah	OK	Oklahoma
9	Wemble Naalam T'at'aksni House	Klamath Falls	OR	Portland
10	Chief Gall *	Mobridge	SD	Aberdeen
11	Healing Lodge of Seven Nations	Spokane	WA	Portland

* Federally operated

The IHS methamphetamine prevention initiative focuses on the reduction, prevention, and treatment of methamphetamine use and abuse among AI/AN populations. Methamphetamine use and abuse is one of the most important health issues for Tribes, according to both formal and informal Tribal consultation.

The suicide prevention initiative is directly related to the Health and Human Services national strategy for suicide prevention, to transform the health care system by supporting community-based approaches to closing the healthcare gap, particularly among racial and ethnic minority populations. This initiative also addresses the IHS Director's Behavioral Health Initiative.

In FY 2008, the IHS received $14 million to tackle methamphetamine use and abuse as well as suicide, two very serious issues affecting Indian country. In the spring of 2008, the IHS National Tribal Advisory Committee on Behavioral Health (NTAC) was formed. This committee is made up of an elected Tribal leader from each of the twelve IHS Areas. The NTAC is charged with advising the IHS on how to spend these funds in the best interests of AI/AN communities.

As part of these efforts, expanding access to behavioral health services in a variety of settings remains an important goal. In particular, this includes access to specialty services such as psychiatry and psychology where continued service gaps remain in many locations.

Tele-Behavioral Health (TBH) or tele-videoconferencing is a technical tool that helps address chronic service gaps. In addition to supporting computerized provider order entry and documentation, this technology provides a basic structural support for providing services across large areas without any loss of efficiency. The technology is currently focused on psychiatric support, but it is readily adaptable to provide a variety of clinical and clinical support services from counseling and assessments to clinical supervision to virtual group therapy opportunities.

TBH activities in FY 2008 included the following:

- Identified the scope and extent of TBH implementation partly through a formal assessment of selected programs to establish best practices slated for Fall of 2008 (20+ active programs varying in size from several hours per month to a primary care site to complex programs serving multiple sites);
- Clarified and established TBH data sets including a retrospective review of use from 2003 through 2007 that suggests a marked ramp-up in service provision (24 contacts in 2003 to 1659 contacts in 2007);
- Proposed a TBH clinic code to improve tracking in the future that has since been approved and was implemented as of June, 2008;
- Reviewed existing MIS processes and identifying changes needed to support TBH implementation;
- Modeled potential funding models to improve scalability of TBH services including potential regionalization;
- Promoted the use and integration of TBH technologies in a number of venues including the national IHS/SAMHSA conference in August 2008, a nationally broadcast IHS-Director sponsored telehealth presentation, the IHS Combined Council Meeting in February 2008, and through meetings and teleconferences with interested

- Negotiated funding policy changes with states resulting in significant improvements in potential TBH funding support in at least one state (Arizona); and
- Established a national level project manager for TBH services.

Ongoing behavioral health data systems and software development are program priorities for IHS which include the widely deployed Behavioral Health System v3.0. The Behavioral Health Graphical User Interface (GUI) focuses on the Data Entry module of BHS v3.0 with the goal of facilitating direct provider entry of clinical data, including alcohol screenings. Data collection, management, training, and improvement efforts include expansion of the behavioral health management information system to I/T/U facilities to increase and improve alcohol screenings. Two integrated behavioral health clinical documentation and data platforms have been deployed. There are currently over 340 clinics and Tribal programs reporting to the IHS National Database using one of these platforms. Efforts are underway to integrate these platforms with the IHS Electronic Health Record. This allows access to the development of clinical reminders as well as more sophisticated case and population management tools such as iCare. It will promote interchange of information between primary care and behavioral health settings.

Even with the focused activities undertaken in FY 2008, significant disparities among AI/AN (relative to the general population) exist across the spectrum of substance abuse problems. The AI/AN drug-related death rate is 18 percent higher than the rate for the overall U.S. population. Among youths aged 12 to 17, the rate of current illicit drug use was highest among AI/ANs (23.0 percent for combined 2000 and 2001 data).

FUNDING HISTORY

Fiscal Year	Amount	Program Increases
2005	$139,073,000	
2006	$143,198,000	
2007	$148,226,000	
2008	$173,243,000	$13,782,000 – MSPI
2009 Recovery Act	$0	
2009 Omnibus	$183,769,000	$2,609,000 - MSPI

BUDGET REQUEST

The FY 2010 Budget request for Alcohol and Substance Abuse is $194,409,000, an increase of $10,640,000 over the FY 2009 Omnibus level. This increase represents $2,820,000 for Tribal and Federal pay increases; $25,000 for non-medical inflation at 1.0 percent and $4,748,000 for medical inflation at 3.0 percent; $2,757,000 for population growth at 1.5 percent; and $290,000 for program increases for 2 new Tribes, the Mashpee Wampanoag Tribe and the Tuscarora Tribe under the Nashville Area Office.

The FY 2008 alcohol screening (to prevent Fetal Alcohol Spectrum Disorders) performance target was to maintain the FY 2007 target of 41 percent. However, the actual rate was 47 percent. The FY 2009 alcohol screening (to prevent Fetal Alcohol Syndrome) performance target is to maintain the rate at 47 percent. With the FY 2010 requested funding, the program anticipates increasing this screening rate to 50 percent; the performance target for the accreditation of YRTCs will be maintained at 100 percent after it is restored to this level in 2009.

Funding distribution: approximately 90 percent of the community level Alcohol and Substance Abuse funding is distributed to Tribal operated programs via P.L. 93-638 compacts and contracts.

OUTCOMES

Measure	FY 2008	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
10. **RTC Improvement/ Accreditation:** Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more)	91% (Target Unmet)	100%	100%	Maintain
11. **Alcohol Screening (FAS Prevention):** Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients. IHS-All	47% (Target Exceeded)	47%	50%	+3%
11. Tribally Operated Health Programs	41% (Target Exceeded)	41%	44%	+3%
Program Level Funding ($ in millions)	**$173.2**	**$183.7**	**$194.4**	**+$10.6**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	FY 2008	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Outpatient Visits	60,800	63,500	66,200	+2,700
Inpatient Days	2,900	3,000	3,200	+200
The proportion of identified meth using patients who enter methamphetamine treatment program	N/A	N/A	Baseline	N/A
Reduce the incidence of suicidal activities (ideation, attempts) in AI/AN communities through prevention, training, surveillance & intervention programs	N/A	N/A	Baseline	N/A
Reduce the incidence of methamphetamine abuse in AI/AN communities through prevention, training, surveillance & intervention programs	N/A	N/A	Baseline	N/A
The proportion of youth (ages 6 – 21) who participate in evidence-based and/or promising practice prevention or intervention programs	N/A	N/A	Baseline	N/A
Establishment of trained suicide crisis response teams	N/A	N/A	Baseline	N/A
Increase tele-behavioral health encounters	N/A	N/A	Baseline	N/A
Program Level Funding ($ in millions)	**$173.2**	**$183.7**	**$194.4**	**+$10.6**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

GRANT AWARDS

There were no grant awards from Alcohol and Substance Abuse.

AREA ALLOCATION – Alcohol & Substance Abuse

Discretionary SERVICES	FY 2008 Actual	FY 2009 Omnibus	FY 2010 Estimate	FY 2010 +/- FY 2009
Aberdeen	$14,012,946	$14,864,353	$15,724,981	+$860,628
Alaska	30,930,072	32,809,340	34,708,960	+1,899,621
Albuquerque	12,267,166	13,012,501	13,765,909	+753,408
Bemidji	10,084,442	10,697,159	11,316,511	+619,352
Billings	11,182,675	11,862,119	12,548,921	+686,802
California	11,073,795	11,746,624	12,426,739	+680,115
Nashville	8,566,053	9,086,514	9,612,612	+526,098
Navajo	18,979,337	20,132,494	21,298,141	+1,165,647
Oklahoma	14,720,365	15,614,754	16,518,829	+904,075
Phoenix	16,444,287	17,443,418	18,453,371	+1,009,953
Portland	16,568,027	17,574,677	18,592,230	+1,017,552
Tucson	3,123,910	3,313,714	3,505,574	+191,860
Headquarters	5,289,925	5,611,333	5,936,222	+324,889
Total, A&SA	**$173,243,000**	**$183,769,000**	**$194,409,000**	**+$10,640,000**

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

CONTRACT HEALTH SERVICES

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$579,334,000	$634,477,000	$0	$779,347,000	+$144,870,000
FTE	2	2	0	2	0

Authorizing Legislation.....25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act, 42 U.S.C. 2001

FY 2010 Authorization.....Expired 2000

Allocation Method.....Direct Federal, '638 Contracts and Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Service (IHS) Contract Health Services (CHS) program originated under the Department of Interior, Bureau of Indian Affairs, when authority to enter into health services contracts for American Indian and Alaska Natives (AI/AN) was provided under the Johnson O'Malley Act of 1934. In 1955, it was transferred to the Department of Health, Education, and Welfare.

The CHS program supplements and complements direct care and other health care resources available to eligible AI/ANs.

CHS payments are made to community healthcare providers in situations where:

- There is a designated service area where no IHS or Tribal direct care facility exists;
- The direct care facility does not provide the required health care services;
- The direct care facility has more demand for services than it has capacity to provide; and/or
- The patient must be taken to the nearest Emergency Services facility

The CHS budget supports the purchase of essential healthcare services from community healthcare providers that include, but are not limited to, inpatient and outpatient care, routine and emergency ambulatory care, medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, and physical therapy. Additional services include treatment and services for diabetes, cancer, heart disease, injuries, mental health,

domestic violence, maternal and child health, elder care, refractions, ultrasound examinations, dental hygiene, orthopedic services, and transportation.

In FY 2008, the estimated number of one-way trips for patient and escort travel is over 40,000. In FY 2009, the estimated number of trips increases to 42,822 and in FY 2010 the estimated number of one-way trips is 44,114. The budget increases will allow IHS to fund a greater number of trips although the rising costs of both ground and air transportation continues to be a challenge because many AI/ANs live in remote areas of the country. However, the unprecedented 23 percent increase in funding proposed for CHS will allow IHS to cover these costs and dramatically increase access to care to IHS beneficiaries

In FY 2008, the estimated number of dental services provided through CHS is 65,700. In FY 2009, the estimated number of dental services increases to 69,763 and in FY 2010, the estimated number is 84,010. Again, rising cost of health care services, transportation, and demand for CHS play a critical role in the number of services that the program can purchase. In addition, dental services must meet the highest dental priority in order to be funded. The unprecedented 23 percent increase in funding proposed for CHS will allow IHS to cover dental services and dramatically increase access to care to IHS beneficiaries.

The CHS funds are provided to the Area Offices, which in turn provide resource distribution, program monitoring and evaluation activities, and technical support to 163 Federal and Tribal OUs (local level), and health care facilities providing care. In FY 2010, the funds will be distributed based on the following:

- $374.1 million, or 48 percent, for federally operated facilities, and
- $405.2 million, or 52 percent, for tribally operated programs.

The CHS budget also includes $48 million for the Catastrophic Health Emergency Fund (CHEF) that provides funding for high cost cases and catastrophic events that affect IHS and Tribal CHS programs. The significant increase recommended in FY 2010 will allow IHS to provide additional critical services to AI/ANs. The table below demonstrates the type of high cost cases CHEF paid in FY 2008.

CHEF Payments by DIAGNOSIS -- FY 2008

ICD-9-CM CODE	CATASTROPHIC ILLNESS OR EVENT	No.	CHEF AMOUNT	Organ Transplant
390-429.9	Dx-Circulatory,Cerebrovascular,Heart	278	$6,332,133	1 Heart
800-999.9	Injuries & Poisionings	205	$5,486,794	
140-239.9	Neoplasms (Cancer)	150	$ 5,161,514	3Bone Marrow
520-579.9	Diseases-Digestive System	118	$ 2,775,086	
460-519.9	Diseases-Respiratory System	52	$ 1,311,129	
580-629.9	End Stage Renal/Genital Diseases	61	$ 1,304,060	
710-739.9	Diseases-Musculoskeletal system	74	$ 1,087,966	
780-799.9	Symtoms, signs & ill-defined conditions	37	$ 850,854	
240-279.9	Diabeties, Edocrine, Metabolic Diseases	23	$ 548,478	
630-779.9	Complications-Pregnancy/Prematures	17	$ 375,952	
001-139.9	Infectious and Parastitic Diseases	12	$ 357,974	

680-709.9	Diseases-Skin & Subcutaneous Tissue	15	$ 335,452	
320-389.9	Diseases-Nervous System	19	$ 271,596	
290-319.0	Mental Disorders	13	$ 225,384	
280-289.9	Diseases-Blood Formaing Organs	5	$ 86,468	
740-759.9	Congenital Anomalies	5	$ 67,960	
	TOTAL	**1,084**	**$26,578,800**	

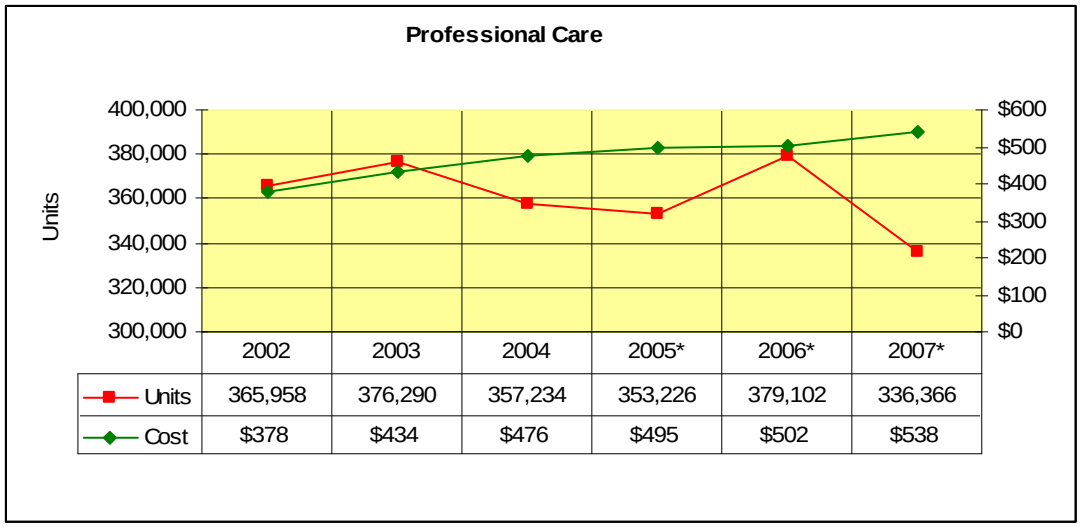
In FY 2008, after the $25, 000 threshold was met the $26,578,800 CHEF program provided funds for over 1,084 high cost cases in amounts ranging from $500 to over $575,000. Most tribal facilities do not report their data.

In FY 2007, the CHS program implemented Section 506 of the Medicare Modernization Act (MMA) that required Medicare participating hospitals to accept Medicare-like rates as payment in full. The MMA Medicare-like rates provision enable IHS, Tribes, and Urban health programs to pay full-billed Medicare-like rates for inpatient services and associated costs for hospitals that participate in Medicare programs.

To assist the CHS program in maximizing its annual resources the program contracts with Blue Cross/Blue Shield of New Mexico, as its fiscal intermediary (FI). The FI assists the Agency by ensuring CHS payments made are in accordance with the IHS payment policy. In addition, the FI focuses on quality of care and coordinates benefits with other payers to maximize the CHS dollar. The FI also calculates payment rates as set forth in negotiated provider contracts.

An important and integral function of the FI is to provide management reports on the provision of services to the AI/AN patient population and services from health care providers from the non-IHS community. These management reports are necessary to ensure the appropriateness of care and the use of CHS funds to enhance the overall effectiveness and management of the CHS program. The FI monitors data, processes payments, provides workload, and financial data in support of the IHS statistical and financial CHS program needs.

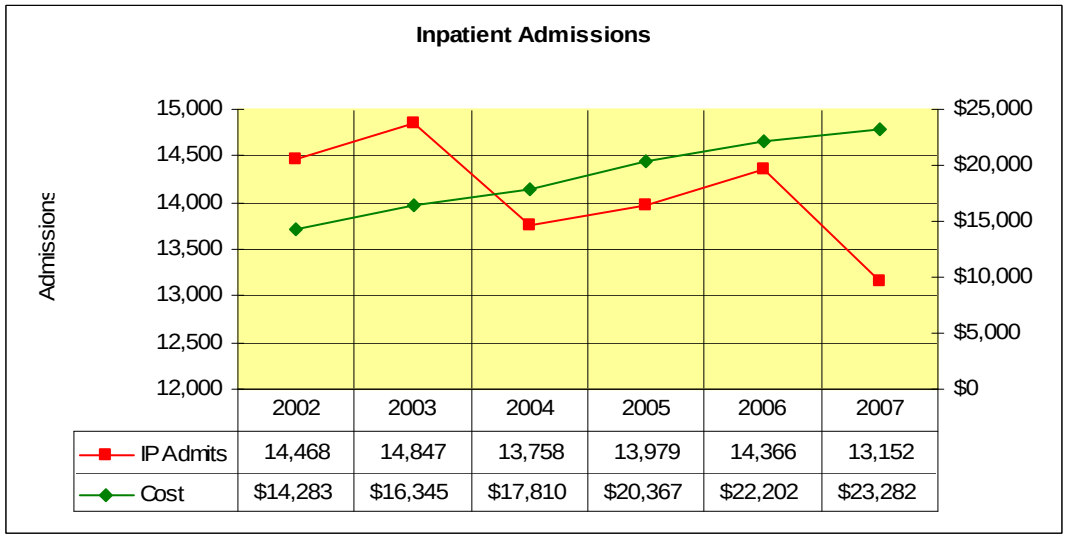
The IHS/CHS FI reports demonstrate that the annual medical costs continue to increase while the level of services provided annually is decreasing as follows:



* Data for FY 2005, 2006, & 2007 are based on annualized projections.

- From 2002 to 2007, CHS purchased professional services** decreased 6,796 or 2 percent from 365,958 to 359,165 units of service.
  At the same time, billed costs per visit increased $160 or by 42 percent from $378 to $538.

**Includes: Physician, Dental, Eye, Lab, Radiology and Other Professional Care services such as Ambulance, Cardiography, Pacemaker Analysis, Ventilation, Physical Therapy etc.



- From 2002 to 2007, CHS inpatient admissions declined by 9 percent from 14,468 to 13,152
- At the same time, billed costs per admission increased 63 percent from $14,283 to $23,282

FUNDING HISTORY

Fiscal Year	Amount
2005	$498,068,000
2006	$517,297,000
2007	$543,099,000
2008	$579,334,000
FY 2009 Recovery Act	$0
FY 2009 Omnibus	$634,477,000

BUDGET REQUEST

The FY 2010 budget request for the CHS program is $779,347,000, an increase of $144,870,000 over the FY 2009 Omnibus level. This represents $26,888,000 for pay costs increases, inflation, population growth, and $117,982,000 for program increase CHS and CHEF, and funds for two new tribes.

Current Services:

Pay Cost: +$11,000 - will fund pay increases for seven (7) Tribal employees. One position is identified for the Klamath Falls Tribe and six (6) positions are for the Pascua Yaqui Tribe in accordance with the FY 2003 Interior Appropriations Conference Report (No.108-10) language. The language states, "The conference agreement also permits funds, provided to new tribes through the contract health services activity to be used for direct medical services in addition to contract care. The Service began funding new tribes from the contract health services account several years ago and it was never the intent of the House and Senate Committee on Appropriations to limit new tribes funding to contract health care only." The FY 2003 language does provide some flexibility to Tribes for funding of positions.

Population Growth: +$9,517,000 - These funds will support additional services need resulting from the growing AI/AN population. A 1.5% growth rate is projected, based on State births and deaths data.

Inflation Non-Medical: +$3,000 - These funds will address non-medical cost increases.

Inflation Medical Care +$17,357,000 – These funds will address the increased cost of health care.

Program Increases:

Program Increase +$100,000,000 – This unprecedented increase for CHS will allow IHS to cover a significant number of CHS cases which may otherwise go uncovered.

The increase will enable the CHS program to cover not only priority I cases, but may cover some priority II and preventive services.

Because it is difficult to measure denials and deferred services, health care needs which vary greatly throughout Indian country the programs relies on the data it receives to do estimates and projections. In addition, Tribes operate 52 percent of the CHS budget and do not always report all their denial and deferred data. The continued increased cost of health care plays a vital role in number of services that can be purchased from the non-IHS community.

CHEF Increase +$17,000,000 – This increase will fund over 700 additional high cost cases that were not previously funded by the CHEF program, this increase will bring the total funding level for the CHEF to $48 million. The CHEF funds supplements the CHS program, by providing more resources for CHEF will alleviate the affects of high cost cases and enable CHS programs to provide more services at the lower priory levels.

New Tribes +$982,000 - These funds will provide funding that will integrate two new Tribes into the IHS system, the Mashpee Wampanoag of Massachusetts and the Tuscarora of New York.

The amount of CHS care in relation to direct care dollars and the types of services purchased under CHS vary among IHS Areas; the table below shows provisional budget obligations, or commitments, by general category of CHS expenditure from FY 2005 through 2008, with estimated obligations for 2009 and 2010. The CHS outputs show the relative importance of four major categories provided annually. The change in IHS hospital replacements and emphasis on outpatient care has resulted in an increased reliance on CHS resources. Over the past 10 years, the IHS has initiated the replacement of hospitals with more cost effective comprehensive health care centers requiring the IHS to purchase inpatient, emergency room services and specialized care from outside sources. This trend reflects the transition of the Indian health care delivery from an acute care to a preventive and community-based patient care.

Through the following activities, CHS is working toward providing the highest level of health care to AI/ANs:

- Provide comprehensive support with emphasis on improving the efficiency and effectiveness of CHS programs through managed care initiatives.
- Provide National training and technical assistance for both IHS and Tribal CHS programs.
- Increase partnership with the IHS Business Office to maximize and access all third party resources.
- Promote health education and prevention initiatives.
- Provide comprehensive healthcare services that improve life expectancy and address chronic disease, morbidity and reduces the disparity in health status of AI/ANs as compared to the general U.S. population.
- Negotiate contracts for the best possible rates.
- Adhere to the CHS regulations and the IHS medical priority system.

OUTPUT

Measure	FY 2008	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Gen. Med & Surgery Hospitalization: Average Daily Patient Load	236	252	304	+52
Ambulatory: Out Patient Visits	511,000	528,400	606,000	+77,600
Patient Travel: One Way	40,200	42,822	44,114	+1,292
Dental Services	65,700	69,763	84,010	+14,247
Program Level Funding ($ in millions)	**$579.30**	**$634.47**	**$779.35**	**+$144.87**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

AREA ALLOCATION – Contract Health Services

Discretionary SERVICES	FY 2008 Actual	FY 2009 Omnibus	FY 2010 Estimate	FY 2010 +/- FY 2009
Aberdeen	$62,965,125	$68,477,842	$82,904,097	$+14,426,255
Alaska	57,895,982	62,964,886	76,229,724	+13,264,838
Albuquerque	27,107,071	29,480,347	35,690,984	+6,210,636
Bemidji	38,095,003	41,430,293	50,158,430	+8,728,137
Billings	45,631,475	49,626,598	60,081,453	+10,454,855
California	28,280,633	30,756,656	37,236,174	+6,479,517
Nashville	22,288,963	24,240,404	29,347,140	+5,106,736
Navajo	63,397,692	68,948,281	83,473,643	+14,525,362
Oklahoma	68,813,330	74,838,069	90,604,235	+15,766,166
Phoenix	47,140,406	51,267,639	62,068,213	+10,800,574
Portland	63,536,321	69,099,047	83,656,171	+14,557,124
Tucson	13,723,871	14,925,422	18,069,767	+3,144,345
Headquarters	13,879,328	17,421,514	21,826,969	+4,405,455
CHEF	26,578,800	31,000,000	48,000,000	+17,000,000
Total, CHS	**$579,334,000**	**$634,477,000**	**$779,347,000**	**+$144,870,000**

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

	FY 2008	FY 2009		FY 2010	FY 2010
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	+/- FY 2009 Omnibus
BA	$127,587,000	$135,227,000	$0	$144,315,000	+$9,088,000
FTE	270	284	0	288	+4

SUMMARY OF PROGRAM

The FY 2010 budget request for Preventive Health is $144,315,000, an increase of $9,088,000 over the FY 2009 Omnibus level. This change represents $8,464,000 for pay increases, population growth, inflation and staffing 4 new facilities and $624,000 program increase for 2 new tribes.

- $64 million for **Public Health Nursing** reflects an increase of $4,186,000 over the FY 2009 Omnibus level. These funds are necessary to provide community nursing programs focused with the goals of promoting health and preventing disease and disability. The Public Health Nursing's health promotion and disease prevention focus is accomplished through primary prevention, secondary prevention, and tertiary prevention focused health interventions towards individuals, families, and community groups as well as improving health status by early detection through screening and disease management. Primary prevention targets healthy populations and activities are aimed at preventing the onset of disease in high risk populations through education, health awareness, and risk reduction. Secondary prevention detects and treats problems in the early stages of illness or disease. These interventions target disease before complications arise and before signs or symptoms appear. Secondary prevention targets populations with common risk factors. Tertiary prevention reduces further complications from a disease or illness and restores the individual to their optimum level of health. Tertiary prevention interventions occur after a disease or illness has developed.

- $17 million for **Health Education** reflects an increase of $959,000 over the FY 2009 Omnibus level. These funds are necessary to provide community health, school health, worksite health promotion, and patient education. The Health Education standardizes, coordinates and integrates education issues within the IHS including health literacy for clients, professional education and training, as well as educational materials for staff, patients, families and communities.

- $62 million for **Community Health Representatives** reflects an increase of $3,832,000 over the FY 2009 Omnibus level. These funds are necessary to bridge gaps between AI/AN persons and health care resources by integrating basic medical knowledge about health promotion/disease prevention and local community knowledge in specially trained indigenous community members.

- $2 million for **Immunization AK** reflects an increase of $111,000 over the FY 2009 Omnibus level. These funds are necessary to provide vaccines for preventable diseases, vaccine performance, immunization consultation/education, research and liver disease prevention treatment and management as top health priorities. The Hepatitis B and Haemophilus Immunization Programs (Alaska) budget supports these priorities through direct patient care, surveillance and education AI/AN patients.

Preventive Health services contribute widely to the performance measures that fall under the auspices of Hospitals & Health Clinics. Public Health Nursing provides community based clinical services which directly contribute to overall performance achievement activities such as immunizations, case management, and patient education. Community Health Representatives are also community based and integral in their contribution to follow up care and patient education. Health education activities permeate the Indian Health System and are integral to many of the screening measures. The Immunization Alaska program plays a key role by tracking immunization rates through specific immunization registries throughout the state of Alaska, and such efforts contribute to the national immunization rates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
PUBLIC HEALTH NURSING

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$55,939,000	$59,885,000	$0	$64,071,000	+$4,186,000
FTE	243	256	0	260	+4

Authorizing Legislation.....25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act, 42 U.S.C. 2001

FY 2010 Authorization.....Expired 2000

Allocation Method..... Direct Federal, P.L. 93-638 Contracts, Grants, & Compacts with Tribal nations and Tribal consortia; competitive grants; interagency agreements; commercial contracts.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Service (IHS) Public Health Nursing (PHN) is a public/community health nursing program that focuses on the goal of promoting health and quality of life, and preventing disease and disability in the community that is served. The PHN services were carried out by the Bureau of Indian Affairs in the early 1910 – 1920's then were delegated to the IHS with the Transfer Act in 1955.

The American Indian and Alaska Native (AI/AN) population experiences disproportionate rates of diabetes mellitus, cardiovascular disease, obesity, suicide, and unintentional injuries. A program focus on health promotion and disease prevention is accomplished through community-based primary, secondary and tertiary prevention services that are provided to individuals, families, and community groups. The Public Health Nurses are members of the multidisciplinary health care team and they provide continuity and coordination of healthcare which results in improved outcomes for the AI/AN population. Their work supports high quality, community-based, culturally appropriate care that reduces disparities in access and health outcomes.

Services include: communicable disease – surveillance & monitoring, immunizations; PHN case management; maternal and child health care – prenatal/postpartum case management and education, newborn/child education, developmental screening, and case management of special needs children; chronic disease care and case management; health education and screenings for at-risk diseases or health concerns, and; school health screenings.

To highlight the critical role PHNs play in the community, USA Today, July 18, 2008 and Nursing Spectrum magazine, July 28, 2008 reported the "Salmonella outbreak that sickened nearly 1200 people nationwide has showcased the critical role of the public health nurses' job." An IHS public health nurse played a key role, with her keen assessment skills and quick identification of patterns of illness, which led to the discovery of the widespread problem.

PHN programs focus on measurable clinical activities that address health disparities, and activities that support the IHS initiatives: Chronic Disease, Health Promotion/Disease Prevention (HP/DP), Behavioral Health and; the HHS Strategic Plan. The PHN outcome performance measure supports several elements of the IHS Strategic Plan - Goals 1 and 2: Build and Sustain Healthy Communities and; Provide Accessible and Quality Health Care – specifically, providing community-based approaches that address the health gap in the AI/AN population.

Forty-three percent of this budget request supports Tribal compacted and contracted PHN programs. Public Health Nurse contributions to the agency and department goals are funded through the distribution of program awards for IHS and Tribal PHN programs. There were 15 grants and program awards issued in FY 2008 that will continue through the FY 2009-2011 cycles. The grants emphasize Departmental and Agency goals of access to health care and disease prevention services. The FY 2008 through FY 2011 grant awards focus on improving health outcomes through primary, secondary and tertiary prevention activities and PHN case management services with the patient and family. The grant extension will enhance sustainability of services.

In FY 2009, there has been an improvement in the Public Health Activities Database (PHAD) (formerly titled the CHAPS database) which has the capability of capturing specific public health nursing services at the local level. Training sessions have been implemented that targets data improvements pertaining to documentation and coding practices. This training is in process and will continue through FY 2009. The coding and documentation training provides the skills to learn the data process and to analyze and troubleshoot local data issues. The PHAD database is an Indian Health Performance Evaluation System. The PHAD database has the ability for the PHN programs to track performance related clinical and quality improvement activities.

Overall, the PHN program contributes towards 10 agency performance measures; six are highlighted in the corresponding output table: tobacco screening, domestic violence screening, depression screening, Pap smear follow-up, adult influenza vaccinations, and adult pneumococcal vaccinations. PHN home visit activities prioritize interventions that target the maternal and pediatric population, including: childhood obesity prevention through breastfeeding promotion, screening for early identification of developmental problems, parenting education and chronic disease management. Community health individual and group activities include health education related to communicable disease prevention; chronic disease prevention; wellness promotion; safety, such as, all-age seatbelt use, bicycle safety, home safety; health risk screenings for diabetes, cholesterol, and hypertension, and; providing school screenings that include immunizations and

health assessments. Public Health Nurse case management improves health outcomes and reduces hospitalizations.

The performance goals require that the PHN programs focus on:

- Evidence-based *primary, secondary and tertiary prevention interventions.* An overview of the prevention interventions are:
  - *Primary prevention interventions* that avert diseases from occurring, such as: immunizations; breastfeeding; health promotion/disease prevention education; building assets in youth, etc.
  - *Secondary prevention* interventions that detect and treat problems in their early stages, such as: health screening of high-risk populations; screening for diabetes and hypertension; fall risk assessments; school health assessment, etc.
  - *Tertiary prevention* interventions that keep existing problems from getting worse, such as: chronic disease & home self-management; medication management; periodic home visit assessments that prevent limb amputations, blindness or renal failure; coordination of external home management resources, etc.
- Maintaining community-based PHN services to individuals, families and community groups.
- PHN competitive awards and grants that provide funding to program awardees to increase public health nursing primary, secondary and tertiary prevention interventions that reduce morbidity and mortality in local communities through evidence based practice services.

- A major challenge faced by PHN programs is the increasing vacancy rates over the past five years. The vacancy rate in FY 2004 was 9 percent; FY 2005 was 20 percent; FY 2006 was 21 percent; FY 2007 was 22 percent and FY 2008 continues at a 22 percent vacancy rate and 4 percent staff turnover.

FUNDING HISTORY

Fiscal Year	Amount
2005	$45,015,000
2006	$49,453,000
2007	$52,445,000
2008	$55,939,000
2009 Recovery Act	$0
2009 Omnibus	$59,885,000

BUDGET REQUEST

The FY 2010 budget request for Public Health Nursing is $64,071,000, an increase of $4,186,000 over the FY 2009 Omnibus level. This increase represents $3,929,000 for pay increases, inflation, population growth and staffing new facilities and $257,000 for program increase for 2 new tribes.

The 2010 performance measure is an increase of 2,300 encounters over the 2009 target. This will be accomplished by improved data collection and decreased position vacancies as a result of:

- PHN documentation and coding training
- Development of standardized PHN documentation templates and embedded codes
- Increased PHN program implementation of EHR documentation
- Reorganized recruitment strategies

Funding for new tribes and new facilities/staffing equates to a total of 17.5 FTEs, or approximately seven percent of the total PHN workforce. The impact on performance may not be as significant in FY 2010 given that 2.5 of these FTEs will be for new tribes that will need time to establish the programs and hire staff. The impact of increasing performance will result in more secondary and tertiary prevention services provided to AI/AN communities, improving early detection and prevention of the complications of chronic disease.

Staffing for New Facilities	Amount	Tribal Positions
Absentee Shawnee Health Center (JV), Little Axe, OK	$157,000	2
Santee Health Center (JV), Santee, NE	$254,000	3
Carl Albert Hospital, Replacement (JV), Ada, OK	$689,000	9
Lake County Tribal Health Center (JV), Lakeport , CA	$83,000	1
TOTAL	**$1,183,000**	**14**

OUTCOMES

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
23: **Public Health Nursing:** Total number of public health activities captured by the PHN data system; emphasis on primary, secondary and tertiary prevention activities to individuals, families and community groups.	FY 2008: 415,945 (Target Unmet)	427,700	430,000	+2,300
Program Level Funding ($ in millions)	**$55.9**	**$59.9**	**$64.1**	**+ $4.2**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
PHN Vacancy Rates	22%			
Encounters	415,945	427,700	430,000	+ 2,300
Contributes to the following performance measures:				
Tobacco Screening	41,308	42,423	44,544	+ 2.121
Domestic Violence Screening	4,517	4,639	4,870	+ 231
Depression Screening	3,484	3,578	3,757	+ 179
Pap smear or Follow-up	4,819	4,949	5,196	+ 247
Adult Influenza Vaccine	43,320	44,490	46,715	+ 2,225
Adult Pneumococcal Vaccine	8,843	9082	9536	+ 454
Program Level Funding ($ in millions)	**$55.9**	**$59.9**	**$64.1**	**+ $4.2**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

GRANTS AWARDS

	FY 2008	FY 2009	FY 2010
Number of Awards	15	15	15
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

AREA ALLOCATION – Public Health Nursing

Discretionary SERVICES	**FY 2008 Actual**	**FY 2009 Omnibus**	**FY 2010 Estimate**	**FY 2010 +/- FY 2009**
Aberdeen	$7,266,865	$7,586,956	$8,221,831	+$634,876
Alaska	3,530,033	3,685,523	3,870,045	+184,521
Albuquerque	3,175,909	3,315,801	3,481,812	+166,011
Bemidji	1,980,544	2,067,783	2,171,309	+103,527
Billings	3,940,261	4,113,822	4,319,787	+205,965
California	487,771	509,256	618,087	+108,831
Nashville	707,421	738,581	775,560	+36,978
Navajo	12,605,165	13,160,397	13,819,293	+658,896
Oklahoma	9,386,830	10,532,301	11,909,024	+1,376,723
Phoenix	5,813,987	6,820,081	7,161,539	+341,458
Portland	2,750,403	2,871,553	3,015,322	+143,769
Tucson	936,732	977,993	1,026,958	+48,965
Headquarters	3,357,080	3,504,953	3,680,434	+175,481
Total, PHN	**$55,939,000**	**$59,885,000**	**$64,071,000**	**+$4,186,000**

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

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$14,991,000	$15,723,000	$0	$16,682,000	+$959,000
FTE	22	23	0	23	0

Authorizing Legislation.....25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001

FY 2010 Authorization.....Expired 2000

Allocation Method..... Direct Federal, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Service (IHS) Health Education program has been in existence since 1955. The program continues to focus on the importance of educating our American Indian/Alaska Native (AI/AN) clients in a manner that empowers them to make better choices in their lifestyles and how they utilize health services. The 22 IHS and approximately 75 tribal Health Education program staff partner with other IHS disciplines and programs to ensure that the education of our clients continues to occur even at sites without a full-time health educator. The IHS can demonstrate a steady increase in the health and patient education encounters that are being provided to AI/AN clients by all providers within the IHS and by our Tribal partners. This model concept demonstrates not only the collaboration between the IHS Health Education Program and all IHS health disciplines and programs but also demonstrates an IHS-wide focus and commitment on education. As the Health Education Output Table demonstrates, we have maintained a steady increase in the number of AI/AN clients that have participated in an educational encounter. The number of visits in which education was provided has moved from 777,000 visits with education provided in FY 2004 to 2,202,279 at the end of FY 2008 (183% increase). Clearly this demonstrates the IHS commitment to improve health education access, increased health literacy, increased patient-provider communications, and ultimately better health outcomes.

The Health Education program maintains data tracking of two key program objectives – Tobacco Cessation and Cardiovascular disease (CVD) assessment. During the most recently completed Government Performance and Result Act (GPRA) data collection period, the Health Education program contributed to increased performance from the 12 percent FY 2006 baseline to 21 percent in FY 2008 of the proportion of tobacco-using

patients that receive tobacco cessation intervention; and increased the proportion of at-risk patients who have a comprehensive assessment for all CVD-related risk factors to 30 percent.

While not a GPRA indicator, the IHS Health Education maintains IHS-wide statistics on educational encounters. Examples of educational statistical encounters reveal: 1) the number of clients educated, 2) which providers provided education, 3) where the education took place, 4) what information the patient was provided with, 5) the amount of time spent providing this education, 6) whether the patient understood the education provided, and 7) whether the patient set a behavior goal change. These IHS statistics are currently available from the RPMS system. In partnership with all IHS programs, disciplines and staff, the Health Education Program staff continues to:

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

The Health Education Program has identified the following areas of emphasis:

- Continue and strengthen the development of standardized, nationwide patient and health education program through 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 assists IHS to meet *Healthy People 2010* Objectives to improve consumer access to health information and to improve health communications to our clients.

- Increase a concentrated focus on the area of *Healthy People 2010*: Health Communications:
  - Increase the proportion of AI/ANs with access to health information;
  - Improve the health literacy of AI/AN with inadequate or marginal literacy skills;
  - Increase the health information contained on www.ihs.gov ensuring that information disclosed is quality-assured and cultural appropriate for AI/AN clients;
  - Maintain support to the established Center of Excellence in Health Communications based at the IHS Clinical Support Center, Phoenix, AZ to enhance the capacity of staff that provides 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; and
  - Improve patient-provider communication skills.

FUNDING HISTORY

Fiscal Year	Amount
2005	$12,429,000
2006	$12,429,000
2007	$14,287,000
2008	$14,991,000
2009 Recovery Act	$0
2009 Omnibus	$15,723,000

BUDGET REQUEST

The FY 2010 budget request for the Health Education program is $16,682,000, an increase of $959,000 over FY 2009 Omnibus level. This increase would support pay costs, population growth, inflation, staffing for new facilities, and 2 newly recognized tribes.

This funding supports the provision of the existing services to a slightly expanded population of AI/AN people served and supported by new facilities. This funding also supports two key program objectives – Tobacco Cessation and Cardiovascular disease (CVD) assessment both of which are targeted for performance increases in FY 2010. These two measures are critical for IHS in terms of impacting health disparities afflicting the AI/AN population, particularly diabetes, cancer, and cardiovascular disease. Health education continues to be an integral part of impacting the rates of these and other chronic diseases, not only in terms of reaching a higher percentage of the population, but in educating each high risk patient about the risks of smoking, or ensuring that such high-risk patients receive the appropriate screening to assist in monitoring the status of ischemic heart disease. IHS anticipates that the CVD baseline will be maintained at 30 percent in FY 2009 but increased to 31 percent in FY 2010. Rates for tobacco cessation will also be maintained at 21 percent in FY 2009 and increase to 24 percent for FY 2010. Similarly, overall increases in Health Education patient encounters for FY 2010 will be increased by 5 percent over the FY 2009 level.
These performance increases represent the IHS Health Education program's commitment to supporting the IHS Chronic Disease and HP/DP initiatives and will be achieved by improving efficiency in delivering and reporting these critical services.

Staffing for New Facility	Amount	Tribal Position
Carl Albert Hospital Replacement (JV), Ada, OK	$58,000	1

OUTCOMES

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
32: **Tobacco Cessation Intervention:** Proportion of tobacco-using patients that receive tobacco cessation intervention. IHS-All	FY 2008: 21% (Target Exceeded)	21%	24%	+3%
32: Tribally Operated Health Programs	FY 2008: 17% (Target	17%	20%	+3%

	Exceeded)			
30: **CVD Comprehensive Assessment**: Proportion of Ischemic Heart Disease patients who have a comprehensive assessment for all CVD-related risk factors. IHS-All	FY 2008: 30% (Target Met)	30%	31%	+1%
30: Tribally Operated Health Programs	FY 2008: 25% (Target Exceeded)	25%	26%	+1%
Program Level Funding ($ in millions)	**$14.9**	**$15.7**	**$16.7**	**+$1**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Number of Visits with Health/Patient Education	2,202,279 (9.0%)	2,235,800 (+5%)	2,286,500 (+5%)	+50,700
Program Level Funding ($ in millions)	**$14.9**	**$15.7**	**16.7**	**+$1.0**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

AREA ALLOCATION – Health Education

Discretionary SERVICES	FY 2008 Actual	FY 2009 Omnibus	FY 2010 Estimate	FY 2010 +/- FY 2009
Aberdeen	$1,546,121	$1,621,617	$1,714,515	+$92,898
Alaska	1,738,333	1,823,215	1,927,662	+104,447
Albuquerque	1,127,390	1,182,439	1,250,178	+67,739
Bemidji	559,795	587,129	620,765	+33,635
Billings	1,119,660	1,174,332	1,241,607	+67,275
California	222,721	233,596	246,978	+13,382
Nashville	390,850	409,935	433,419	+23,484
Navajo	2,134,292	2,238,508	2,366,747	+128,238
Oklahoma	2,305,679	2,418,264	2,615,069	+196,805
Phoenix	1,655,060	1,735,875	1,835,319	+99,444
Portland	870,508	913,014	965,319	+52,304
Tucson	194,881	204,397	216,107	+11,709
Headquarters	1,125,710	1,180,677	1,248,316	+67,638
Total, Health Ed	**$14,991,000**	**$15,723,000**	**$16,682,000**	**+$959,000**

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

COMMUNITY HEALTH REPRESENTATIVES

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$54,925,000	$57,796,000	$0	$61,628,000	+$3,832,000
FTE	5	5	0	5	0

Authorizing Legislation.....25 U.S.C. 13, Snyder Act; P.L. 83-568, Transfer Act 42 U.S.C. 2001; P.L. 94-437, Indian Health Care Improvement Act, as amended.

FY 2010 Authorization.....Expired 2000

Allocation Method.....Direct Federal, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

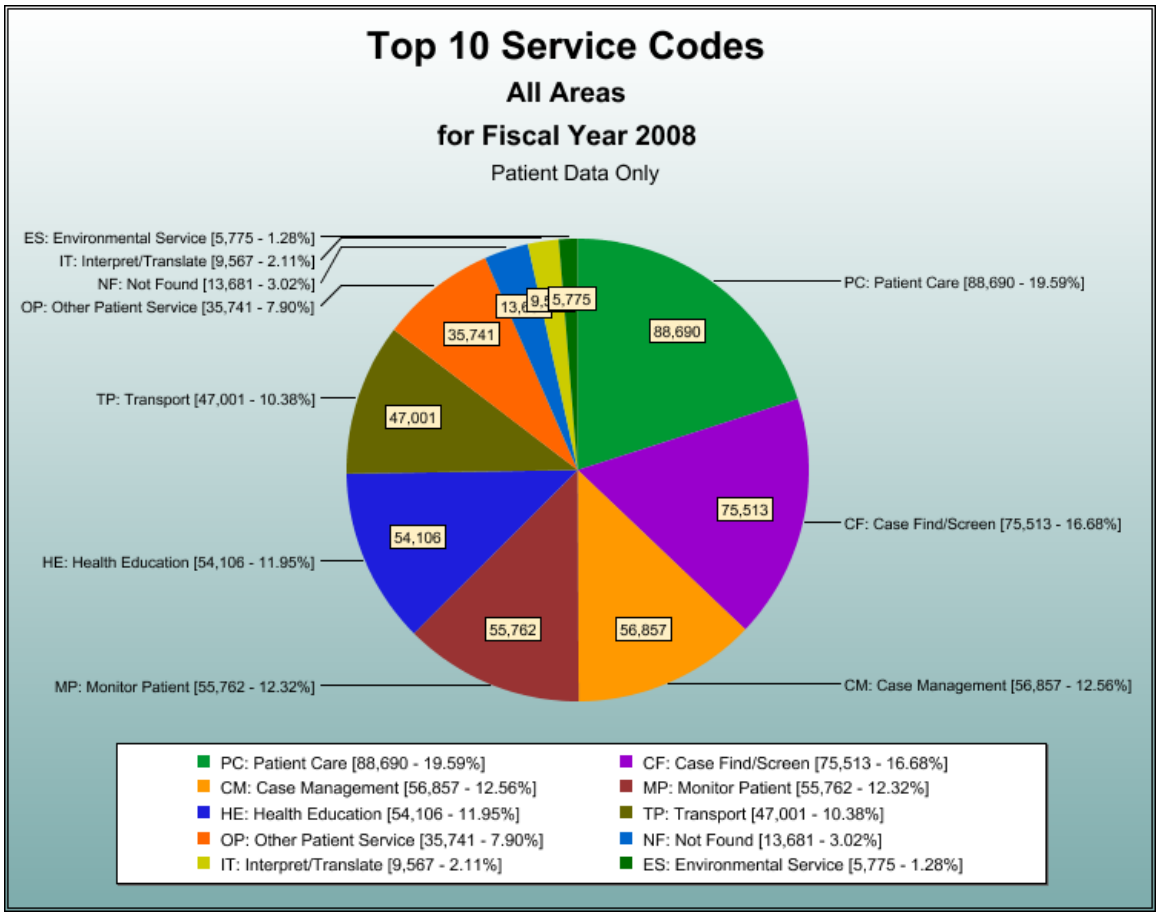
Originally begun by the Office of Economic Opportunity in 1968, the Community Health Representatives (CHR) Program was transferred to the IHS at a time when IHS was looking for ways to support the Tribes in self-determination through the provision of health care. Under the concept of utilizing community members as health para-professionals to expand health services and initiate community change, CHRs serve tribal members and communities as charged by Congress to provide health care, health promotion and disease prevention services to Indian communities (Indian Health Care Improvement Act [IHCIA] as amended, Public Law 100-713, dated November 23, 1988). The IHCIA also mandated the Secretary to provide a quality training program, including continuing education needs for CHRs.

Funds are distributed to the Tribes through Area allocations. All but two of 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). Headquarters CHR shares are utilized primarily for 1) training, 2) data/software development through the Resource Patient and Management System's (RPMS) CHR Patient Care Component (PCC) data application and 3) Special Projects in support of training and data software development.

Training is a key tool when providing laypersons with the comprehensive health education needed to perform the wide variety of job responsibilities the various Tribes assign to their CHRs. Training affords CHRs the skills needed to provide 16 categories of services that make a difference in their patients' lives and which contribute to

performance measures under Hospitals and Health Clinics.

For FY 2008, direct ***Patient Care*** led in types of services provided by CHRs at nearly 20 percent; ***Case Finding/Screening*** nearly 17 percent; ***Case Management*** nearly 13 percent; ***Monitoring Patients*** over 12 percent; ***Health Education*** nearly 12 percent ***Transportation*** over 10 percent; and ***Other Patient Services*** nearly 8 percent (please see following chart):



CHRs provide services to all eligible AI/AN patients as defined by 42 Code of Federal Regulations (CFR), subpart A-G (1986). National CHR Program data shows that for the top 6 health problems for which CHRs provide services, primary beneficiaries in the AI/AN population are elders (please see chart and table below, "Top 6 Health Problem Codes by Age"). "Unknown" typically reflects patients who are not on the specific patient registry at the health facility serving the local population and thus their specific ages are unknown, yet CHRs provide services because they are eligible elsewhere or fall into another eligible category.

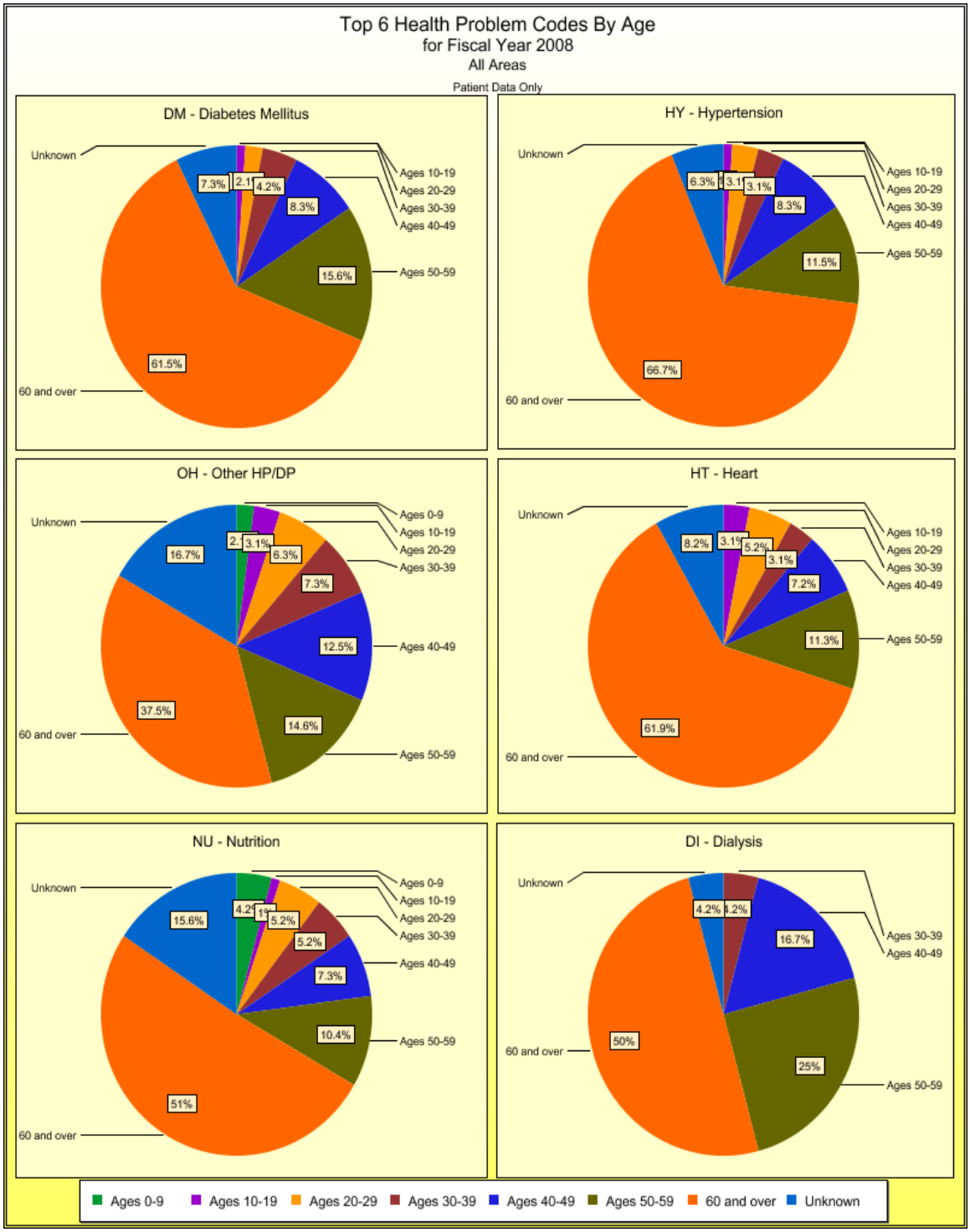

Top 6 Health Problem Codes By Age
for Fiscal Year 2008
All Areas
Patient Data Only
DM - Diabetes Mellitus
Unknown
7.3%
2.1%
4.2%
8.3%
15.6%
61.5%
60 and over
Ages 10-19
Ages 20-29
Ages 30-39
Ages 40-49
Ages 50-59
HY - Hypertension
Unknown
6.3%
3.1%
3.1%
8.3%
11.5%
66.7%
60 and over
Ages 10-19
Ages 20-29
Ages 30-39
Ages 40-49
Ages 50-59
OH - Other HP/DP
Unknown
16.7%
2.1%
3.1%
6.3%
7.3%
12.5%
37.5%
14.6%
60 and over
Ages 0-9
Ages 10-19
Ages 20-29
Ages 30-39
Ages 40-49
Ages 50-59
HT - Heart
Unknown
8.2%
3.1%
5.2%
3.1%
7.2%
11.3%
61.9%
60 and over
Ages 10-19
Ages 20-29
Ages 30-39
Ages 40-49
Ages 50-59
NU - Nutrition
Unknown
15.6%
4.2%
1%
5.2%
5.2%
7.3%
10.4%
51%
60 and over
Ages 0-9
Ages 10-19
Ages 20-29
Ages 30-39
Ages 40-49
Ages 50-59
DI - Dialysis
Unknown
4.2%
4.2%
16.7%
50%
60 and over
25%
Ages 30-39
Ages 40-49
Ages 50-59
Ages 0-9
Ages 10-19
Ages 20-29
Ages 30-39
Ages 40-49
Ages 50-59
60 and over
Unknown

Table: Top 6 Health Problem Code Report with Age – FY 2008 – Patient Data Only

	Diabetes	Hypertension	Other HP/DP	Heart	Nutrition	Dialysis
Ages 0-9	252 (0.3%)	200 (0.3%)	1255 (2.5%)	84 (0.4%)	1023 (4.7%)	3 (0.0%)
Ages 10-19	1056 (1.2%)	1,094 (1.5%)	1,974 (3.9%)	708 (3.0%)	332 (1.5%)	25 (0.2%)
Ages 20-29	2,322 (2.6%)	2,309 (3.2%)	3,018 (6.0%)	1,276 (5.4%)	1,168 (5.3%)	139 (0.9%)
Ages 30-39	3,529 (4.0%)	2,645 (3.6%)	3,796 (7.6%)	882 (3.7%)	1,251 (5.7%)	735 (4.8%)
Ages 40-49	7,710 (8.7%)	5,846 (8.0%)	6,267 (12.5%)	1,801 (7.6%)	1,675 (7.6%)	2,565 (16.8%)
Ages 50-59	14,093 (15.9%)	8,666 (11.9%)	7,229 (14.4%)	2,767 (11.6%)	2,244 (10.2%)	3,741 (24.5%)
Ages 60+	53,217 (59.9%)	47,235 (64.7%)	18,496 (36.8%)	14,397 (60.4%)	10,914 (49.6%)	7,378 (48.3%)
Unknown	6,649 (7.5%)	4,993 (6.8%)	8,182 (16.3%)	1,925 (8.1%)	3,390 (15.4%)	697 (4.6%)
All Ages[1]	88,828 (12.9%)	72,988 (10.6%)	50,217 (7.3%)	23,840 (3.5%)	21,997 (3.2%)	15,283 (2.2%)

1 *Percentages combined do not total 100% because these represent only the top 6 health problems for which patients are seen, not for all health problems in the entire population served.*

Acquiring data in CHR PCC is challenged by underutilization of the application, under-reporting and access issues to RPMS. Marketing the benefits of the application and focusing on training of CHRs on the proper use, data entry and export of CHR PCC data will support the HHS Strategic Plan in advancing the development and use of health information technology; contribute to statistics which prove program effectiveness; and improve coordination and communication between CHRs and clinicians regarding patient care.

All the charts and data provided here are the results of Tribes using RPMS CHR PCC. The numbers reported will increase as CHR Programs utilizing RPMS CHR PCC are added and as CHR Programs which currently use the software application improve their data entry capability and/or are able to export their files to IHS Headquarters.

A CHR Program performance target is to increase service hours of Chronic Disease services for CVD, Diabetes and Cancer provided by CHRs to support clinical and community-based initiatives such as the Health Promotion/Disease Prevention, Behavioral Health and Chronic Care Initiatives. These measures impact access to health care services, expand consumer choices and promote healthy behaviors. "High talk, low tech" (the concept that service providers can sometimes utilize human interaction and supportive relationships with much greater effect and intensity than relying on technological resources with patients) pays dividends, as shown in recent studies on services provided by community health workers (CHW, an overall descriptive term reflecting this group of workers) for services like direct patient care and outreach, advocacy, education and screening services that are established as cost effective. For example, Beckham (2004)[1] showed that CHW programs utilized for asthma management

reduced total per capita costs from $310 to $129 and Emergency Department (ED) costs from $1,119 per participant to $188. On Diabetes Management, Fedder (2003)[2] showed that Medicaid costs were reduced an average of $2,245 per patient per year by utilizing CHWs.

The health and socio-economic services CHRs provide to their communities support the HHS goal to improve the economic and social well-being of individuals, families and communities and serve to support patient self-management.

Program accomplishments during FY 2008 include:
1) Increased individual tribal CHR Programs' use of RPMS CHR PCC;
2) Enhanced collaboration with various disciplines and offices within IHS on projects, including:
   - Diabetes Program to provide outreach, referral and monitoring services;
   - Nutrition Program in the implementation of a 3-day specialty course emphasizing motivational interviewing, emotional eating and support to parents, with revisions planned based on student comments and evidence-based updates;
   - Chronic Care Initiative (CCI) Leadership and Innovations in Planned Care (IPC) Pilot Sites –One great example from an IPC pilot site wonderfully illustrates the value of the clinic and community-based provider connection to benefit patients. At White River Service Unit, which serves the White Mountain Apache Tribe (WMAT), colorectal cancer (CRC) screening rates were vastly improved due to inclusion of the CHRs in the entire process. Clinic staff met with the CHRs regarding CRC and Fecal Occult Blood Test (FOBT) screening. WMAT CHRs encouraged the use of simple English and pictures in the handouts but also advised that the explanation of the testing, rationale, etc. be in Apache as well. As a result, low-level literacy Instructions for FOBT were created which were "low-tech" in words and pictures and very simple for patients to understand and follow. Clinic staff partnered with CHRs for the latter to do home follow-up of unreturned tests. These and other changes based on recommendations which came out of their meetings were implemented. White River Service Unit has seen the results in its improved CRC screening measure. More importantly, community members are being screened and educated on risk factors and are understanding the importance of such for their own health;
   - Continued support of CHR Work Groups to advise on Medications, CHR PCC training and data application enhancements, Curriculum, etc.
3) Enhanced collaboration within HHS:
   - Specialized HIV/AIDS training and community projects designed to increase awareness and enhance screening efforts in conjunction with the Minority Aids Initiative;
   - Funds leveraged from resources outside CHR line item funding provided training for 506 CHRs for HIV awareness, outreach and referrals for screening; First Responder; Basic Life Support Health Care Provider: Community Emergency Response Team; and Disaster Drills training courses;
   - Implementation and incorporation into the CHR Curriculum of a CHR cancer training module through a National Cancer Institute-funded project aimed at

involving the CHRs more effectively as part of the care team for cancer prevention, screening, education and tobacco cessation as the community arm of an expanded care team. Additional project work products included "Winds of Hope", an interactive CD-ROM; and "Talking Tools" - templates to help build communication bridges between Clinic Providers and CHRs which were tested with positive feedback from CHRs and clinic providers to help achieve the goal of improving overall cancer care to patients. Cancer was the second highest health priority identified by tribal leaders for FY 2009

- Implementation of NIH quarterly mailings of NIH health information focusing on improving the development and dissemination of health information with American Indian and Alaska Native communities.

4) Revision of the CHR curriculum to content which incorporates more certified nurse aide (CNA)-type training. Students pass upon scoring 75% on their written exam, completion of public speaking, presentation of a group project, and upon approval of taking vitals signs. Students felt their knowledge and skills improved. One CHR stated "I felt the learning techniques used by Instructors were very good. I feel that I am much better prepared to meet the needs of my community and I feel that the knowledge I learned I'll be able to retain."

IHS and Tribal health facilities depend on CHRs to track down, contact and deliver critical patient health information to patients; educate and encourage them to make and follow up on appointments; and transport them if necessary. CHRs directly impact patient access to and delivery of services. Programmatic activities contribute towards clinical performance measures.

FUNDING HISTORY

Fiscal Year	Amount
2005	$51,365,000
2006	$52,946,000
2007	$54,891,000
2008	$54,925,000
2009 Recovery Act	$0
2009 Omnibus	$57,796,000

BUDGET REQUEST

The FY 2010 budget request for Community Health Representatives program is $61,628,000; an increase of $3,832,000 over the FY 2009 Omnibus level. This increase represents $1,047,000 for pay increases, $1,628,000 for inflation, $867,000 for population growth, and $290,000 for 2 new Tribes (Mashpee and Tuscarora).

The total funding for Community Health Representatives will provide:

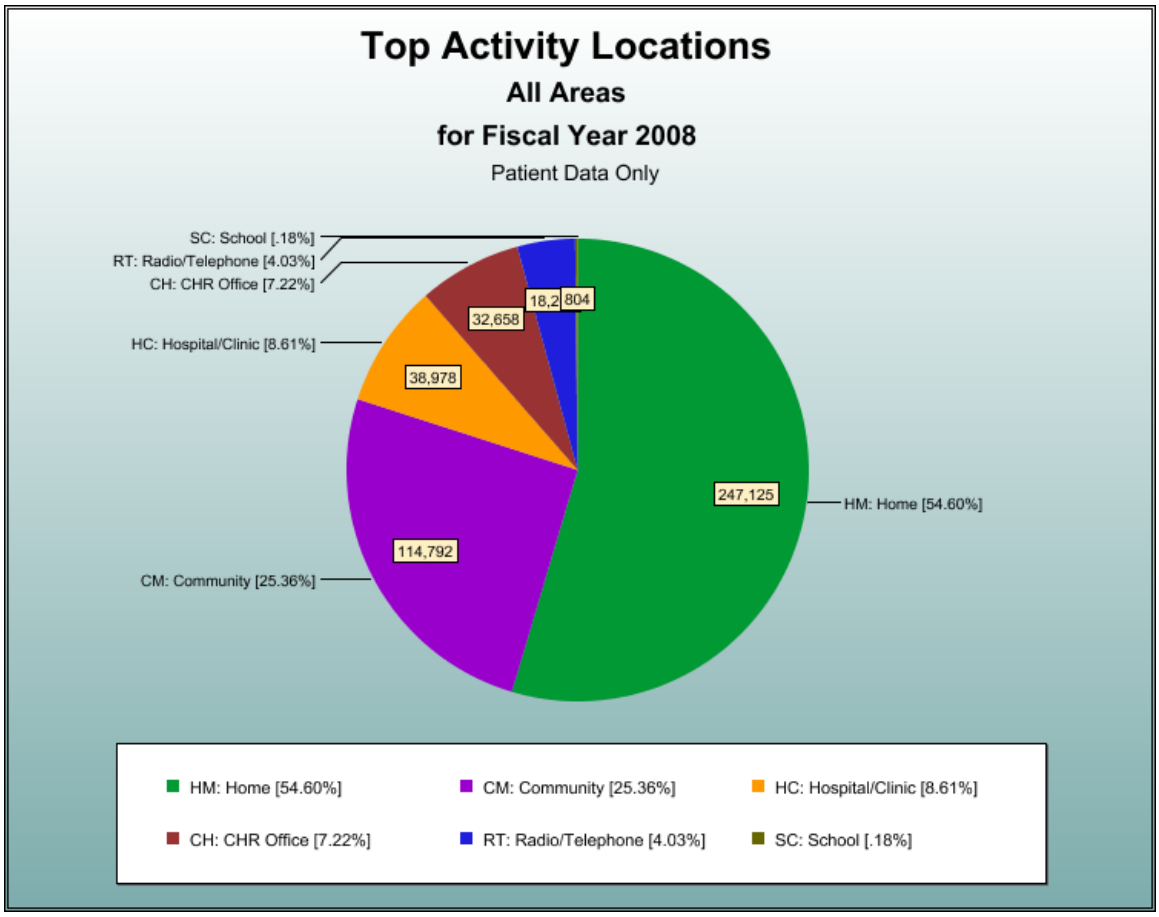
- $60,395,440 (or 98%) for '638 Self-Determination contracts and compacts with Tribes for direct health care, health promotion and disease prevention services as

identified in tribal funding agreements and scopes of work to 1.9 million AI/AN population throughout 12 Areas in homes and other community-based settings.

- $1,232,560 (or 2%) is under direct Federal administration for training, information technology costs, special projects and national education meeting(s); and is subject to tribal shares. These retained funds will also support the following plans in FY 2010, but not limited to:
  - continue efforts to train CHRs nationally on the CHR PCC data application;
  - continue HIT development and data support, specifically to (a) include limited patient education protocols and codes, (b) require notation of referrals made to and from CHRs to help track access issues and the potential impact CHRs make there, and (c) attempt to integrate continuous quality improvement efforts into data collection and data integrity;
  - enhancement of the national CHR web-based tracking system to improve data reporting to/by the national level;
  - continue encouraging Tribes to send CHRs to training and to utilize the RPMS CHR PCC data application;
  - assessment and dissemination of information related to CHR involvement and integration as part of the health care team in the Chronic Care Initiative and system improvement efforts which incorporate CHRs;
  - exploration of CHR involvement with overall IHS Alcohol Screening Brief Intervention (ASBI) efforts;
  - continue curriculum enhancement and provision of training (as mandated in the Indian Health Care Improvement Act as amended) to as many CHRs as can attend;
  - encourage injury prevention activities including home assessments, child safety seat usage, safe cycling and helmet classes, smoke detectors, and gun locks to reduce the tremendous injury rates among AI/AN persons; and
  - Maintain special projects such as certification of CHRs as CHR PCC trainers and consultation with the CHR PCC User Requirements Work Group. The CHR PCC User Requirements Work Group, comprised of CHRs, clinicians and technical experts, will work other important stakeholders in the IHS RPMS to address functionality of the data system to include appropriate patient education components (cancer, diabetes, cardiovascular, etc.), appropriate medical terminology, and tracking of referrals made, along with patient access to and attendance at clinical appointments. Among other responsibilities it will help address deployment and implementation issues for non-federal employees of CHR PCC.

The majority of CHR services are provided to patients in their homes or community settings (see the following chart), which require funds for transportation. Data indicates that services provided in homes increased dramatically over the last year - nearly 55% for FY 2008 compared to 36% in FY 2007 - perhaps reflecting patients' transportation challenges to access health services. Many factors impact the amount and level of services CHRs are able to provide: the relative isolation of many AI/AN living in rural areas; the wide fluctuation of gas prices; and certainly the effect of the receiving funding so late in the year pursuant to continuing resolutions, impacting the ability of these

providers to plan and provide for other than essential services, such as those for dialysis patients with no other transportation resource.



OUTPUTS

Measure	Most Recent Result - 2008	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Patient Services in Hours directed to Chronic Diseases (1), (2), (3)	131,776	151,700[7]	151,700	0
# of contacts (3), (4)	1,259,187	879,681[7]	1,300,000	+420,319
# of CHRs trained in basic, refresher, and first responder training	267	200[8]	267	+67
Number of CHRs trained on CHR PCC	363	640[9]	640	0
Program Level Funding ($ in millions)	**$54.9**	**$57.8**	**$61.6**	**+$3.8**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

[1, 3]162 of 290 (55% in 2008 while only 33% reported in 2007) CHR Programs assigned Program Codes are reporting with CHR PCC, the only way IHS Headquarters can track CHR data. This number was extrapolated from 55% reporting; however it should be noted that more than 20 of the reporting CHR Programs had just started in late 2008.
[2]The Program Performance target above represents an effort by the IHS national CHR Program to obtain specific service hours provided in the categories of diabetes, heart, hypertension, nutrition, cancer, other chronic, dialysis, obesity, depression, renal failure, and liver disease related to IHS GPRA indicators and drawn from the CHR PCC software application.
[3]Training conducted on CHR PCC suggests that CHRs routinely under-report the services they provide. Typically they report 2-3 services, but when queried further they identify 5-7 additional services that regularly are unreported

(checking homes for hazards as part of injury prevention efforts, providing homemaker services, providing health information on/checking medications, coordinating appointments, interpreting/translating, health education).
[4]*Patient contacts are the number of services x number served*
[5] *Estimate based on inclusion of continuing education trainees at FY 2008 National CHR Education meeting*
[6]*National educational meeting in 06 accounted for additional persons trained.*
[7]*Revised from previously published estimates*
[8]*Revised from previously published estimates – reduction in percentage of budget estimated for training purposes*
[9]*Revised from previously published estimates*

We believe the increased number of patient contacts reflects improvement of the data system to reflect data integrity; and that more CHRs are beginning to code accurately the types and number of services they're providing. We think that reasons why the CHR Program missed its Chronic Disease targets include:

1) data-related issues mentioned in the key challenges below;
2) the fact that so many CHRs still need training on how to enter data into RPMS CHR PCC;
3) increased costs of trying to do business in a year when record-breaking oil and gasoline prices affected so many services provided in the community, such as patient transportation by CHRs and travel for CHRs to reach patients; and
4) measuring "hours" of services may not be the optimal measure.

With the proposed funding increase for FY 2010, the CHR program will strive to reach the level of services proposed in FY 2009. Key challenges affecting results:

1) Tribes have the option under self-determination to use any data system they deem best supports their needs. RPMS CHR PCC is the only data system by which IHS can furnish data for budget purposes or Program management. If Tribes elect a data source other than RPMS CHR PCC, IHS cannot report the services, activities, trends, or achievements of tribal CHR Programs. Support by tribal leadership for use of CHR PCC is needed.
2) Access to RPMS CHR PCC is challenged by geographic barriers (remoteness) which impact connections to internet via phone or satellite.
3) Access is further complicated by
   a) necessary federal security requirements for Tribal members to request access to RPMS through the Network Operation Security Center (NOSC), to complete the IHS Information Technology Access Control (ITAC) and Rules of Behavior (RoB) forms, and to complete annual security awareness training; and
   b) the need to persuade Chief Executive Officers at the facility level that CHRs should have access to RPMS CHR PCC.

GRANTS AWARDS

No grant awards were made in FY 2008 and FY 2009; none are anticipated for FY 2010.

AREA ALLOCATION – Community Health Representatives

Discretionary SERVICES	FY 2008 Actual	FY 2009 Omnibus	FY 2010 Estimate	FY 2010 +/- FY 2009
Aberdeen	$6,588,693	$6,933,093	$7,392,772	+$459,679
Alaska	3,967,887	4,175,294	4,452,125	+276,831
Albuquerque	3,154,736	3,319,638	3,539,737	+220,099
Bemidji	4,357,591	4,585,368	4,889,388	+304,020
Billings	4,055,134	4,267,101	4,550,019	+282,918
California	1,767,292	1,859,671	1,982,971	+123,300
Nashville	2,875,890	3,026,217	3,226,861	+200,645
Navajo	6,208,819	6,533,362	6,966,538	+433,176
Oklahoma	7,943,991	8,359,234	8,913,469	+554,235
Phoenix	5,578,599	5,870,199	6,259,406	+389,207
Portland	4,304,090	4,529,070	4,829,357	+300,287
Tucson	1,790,153	1,883,727	2,008,622	+124,895
Headquarters	2,332,125	2,454,028	2,616,736	+162,707
Total CHR	**$54,925,000**	**$57,796,000**	**$61,628,000**	**+$3,832,000**

[1] Beckham, S, Kaahaaina D, Voloch KA et al. A community-based asthma management program: effects on resource utilization and quality of life. Hawaii Medical Journal 2004; 63(4):121-6.

[2] Fedder DO, Chang RJ, Curry S et al. The effectiveness of a community health worker outreach program on healthcare utilization of West Baltimore City Medicaid patient with diabetes, with or without hypertension. Ethn Dis 2003; 13(1):22-7.

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

HEPATITIS B AND HAEMOPHILUS IMMUNIZATION PROGRAMS (ALASKA)

	FY 2008	FY 2009		FY 2010	FY 2010
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	+/- FY 2009 Omnibus
BA	$1,733,000	$1,823,000	$0	$1,934,000	+$111,000
FTE	0	0	0	0	0

Authorizing Legislation .....25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001

FY 2010 Authorization .....Expired 2000

Allocation Method.....Tribal contracts; Tribal Shares; Grants

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Liver Disease and Hepatitis Program (Hepatitis B Program) was initiated in 1983 because of the need to prevent and monitor hepatitis B infection among a large population of Alaska natives with or susceptible to the disease. It continues to provide this service in addition to evaluation of vaccine effectiveness and the medical management of persons with hepatitis and liver disease. The Immunization (Haemophilus Influenza; Hib) Program started in 1989 with a targeted Haemophilus influenzae type b prevention project in the Yukon Kuskokwim Delta and now maintains high vaccine coverage by providing resources, training and coordination to tribal facilities throughout Alaska. These programs are components of the Alaska Native Tribal Health Consortium (ANTHC) which is based in Anchorage, Alaska.

Hepatitis B Program

According to the report “Regional Differences in Indian Health” released March 2008, liver disease is the 5th leading cause of death in American Indian and Alaska Natives (AI/AN), just behind diabetes. Based on demonstrated high rates of disease, program activities include clinical care of chronic liver disease patients, consultation on immunization and hepatitis issues, regular medical monitoring and clinical care follow-up of hepatitis B carriers, follow-up and new evaluation of hepatitis C infected persons, follow-up of persons with autoimmune liver disease, and follow-up of large cohorts of infants, children and adults vaccinated with hepatitis A and B vaccine to determine duration of immunity and if booster doses will be needed in the future. In addition, the program implemented a clinical protocol to diagnose, evaluate and counsel patients with non-alcoholic fatty liver disease. The program uses sophisticated computer-based

applications that integrate laboratory and other clinical data into a series of reports which allows program clinicians to follow a large number of patients with chronic hepatitis and other liver disease. This allows IHS to work closely with Tribal and Alaska Native Regional Corporations to care for these patients, including making at least one visit yearly to all rural Tribal Hospitals and regional clinics to conduct liver clinics, educate staff and advise public health administrators and Native Health Boards.

The program accomplishments are:

- The Liver Disease and Hepatitis Program follows patients statewide with chronic hepatitis B with the goal of reducing the lifetime risk of death from liver cancer or cirrhosis from 25 percent to <10 percent by early detection and removal of hepatocellular cancer and treatment with antiviral medications. In 2006 and 2007, we screened 60 to 63 percent of AI/AN with chronic hepatitis B or C infection (n = 2251 and 2306, respectively) for liver cancer at least once during the year. Among AI/AN with chronic hepatitis B (n = 1148), 70 (6 percent) patients started antiviral therapy and it is estimated that 200-300 (17-26 percent) may need antiviral therapy in the next 5 years.
- The program monitors Alaska Natives statewide with hepatitis C infection for alpha-fetoprotein to detect liver cancer early and perform liver function tests to identify potential treatment candidates. Among AI/AN with chronic hepatitis C (n = 1196 91 patients, or 8 percent, have been treated with 6 month to 1-year courses of antiviral therapy. With the advent of several new potent and more effective antiviral agents are expected to be licensed in the next 2 to 3 years, an estimated 300 to 400, or 25 to 33 percent, patients will need therapy for Hepatitis C in the next 5 years.
- The program actively screens for autoimmune hepatitis (AIH), primary biliary cirrhosis (PBC) and nonalcoholic fatty liver disease in the Alaska Native population. AIH and PBC have high mortality rates but treatment, usually life long, can reduce mortality to < 10 percent. The program has determined the prevalence of AIH among AI/AN to be 42.9/100,000 (highest of any ethnic group reported in the world) and PBC among the highest in the world. The program will conduct studies to better understand and monitor the treatment of this disease. Due to the high rates of obesity and type-2 diabetes in Alaska Natives, the program has increased surveillance, screening, counseling and treatment of nonalcoholic fatty liver disease (NAFLD) which appears to be present in over 10 percent of the Alaska Native population. NAFLD can lead to cirrhosis and liver cancer in some patients.
- The program is continuing the largest and longest studies on the immunogenicity, safety and long-term efficacy of hepatitis A and B vaccines in infants, children and adults in the world with 1,050 patients enrolled. The results of many of these studies are published and have made a significant contribution to the literature and to date have had great influence on recommendations that the Advisory Committee on Immunization Practices (ACIP) has made that booster doses are not yet needed for children and adults who received hepatitis A and B vaccine. Since these vaccines are universally given to all children in the US, these studies are crucial to the US immunization policy for all US citizens, not just AI/AN.

- The program helped to establish a Molecular Biology Laboratory at the Alaska Native Medical Center, which, to our knowledge, is the only laboratory of this type to be in an IHS facility. Work conducted there has improved our understanding of hepatitis virus genotypes and disease outcomes and allowed us to closely monitor viral loads. Due to budgetary constraints at the Alaska Native Medical Center, laboratory activities have been put on-hold, with the duration of closure anticipated to be about one year. The Hepatitis Program will work to ensure its reopening.
- The program collaborated with Center for Disease Control (CDC) in Atlanta on a study of the prevalence of chronic liver disease in patients seen at the Alaska Native Medical Center. This study will help to illustrate the overall health impact and help us better address disease disparities.
- International Activities: The program helped to establish a Circumpolar Hepatitis Working Group whose purpose is to exchange information and develop programs to promote hepatitis vaccination and treatment programs for indigenous populations in the Arctic (Alaska, Greenland, Canadian autonomous Tribal Regions and Siberian Indigenous Groups). The ANTHC Liver Disease Program is helping Greenland plan to introduce universal hepatitis B vaccination into the Inuit population and helping Arctic Countries to develop treatment programs for hepatitis B modeled after the Alaska Program. In addition, the ANTHC program is now advising World Health Organization (WHO) in establishing treatment programs for hepatitis B in underserved countries in Africa and Asia utilizing experience gained from the successful program in Alaska.

Immunization (Hib) Program

The purpose of the Immunization Program is to maximize the prevention of vaccine-preventable disease through advocacy, training, resources, immunization tracking, coordination of vaccine delivery and research on vaccine-preventable disease. We train 13 regional tribal coordinators to track immunizations, recall patients, ensure quality of electronic immunization records and report immunization rates quarterly. We report statewide immunization coverage rates to IHS headquarters.

In 2007 and 2008, the Immunization Program implemented routine rotavirus and human papillomavirus (HPV) vaccination and is currently working with the CDC Arctic Investigation Program and Tribal agencies to promote and monitor the impact of HPV vaccine in Alaska Native females. The program is working with tribal public relations to address parental questions and highlight the importance of vaccines. The program is collaborating with the local tribal corporation to develop a plan to address extremely high rates of non-vaccine invasive pneumococcal disease through early use, under a research protocol, of an expanded pneumococcal vaccine expected to be license by 2010.

The Liver Disease and Hepatitis Program (Hepatitis B Program) and the Immunization (Haemophilus Influenza) Program both provide consultation on immunization and liver disease issues to Indian Health Service and Tribal providers throughout the US. Both programs conduct research and publish journal articles in peer-reviewed journals on

topics related to vaccine-preventable disease, hepatitis, other liver diseases and health disparities in AI/AN.

The program accomplishments are:

- Met the IHS-All GPRA target of 78 percent of childhood immunizations in FY 2008; the current level is 80% for 4-3-1-3-3 and 77% for 4-3-1-3-3-1 (including varicella).
- Greatly exceeded the IHS-All GPRA target objective of 76 percent for pneumococcal (Pneumovax) immunization of elders in FY 2007 with 91 percent of elders immunized; the current level is 90 percent.
- Alaska Area was below the IHS-All GPRA target objective of 59 percent for influenza immunization of elders in FY 2007 with an immunization rate of 53 percent; the current level is 47 percent.
- Elimination of vaccine-type pneumococcal cases among Alaska Native children <2 years old.
- 98 percent decrease in Hib disease with over 450 cases prevented by vaccine.
- Implemented routine rotavirus immunization in Alaska Native infants.
- Rapid increase in HPV vaccine coverage with 1+HPV doses in Alaska Native teen girls from 16 percent at the end of 2007 to the current level of 41 percent.
- Completed Respiratory Virus Study that demonstrates the association of respiratory syncytial virus, parainfluenza virus or metapneumovirus in the majority of respiratory hospitalizations.
- International collaboration with Australia and New Zealand colleagues to study an improvement for prevention and care of chronic lung disease and bronchiectasis in Alaska Native children.
- Published 4 articles in peer-reviewed journals and co-authored two Alaska Epidemiology Bulletins; manuscript accepted for publication demonstrating continued disparity in otitis media visits among Alaska Native children compared with other American Indian and the US population.

FUNDING HISTORY

Fiscal Year	Amount
2005	$1,572,000
2006	$1,621,000
2007	$1,681,000
2008	$1,733,000
2009 Recovery Act	$0
2009 Omnibus	$1,823,000

BUDGET REQUEST

The FY 2010 budget request for the Hepatitis B and Haemophilus Immunization program is $1,934,000, an increase of $111,000 over the FY 2009 Omnibus level for pay increases, inflation, and population growth.

Given the addition of grant funding made available through research studies conducted by the Hepatitis and Immunization Programs, this program can support the current level of services. Planned activities for FY 2010 include focused clinical and research activities in persons with chronic hepatitis B infection, and the continuance of clinical and research activities in persons with hepatitis C, nonalcoholic fatty liver disease, autoimmune and other liver diseases.

Beginning in FY 2009, the State of Alaska is implementing a State Immunization Registry (VacTrAK). The Immunization program will continue to be involved with the VacTrAK rollout and will work with our Tribal partners across the state to begin contributing data in FY 2010. VacTrAK will include a 2-way exchange of immunizations which dramatically improve the accuracy and completeness of immunization records and prevent over-vaccination and missed opportunities to vaccinate.

OUTPUTS

Measure	Most Recent Result*	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Hepatitis Program (Targeted/Known Cases = T and Screened = S)				
Hepatitis Patients **Targeted** for Screening	T=2738	T=2774	T=2872	T=+98
Chronic Hepatitis B Patients **Screened**	S=646	S=790 T=1148	S=750 T=1138	S=-40 T=-10
Chronic Hepatitis C Patients **Screened**	S=735	S=708 T=1239	S=788 T=1314	S=+80 T=+39
Other Liver Disease Patients **Screened****	S=252	S=300 T=387	S=300 T=420	S=0 T=+33
Hepatitis A/B vaccinations***	5000	5000	5000	0
Immunization Program				
2010 Objective: Combined (4:3:1:3:3) Immunization Rates for AI/AN Children Aged 19-35 Months	80%	80%	86%	+6%
2010 Objective: Influenza vaccination rates among adult patients aged >65 years	47%	59%	59%	0
2010 Objective: Pneumococcal vaccination rates among adult patients aged 65 years and older	90%	88%	88%	0
3-27 month old Alaska Native immunization rates reported:	5101	5,200	5,200	0
19-35 month olds Imm Audited:	2646	3,100	3,100	0
11-17 year old Imm. audited	11283	12,000	12,000	0
65+ year old Imm. audited	6623	8,100	8,400	+300
Program Level Funding ($ in millions)	**$1.7**	**$1.8**	**$1.9**	**+$0.1**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

*Data as of 12/31/2008

**Other liver disease includes autoimmune hepatitis, primary biliary cirrhosis, nonalcoholic fatty liver disease and hepatitis of unknown etiology.

***Includes vaccination of patients at high risk (e.g. injection drug users, other liver disease, hepatitis C and/or HIV infection) and scheduled/routine vaccination of infants, children and adults (number based on births, incidence of hepatitis and estimations).
All data reported is available to the Alaska Native Tribal Health Consortium.

GRANTS AWARDS

The program does not award any grants.

AREA ALLOCATION – Immunization AK

Discretionary SERVICES	FY 2008 Actual	FY 2009 Omnibus	FY 2010 Estimate	FY 2010 +/- FY 2009
Aberdeen	0	0	0	0
Alaska	$1,733,000	$1,823,000	$1,934,000	+$111,000
Albuquerque	0	0	0	0
Bemidji	0	0	0	0
Billings	0	0	0	0
California	0	0	0	0
Nashville	0	0	0	0
Navajo	0	0	0	0
Oklahoma	0	0	0	0
Phoenix	0	0	0	0
Portland	0	0	0	0
Tucson	0	0	0	0
Headquarters	0	0	0	0
Total, Immun. AK	**$1,733,000**	**$1,823,000**	**$1,934,000**	**+$111,000**

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

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$34,547,000	$36,189,000	$0	$38,139,000	+$1,950,000
FTE	7	7	0	7	0

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

FY 2010 Authorization.....Expired 2000

Allocation Method.....Contracts and grants awarded to Urban Indian Health Organizations

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Urban Indian health program (UIHP) was established in 1976 to provide affordable and accessible health care for the underserved urban American Indians/Alaska Natives (AI/AN) population. The IHS provides funding through contracts and grants with 34 urban Indian 501(c) (3) non-profit organizations to provide health care services in 41 sites throughout the U.S. Urban Indian Health Organizations (UIHO) define their Title V, P.L. 94-437, as amended, scope of work and services based upon the documented unmet needs of the urban AI/AN community they serve. Each UIHO is governed by a Board of Directors of whom at least 51% are AI/AN.

UIHOs provide primary medical health care and public health case management wrap-around services for approximately 76,000 urban AI/ANs who do not have access to the resources offered on the reservation. Urban Indian primary care clinics and case management programs provide high quality, culturally accessible, affordable and accountable health services including ambulatory health care, health assessment, health promotion, disease education, child abuse prevention, immunizations, and behavioral health services. UIHOs fulfill IHS data reporting requirements including the IHS GPRA report and the Diabetes Non-Clinical Audit report. All UIHOs fulfill the HHS and IHS Strategic Plans. Two programs participate in the IHS Innovations in Planned Care Initiative.

The 34 UIHOs are categorized based upon the level of services they have the capacity to provide.

There are 21 full ambulatory facilities. A full ambulatory UIHO provides direct medical care to the population served for 40 or more hours per week. The range of services varies greatly among the programs that are defined as full ambulatory. Some full ambulatory programs have two or more full time medical doctors, full time pharmacist, provide lab and radiology services, and have on site dental providers. At the opposite end of the spectrum, some full ambulatory programs have a full time medical provider on site but do not offer dental, pharmacy, lab or radiology services.

Seven of the 21 full ambulatory programs also receive HRSA 330 funding and are designated HRSA 330 Community Health Centers.

1. South Dakota Urban Indian Health, Inc., Pierre, SD
2. Nebraska Urban Indian Health Coalition, Lincoln, NB
3. Denver Indian Health and Family Services, Denver, CO
4. **First Nations Community Health Source, Albuquerque, NM 330**
5. **Indian Health Board of Minneapolis, Minneapolis, MN 330**
6. Gerald L. Ignace Indian Health Center, Inc., Milwaukee, WI
7. American Indian Health & Family Services of SE Michigan, Detroit, MI
8. Indian Health Board of Billings, Inc., Billings, MT
9. Helena Indian Alliance, Helena, MT
10. Native American Health Center, Oakland, CA
11. San Diego American Indian Health Center, San Diego, CA
12. American Indian Health & Services, Santa Barbara, CA
13. **Indian Health Center of Santa Clara Valley, San Jose, CA 330**
14. Sacramento Urban Indian Health Project, Inc., Sacramento, CA
15. Native Americans for Community Action, Flagstaff, AZ
16. Dallas Inter Tribal Center, Dallas, TX
17. **Hunter Health Clinic, Wichita, KS 330**
18. **Native American Community Health Center, Phoenix, AZ 330**
19. **Native American Rehabilitation Assoc. NW, Portland, OR 330**
20. **Seattle Indian Health Board, Seattle, WA 330**
21. Spokane Urban Indian Health, Spokane, WA

There are 6 limited ambulatory programs. A limited ambulatory facility provides direct medical care to the population served for less than 40 hours per week. The range of direct medical care services provided by limited ambulatory programs varies greatly. These programs have medical providers on-site ranging from 32 hours per week to only 4 hours per week. No limited ambulatory program offers dental, pharmacy, lab, or radiology services on site.

1. American Indian Health Services of Chicago, Inc., Chicago, IL
2. North American Indian Alliance, Butte, MT
3. Native American Center, Inc., Great Falls, MT
4. United American Indian Involvement, Los Angeles, CA
5. Nevada Urban Indians, Inc., Reno, Nevada
6. Indian Walk-In Center, Salt Lake City, Utah

There are 7 Outreach and Referral programs. Outreach and Referral programs provide behavioral health counseling and education services, health promotion/disease prevention education, and immunization counseling. These programs do not provide direct medical care services. All Outreach and Referral programs develop and implement a Memorandum of Understanding with their local health clinics to provide culturally relevant competent health care services for urban AI/AN clients referred to the clinic for medical care.

1. Green Bay, WI (advertising for a new contractor)
2. Missoula Indian Center, Missoula, MT
3. United American Indian Involvement, Bakersfield, CA
4. United American Indian Involvement, Fresno, CA
5. American Indian Community House, New York, NY
6. North American Indian Center of Boston, Jamaica Plains, MA
7. Tucson Indian Center, Tucson, AZ

The target audience or eligibility for UIHP health care services is defined in the authorizing program legislation. An "Urban Indian" eligible for services, as codified in 25 U.S.C. § 1603(c), (f), (g), includes any individual who:

1) Resides in an urban center, which is any community that has a sufficient urban Indian population with unmet health needs to warrant assistance under Title V, as determined by the Secretary of the Department of Health and Human Services ("HHS"); and who
2) Meets one or more of the following criteria:
   a. Irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including:
      i. those tribes, bands, or groups terminated since 1940, and
      ii. those recognized now or in the future by the State in which they reside; or
   b. Is a descendant, in the 1st or 2nd degree, of any such member described in (A); or
   c. Is an Eskimo or Aleut or other Alaska Native; or
   d. Is the descendant of an Indian who was residing in the State of California on June 1, 1852, so long as the descendant is now living in said State; or[1]
   e. Is considered by the Secretary of the Department of the Interior to be an Indian for any purpose; or
   f. Is determined to be an Indian under regulations pertaining to the Urban Indian Health Program that are promulgated by the Secretary of HHS.

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[1]Eligibility of California Indians may be demonstrated by documentation that the individual:
(1) Holds trust interests in public domain, national forest, or Indian reservation allotments; or
(2) Is listed on the plans for distribution of assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), or is the descendant of such an individual.

Urban programs report on the amounts and purposes for which Title V, P.L. 94-437, as amended, funding is used, including: a) the number of eligible Urban Indians for whom services are provided, and b) the number and type of services provided eligible Urban Indians. Information contained in the 2007 Urban Common Reporting Requirements (UCRR) report indicated that the Urban Indian health programs served a population that was 55 percent American Indian. The remaining 45 percent included other minority

groups, Medicare/Medicaid eligibles, and others with private insurance and individuals who paid on a sliding-fee scale. The actual percent of each non-Indian group is not available because this information is not gathered through the UCRR. UIHOs have policies requiring supporting documentation of the eligibility of a particular individual included in their Title V reports which include: Certificate of Degree of Indian Blood (CDIB), BIA Form 4432, Tribal Membership Card, Tribal Correspondence, Birth Certificate(s) (state seal or certified copy) to establish descendants (first or second degree), Family Documents (e.g., family bible), and Self-Certification.

In FY 2008, the UIHOs effectively implemented the HHS Priorities, the HHS Strategic Plan Goals and Objectives Fiscal Years 2007–2011, and the IHS Strategic Plan 2007–2011. Twenty programs were provided circuits and routers and connected to RPMS. All 20 programs also participated in RPMS training courses and are implementing RPMS throughout their programs. In May, 2008, one UIHO successfully implemented RPMS/EHR.

The 2008 GPRA reporting cycle (July 1, 2007 – June 30, 2008) was successful for the Urban Indian programs. Areas of greatest accomplishment included: (1) 100 percent of the urban programs reported GPRA – 34/34, and (2) 5 programs reported through CRS; 25 reported using 100 percent review of the appropriate data source – 25/34 (as opposed to sampling a smaller percentage of records).

It is estimated that in all output categories listed, the UIHOs will increase encounters by 2 percent. Encounters fall into seven categories:

- Medical services cover medical services either on-site or off-site for the prevention, diagnosis, treatment and rehabilitation of illness or injury. This category also includes obstetrics and gynecology services.
- Ancillary services cover services provided for lab services, imaging services and pharmacy.
- Dental services cover all dental services for the purpose of prevention, assessment or treatment of a dental problem.
- Health Education services cover the provision of a defined program of health education services either performed on-site or off-site for the purpose of health education and disease prevention. Educational programs include obesity prevention, HIV/AIDS, diabetes, cardiovascular disease prevention, and smoking cessation.
- Nutrition services cover a defined set of nutrition services for the purpose of prevention, assessment, or counseling of a nutritional problem.
- Behavioral Health services cover a defined set of behavioral health services either on-site or off-site for the prevention, assessment, counseling, treatment, or rehabilitation of a psychosocial problem including substance abuse.
- Other services cover allied health (audiology, optometry, podiatry, speech therapy), community health (outreach to patients, assistance with other services), and enabling (transportation, medical records, referral for additional health care services).

Urban programs established partnerships with the U.S. Department of Veterans Affairs (VA). All urban programs have active partnerships with their local VA. They have agreements with the local VA that identify joint program initiatives and program services such as alcohol/substance abuse prevention and treatment, HP/DP, and mental health services.

The Office of Urban Indian Health Program received a program assessment review in 2003, and received an Adequate rating. The review cited program management as a strong attribute of the program. As a result of the review, the program has taken the following actions:

- Baselines and targets have been established through the IHS GPRA process for the OUIHP.
- A workgroup was established and produced a comprehensive report addressing the issues from the 2003 review. The report identified specific action items for complying with the review recommendations. The workgroup was disbanded after completion of the report.

The OUHIP will continue to pursue the mission of raising the health status of the urban AI/AN population.

FUNDING HISTORY

Fiscal Year	Amount
2005	$31,816,000
2006	$32,744,000
2007	$33,755,000
2008	$34,547,000
2009 Recovery Act	$0
2009 Omnibus	$36,189,000

BUDGET REQUEST

The FY 2010 budget request for the Office of Urban Indian Health Programs is $38,139,000, an increase of $1,950,000 over the FY 2009 Omnibus level. This increase represents $1,950,000 for pay increases, medical inflation, and population growth.

The budget request for the OUIHP will be used to provide quality, culturally-competent health care to the urban AI/AN population. Services include medical, dental, behavioral health, health education, immunizations, and many others. The increases for pay costs, medical inflation, and population growth, will allow the program to continue the current level of services provided.

Measures and targets have been set for the OUIHP for FY 2010.

- The OUIHP Efficiency Measure relates to Cost per User per Year. The program met this measure for FY 2007: $683 per user. The formula for this number uses

- A new measure has been added in FY 2009 during improvement actions from the UIHP program assessment (UIHP-7): Number of AI/AN served. The actual number served for FY 2007 was 76,359 AI/AN clients. Numbers for 2008 will be available, through the UDS report in July 2009. The target for FY 2009 is 79,000 AI/AN clients served, with an increase of 2 percent to 80,500 in FY 2010. With the changing economy, this target should be met as more urban AI/AN will likely seek health care services from the UIHOs.

- The Diabetes targets for the UIHOs include Ideal Glycemic Control and Controlled Blood Pressure (<130/80). UIHOs met the 2008 Ideal Glycemic Control measure at 39 percent (100 percent audit) and this will be maintained through FY 2010. Blood Pressure Control was a baseline for FY 2008 and target measures will be determined for FY 2009 and FY 2010. Baseline data will be available in June 2009.

- By FY 2010 the implementation of RPMS should be completed, thus the elimination of UIHP-4. All 21 full ambulatory care programs will be online and operating RPMS. The OUIHP provided funding for UIHO program health professionals and staff to attend RPMS training including: Patient Information Management Systems (PIMS) training, PCC data entry, patient registration, third party billing, behavioral health, diabetes, i-care, and site manager training. Nine IHS Area Offices' Office of Information Technology (OIT) were funded to: (1) procure and install circuits, hardware, and servers to support urban health programs, and (2) support IT personnel including the business office and health information management office costs in support of urban programs.

It is estimated that in all output categories listed in the table below, the UIHOs will increase encounters by 2 percent. This is keeping in line with the measure for the program increasing AI/AN users by 2 percent for FY 2010.

The UIHOs have been very successful in leveraging their IHS funding through the contracts and grants. In addition, many programs are increasing funding by receiving 330 funding from HRSA to become Community Health Centers; working with SAMHSA for funding of behavioral health projects; and the CDC for disease prevention.

The level of services supported by this request is an increase of 5 percent from the previous year. The UIHOs will continue to report GPRA, implement and utilize RPMS and EHR, and continue to provide quality health services to the urban Indian population.

OUTCOMES

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
UIHP-4: Increase the number of sites utilizing an electronic reporting system.	FY 2008: +6 (Target Unmet)	+5	Eliminate	0
UIHP-E: Cost per service user in dollars per year. *(Efficiency)*	FY 2007: $698 (Target Exceeded)	$845	$918	+$73
Program Level Funding ($ in millions)	**$0**	**$36.2**	**$38.1**	**+$1.95**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	FY 2007 Results*	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Medical Encounters	233,519	238,189	242,953	+4,764
Ancillary Encounters	193,468	197,377	201,325	+3,948
Dental Encounters	53,496	54,566	55,657	+1,091
Health Education Encounters	45,386	46,294	47,220	+926
Nutrition Encounters	85,267	86,972	88,711	+1,739
Behavioral Health Encounters	151,531	154,562	157,653	+3,091
Other Encounters	167,588	170,940	174,359	+3,419
Program Level Funding ($ in millions)	**$34.5**	**$36.1**	**$38.1**	**+$1.95**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

*FY 2008 results will be available July 2009.

GRANTS AWARDS TABLES

	FY 2008	FY 2009	FY 2010
Number of Awards	33	33	33
Average Award	$226,983	$226,983	$226,983
Range of Awards	$119,424-$603,311	$119,424-$603,311	$119,424-$603,311

Grant Awards -- Funding for the Urban Indian health programs for FY 2008 came from the FY 2008 appropriations for both the grants and contracts awarded to the programs.

Area Allocation – Urban Health

Discretionary SERVICES	FY 2008 Actual	FY 2009 Omnibus	FY 2010 Estimate	FY 2010 +/- FY 2009
Aberdeen	$1,126,929	$1,180,492	$1,244,101	+$63,609
Alaska	0	0	0	0
Albuquerque	1,817,385	1,903,764	2,006,346	+102,582
Bemidji	3,574,849	3,744,760	3,946,542	+201,782
Billings	1,533,421	1,606,303	1,692,857	+86,554
California	5,283,008	5,534,107	5,832,305	+298,199
Nashville	798,865	836,834	881,926	+45,092
Navajo	403,054	422,211	444,962	+22,750

Oklahoma	1,560,559	1,634,732	1,722,817	+88,086
Phoenix	1,892,558	1,982,510	2,089,335	+106,825
Portland	4,707,032	4,930,755	5,196,443	+265,688
Tucson	403,045	422,202	444,952	+22,750
Headquarters*	11,446,294	11,990,331	12,636,415	+646,084
Total, Urban	**$34,547,000**	**$36,189,000**	**$38,139,000**	**+$1,950,000**

*Approximately $9 million of the Headquarters' amount is used for the 4-in-1 grant funding under the Title V, Indian Health Care Improvement Act, and for the cooperative agreement of the national urban organization ($994,999).

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

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$36,291,000	$37,500,000	$0	$40,743,000	+$3,243,000
FTE	13	14	0	14	0

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

FY 2010 Authorization ..... Expired 2000

Allocation Method..... Direct Federal, Grants and Contracts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

In 1976, Congress enacted the Indian Health Care Improvement Act (IHCIA) P.L. 94-437 that authorizes the Indian Health Service (IHS) Indian Health Professions (IHP) to manage the Scholarship Program, Loan Repayment Program, Recruitment and Retention activities for IHS. However, IHS made their first awards in 1978 because Congress had not appropriated funds for the IHP program until 1978.

The purpose of the program is:

- To enable American Indians and Alaska Natives (AI/ANs) to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs;
- 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;
- To develop and maintain American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field; and
- To assist Indian health programs to recruit and retain qualified health professionals.

Scholarship Program (Sections 103 and 104) – In FY 1979, the scholarship programs started with three programs. The Preparatory and Pre-Graduate Scholarship Programs, Section 103, prepare students to enter a health profession training/program. The Preparatory Scholarship Program provides financial assistance for AI/AN (federally or state-recognized) students who enroll in compensatory or preparatory courses leading to entry into a health professional school such as nursing, pharmacy and others. The Pre-Graduate Scholarship Program provides financial support for AI/AN (federally or state-

recognized) students who enroll in courses leading to a bachelor's degree in specific pre-professional areas such as pre-medicine, pre-dentistry and others as needed by Indian health programs.

The third scholarship program, the Health Professions Scholarship Program, Section 104, provides financial support for AI/AN students (federally recognized only) who are enrolled in health professions or allied health professions programs. Students incur service obligations and payback requirements on acceptance of funding from this program. Graduate students and junior- and senior-level students have priority unless otherwise specified.

In support of Tribal consultation, the IHS receives a recommended priority list from Tribal health programs that assist the Agency in determining discipline priorities. The FY 2008 priorities consisted of 27 health professions, including physicians, nurses, pharmacists and dentists.

The IHS Scholarship Program made 2,216 scholarship awards between FY 2004 and FY 2008 (an average of 443 awards per year). A total of 337 scholarships were awarded in FY 2008 for school year 2008-2009. A total of 101 of the over 1,900 new applications were able to be funded. A total of 236 continuing scholarship students (students previously receiving the IHS scholarship) were awarded continuing scholarship support. The cost of health professions education continues to increase. According to Bureau of Labor Statistics data from the last 5 years, the IHS can expect average tuition and fee costs to increase over 7 percent annually. The average cost per IHS scholar including tuition, fees, monthly stipend and other school related costs increased almost $14,000 in FY 2008

Seventy-one percent of the scholarships went to students in the Health Professions Scholarship Program. These students received a total of 241 scholarships (38 new and 203 continuing). Fifteen percent or 50 scholarships (33 new and 17 continuing) went to students in Health Professions Preparatory Scholarship Program and fourteen percent or 46 scholarships (30 new and 16 continuing) went to students in Health Professions Pre-Graduate Program. The following disciplines were awarded during the 2008-09 school year:

Section 103 Preparatory - 50 students				
Pre-Nursing	23		Pre-Engineering-	1
Pre-Pharmacy	16		Pre-Medical Technology	1
Pre-Physical Therapy	4		Pre-Sanitarian	1
Pre-Clinical Psychology	2		Pre-Social Work	1
Pre-Dietitian	1			

Section 103 Pre-Graduate - 46 Students				
Pre-Medicine	26		Pre-Dentistry	20

Section 104 Professional - 241 students				
Physician, DO & MD	78		Ultrasonagrapher	2

Nurse (ADN, BS and MS)	41		Sanitarian	1
Pharmacist	33		Chemical Dependency	1
Dentist	25		Coding Specialist	1
Physical Therapist	8		Counseling Psychologist	1
Occupational Therapist	7		Injury Prevention	1
Physician Assistant	6		Substance Abuse Services	1
Medical Technology	5		Nurse Anesthetist	1
Social Work	5		Nurse Practitioner	1
Master Public Health (Epi)	4		Occupational Therapist	1
Clinical Psychologist	3		Public Health Nutrition	1
Health Care Administration	3		Podiatry	1
Health Records	3		Physical Therapy Assistant	1
Dental Hygienist	2		Respiratory Therapist	1
Engineer	2		Women's Health Nursing	1

In FY 2008, a total of 128 Health Professions Scholarship Program, Section 104 students graduated from their health professions school or completed their training program.

Health Professions (Section 104) Graduating/Completing Training-128 students				
Nurse (ADN, BS & MS)	48		Physical Therapy Assistant	2
Physician	22		Clinical Psychologist	1
Pharmacist	9		Coding Specialist	1
Dentist	7		Dental Hygienist	1
Physician Assistant	5		Dietitian	1
Chemical Dependency	3		Health Educator	1
Medical Technology	3		Occupational Therapist	1
Nurse Practitioner	3		Optometrist	1
Respiratory Therapist	3		Podiatry	1
X-Ray Technician	3		Public Health Nutrition	1
Engineer	2		Social Work	1
Master Public Health (Epi)	2		Ultrasonagrapher	1
Physical Therapist	2			

Some health professional disciplines including physicians, clinical psychologists, social workers and dietitians require additional post graduate clinical training before they can become independent licensed practitioners. For other disciplines post graduate training, while not required, is considered to improve clinical skills and knowledge (e.g., pharmacists). Individuals in these disciplines request a deferment of their scholarship service obligation until they complete their post graduate clinical training. Physician deferments are limited to primary care specialty residencies:

Specialties for Deferment	Deferment Period
Physician - Emergency Medicine	3 Years
Family Medicine	3 Years
General Pediatrics	3 Years
Obstetrics and Gynecology	4 Years
General Psychiatry	4 Years
Internal Medicine/Pediatrics	4 Years
Internal Medicine/Family Practice	4 years
General Surgery	5 Years
Anesthesiology	5 Years

Clinical Psychologist	2 years
Social Worker	2 years
Dietician	1 Year
Pharmacist	1 Year

In FY 2008, there were 83 health professionals on deferment. An addition 17 health professionals on deferment completed their residencies/training.

Health Professions (Section 104) Graduates Deferment Status		
Discipline	In Deferment	Completed Deferment
Physician	61	10
Clinical Psychologist	3	0
Social Work	12	0
Dietitian	4	0
Pharmacist	7	7

The FY 2008 IHS Scholarship Program accomplishments include:

- Completed redesign of the scholarship website (www.scholarship.ihs.gov) including the development of an on-line scholarship application for new applicants (implemented in February 2008) and for continuing scholars (implemented in December 2008);
- Worked with the UFMS staff and contractor to assure timely payments to students;
- The program looked at data for 1,500 randomly selected scholars who are or had been federal employees. This sample size is approximately equivalent to the number of new scholarship students entering the program over the last 6 years. The review looked at the service obligation owed and the years of service provided by the scholar. The review showed that on average scholars received 2.21 years of Health Professions (Section 104) scholarship funding and they served an average of 6.13 years of full-time clinical service in their health profession at an Indian health program. On average, scholars served 3.92 years beyond their service obligation.;
- The area scholarship coordinators sought out potential scholars by sending marketing packets of information to schools and Tribes, review 2,000-3,000 applications annually, and assuring follow-up with schools and students to assure payments are processed for tuition and that students are receiving their stipend and are meeting their academic requirements;
- Developed a series of Scholarship E-newsletters that include information for past and unfunded applicants with assistive information for successful re-application and included reminder information and to welcome new students;
- Finalized banner advertisements for print and radio media information about the IHS Scholarship Program.

Loan Repayment Program (Section 108) – The IHS Loan Repayment Program (LRP) offers health care professionals the opportunity to ease qualified health professions related student loan debts and help Indian health programs meet the staffing needs of high priority sites. Applicants agree to serve two years at an Indian health program in exchange for up to $40,000 in loan repayment funding and up to an additional $8,000 to offset the tax liability. Loan repayment recipients with more than $40,000 in loan debt

can extend their two year contract annually and receive up to an additional $20,000 per year, plus up to $4,000 for taxes, until their original loan debt is paid. For many health disciplines (e.g., physician, dentist, podiatrist, and optometrist), the average applicant's loan debt exceeds $140,000 (requiring more than 7 years of loan repayment support).

In FY 2008, the LRP had a total of 907 health care professionals who requested loan repayment funding. The LRP made a total of 581 loan repayment awards totalling $21,502,681. There were 382 new two-year contracts and 199 one-year extensions of existing loan repayment contracts. This number includes the additional $5 million for the LRP added in FY 2008 and additional funding provided by programs and supplemental funding provided by sites (the hospital or clinic provides funding to the LRP to cover the cost of a loan repayment contract to be able to assure eligible applicants that they will receive loan repayment if the health professional accepts a position at that site).

Not all health care professionals who applied for loan repayment could be funded. A total of 326 health care professionals applying for loan repayment did not receive funding in FY 2008. A total of 231 of these health professionals work in Indian health programs (see Matched Not Awarded column below). Of the 581 LRP awards in FY 2008, 322 went to federal employees (191 to civil service and 131 to Commissioned Corps officers), 258 to tribal employees and 1 to an employee of an urban Indian program. In FY 2008, the IHS LRP made loan repayment awards to the following disciplines:

Awards by Profession	Total Awards	New Awards	Contract Extensions	Matched Not Awarded
Nurses	127	123	4	48
Dental*	112	51	61	7
Physicians	94	55	39	3
Pharmacists	87	50	37	33
PA/APN	42	33	9	64
Mental Health	38	22	16	11
Optometry	23	11	12	7
Podiatry	19	6	13	0
Rehabilitative Services	16	10	6	11
Other Professions **	23	21	2	47
TOTAL	581	382	199	231

* Includes Dentists and Dental Hygienists

** Other Professions	Total Awards	Matched Not Awarded
Engineer	4	18
Dietician	4	10
Medical Technician	4	10
X-Ray Technician	4	8
Respiratory Therapist	3	0
Sanitarian	3	1
Chiropractor	1	0
TOTAL	23	47

By Pay System	Awards
Tribal Employees	258
Civil Service	191
Commissioned Corps	131
Urban Health Employees	1
Total	581

The FY 2008 IHS Loan Repayment Program accomplishments include:

- Developed and implemented a new loan repayment database application;
- Completed redesign of the loan repayment website (www.loanrepayment.ihs.gov);
- To help determine the effectiveness of the IHS LRP as a retention tool for health professionals, the program looked at how long LRP recipients stay beyond their service obligation. The IHS Loan Repayment Program (LRP) reviewed the records of 1,300 unique individual who received loan repayment contracts between Fiscal Year (FY) 1989 and FY 2003. FY 2003 was used as a cut off to allow time for LRP recipients to complete their initial two year contract and up to three extension contracts. During this period, the LRP made on average approximately 225 new awards annually. This sample size represents approximately 44 percent of all new awards (and subsequent extensions for these individuals) from this time period. The results of the study showed that the LRP recipient service obligation period average was 2.65 years. The average retention period for loan repayment recipients was 7.44 years. LRP recipients, on average, served 4.79 years beyond their service obligation; and
- In preparation for the next loan repayment cycle (with applications being accepted starting in October 2008 and loan repayment awards starting Spring 2009), the LRP developed or updated many materials, including marketing materials, a LRP recruitment packet including a DVD, a LRP Application Handbook, a LRP Recipient Handbook for new loan repayment recipients, and a series of newsletters to LRP applicants and recipients to keep them updated about the LRP and the program requirements.

In FY 2009 and FY 2010, IHS expects tuition cost increases will continue to lengthen the number of years of loan repayment support required by many health disciplines and will decrease the number of new loan repayment awards. Loan debt data from the IHS Loan Repayment Program for three key disciplines appears to show that IHS loan repayment recipient debt continues to increase at a rate similar to that of college tuition and fee cost increases (average increase of 6.3 percent per year across all three disciplines).

Health Profession	Loan Debt FY 1999	Loan Debt 2008
Physician	$107,230	$143,428
Dentist	$ 78,600	$161,884
Nurse	$ 31,910	$ 35,493

Recruitment and Retention – The IHS continues to support the IHS recruitment and retention efforts and development of health professionals in critical health professional shortage areas.

While most health professionals are recruited to work in full-time positions, some health professionals provided temporary service to IHS facilities through several mechanisms such as direct employment into temporary positions, direct contracting with various facilities, working with contract locum tenens companies, and volunteering their services for various periods of time.

The IHS utilizes recruiters for physicians, nurses, dentists and pharmacists. 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 professions students who come to their facilities as part of their educational training.

In FY 2008, the Health Professions Support Branch (HPSB) became fully staffed with the appointment of a new Branch Chief. The HPSB conducted an extensive review of current health professions staffing, past recruitment and retention strategies and processes and trends in recruitment in the private sector. From this review, an IHS Health Professions Recruitment Plan was developed. The plan calls for better integration of recruitment activities within IHS Headquarters, Area Offices and with field staff. The HPSB is currently in the process of informing IHS leadership about the plan and its related activities.

The Health Professions Recruitment Branch continues to:

- Develop and update recruitment and marketing materials including advertisements, recruitment materials and web sites;
- Advertise in professional journals and on recruitment websites;
- Update the IHS Public Health Professions web site at http://www.careers.ihs.gov/
- Develop new websites including a new physician website (http://www.physicians.ihs.gov). The new physician website will allow physicians and medical residents to request recruitment and application materials and ask questions of recruiters;
- Work with IHS Human Resources staff and with the Office of Commissioned Corps Operations (OCCO) to identify ways to shorten the time required to hire new health professions staff (in both civil service and Commissioned Corps). The IHS and OCCO have two joint recruiter positions assigned to the IHS Health Professions Support Branch to assist in recruiting health professionals into IHS. ;
- Attended health fairs at colleges;
- Attended high school career days; and
- Sent direct mailings to student health professionals.

Currently, vacancy rates and total number of vacancies for key health disciplines continue to remain high.

Profession	Federally Funded Health Centers (2007)[1]	IHS Vacancy Rate (12/2008)	IHS Total Vacancies (12/2008)
Dentist	18.3%	25%	105
Nurse	10.4%	23%	725
Physician	13.3%	24%	379
Optometrist	No Data Available	13%	24
Pharmacist	10.7%	13%	128

1. WWAMI Rural Health Research Center, University of Washington, Nevada Office of Rural Health Recruitment and Retention Symposium, Las Vegas, NV; Jan 10, 2007.

While the dental vacancy rate remains critical, we have seen the most dramatic increase in the physician vacancy rates. The scholarship and loan repayment programs are unable to provide enough health care professionals to reduce the substantial vacancy rates, but they do continue to have a major impact on meeting the staffing needs of hard to fill sites.

Extern Program (Section 105) – The Extern Program, is designed to give IHS scholars and other health professions students the opportunity to gain clinical experience with IHS and Tribal health professionals in their chosen discipline. The program also allows students the opportunity to work at sites they may want to apply to for employment after they complete their health professions training. This program is open to scholars and non-scholars. Students are employed up to 120 days annually, with most students working during the summer months. In FY 2008, the Extern Program funded a total of 133 health professional, pre-graduate and preparatory students. A total of 94 participants (or 71 percent) were Health Professions students, 7 participants (or 5 percent) were pre-graduate students and 32 participants (or 24 percent) were preparatory students. Twenty-four (or 18 percent) of the 133 externs were IHS scholarship recipients (19 were Health Professions scholars, 3 were Pre-Graduate and 2 were Preparatory). Ninety-five (or 71 percent) of the 133 student externs were American Indian or Alaska Native. The following health disciplines were funded in FY 2008:

Extern Program (Section 105) Preparatory - 32 students				
Pre-Nursing	8		Pre-Sanitarian	1
Pre-Physical Therapy	2		Pre-Social Work	1
Pre-Engineering	1		Other	18
Pre-Pharmacy	1			

Extern Program (Section 105) Pre-Graduate - 7 Students				
Pre-Medicine	5		Pre-Dentistry	2

Extern Program (Section 105) Health Professions - 94 students				
Nurse (ADN, BS & MS)	36		Physical Therapist	3
Pharmacist	11		Dentist	2
Counseling Psychologist	9		Health Records	2
Health Education	8		Physician (MD & DO)	2
Health Care Administration	6		Dental Hygienist	1
Engineer	4		Occupational Therapist	1
Social Work	4		Medical Technology	1
Dietitian	3		Master Public Health (Epi)	1

Grant Programs - The IHP administers three grant programs: Indians Into Nursing (Section 112); Indians Into Medicine (Section 114); and Indians Into Psychology (Section 217). Almost half of all IHS IHP grant funds are not competitively awarded.

The Quentin N. Burdick American Indians into Nursing Program, Section 112, helps to increase the number of nurses, nurse midwives, nurse anesthetists, and nurse practitioners who deliver health care services to Indians.

In FY 2008, grantees supported numerous student participants:

- Interacting with pre-nursing and nursing Indian students through professional development workshops, health career forums, and other activities; and
- Directly supporting AI/AN nursing students.

The Indians into Medicine (INMED) Program, Section 114, encourages and assists Indian students preparing for a career in healthcare. The outreach goal to tribal communities is to provide greater exposure to careers in healthcare, providing academic support for students through tutoring and career counseling, assisting with financial aid and scholarship applications, and offering summer educational sessions.

Grantees supported over 200 student participants:

- Interacted with Indian students through professional development workshops, health career forums, and other activities;
- Conducted site visits to tribes to identify potential students, worked with health career clubs at Indian schools, and provided workshops in tribal communities to discuss health issues;
- Provided travel grants to high-school and undergraduate students to assist them in attending health profession and Indian health conferences; and
- Hosted a series of other programs that included a Summer Institute to expose students to advanced math and science, a Pathway Program to ease the transition between community colleges and the university, and MCAT Prep classes.

The American Indians into Psychology (INPSYCH) Program, Section 217, increases psychological services provided to Indian communities. The goal is to outreach to tribal communities in order to provide greater exposure to the field of psychology, providing stipends to undergraduate and graduate students pursuing careers in psychology, and establishing training opportunities for psychology graduate students within tribal communities. Grantees supported over 300 student participants including:

- Undergraduate and graduate psychology students;
- Students working in tribal mental health facilities; and
- Conducting school visits to identify potential students and provide workshops in tribal communities to discuss health issues.

The projected allocation for the Indian Health Professions program in FY 2010 is:

Section	Title	Amount	Expected Outcome
103	Health Professions Preparatory Scholarship	$3,139,560	55 continuing and 9 new contracts
104	Health Professions Scholarship	$12,626,281	230 continuing and 55 new contracts
105	Extern Programs	$1,181,932	135 temporary clinical assignments
108	Loan Repayment Program	$20,197,964	430 contract extensions and 176 new contracts.
112	Quentin N. Burdick American Indians Into Nursing Program	$1,713,624	5 grants
114	Indians into Medicine (INMED) Program	$1,126,253	2 grants
217	American Indians Into Psychology Program	$757,386	3 grants
	TOTAL	**$40,743,000**	

FUNDING HISTORY

Fiscal Year	Amount
2005	$30,392,000
2006	$31,039,000
2007	$31,375,000
2008	$36,291,000
2009 Recovery Act	$0
2009 Omnibus	$37,500,000

BUDGET REQUEST

The FY 2010 budget request for Indian Health Professions is $40,743,000, an increase of $3,243,000 over the FY 2009 Omnibus level. This increase represents $389,000 for pay increases, non-medical inflation and $2,854,000 for program increases.

Scholarship Program

In FY 2010, the scholarship budget of $15,765,841 would be an increase of $1,243,000 from the FY 2009 budget of $14,522,841. Administrative costs are expected to be to be approximately $750,000 (divided equally between continuing Section 103 and 104) leaving $15,015,841 available for scholarship awards.

The FY 2010 priority funding includes the current scholarship recipients as well as the Section 104 scholars. The IHS Scholarship Program anticipates funding the 103 program at $3,139,560. Available funding for scholarship awards will be $2,764,560 (total Section 103 budget of $3,139,560 minus $375,000 in administrative costs) to include 55 continuation awards for Section 103 scholars at a cost of $2,364,560 and 9 new awards at a cost of approximately $386,928. Approximately 230 continuing Section 104 and 55 new Section 104 scholarship students (mostly Section 103 scholars converting to Section 104) funding costs is approximately $12,251,281 (total Section 104 budget of

$12,626,281 minus $375,000 in administrative costs). These calculations assume the average cost of a scholarship in FY 2009 is $39,918 and increases to $42,992 in FY 2010.

According to the Bureau of Labor Statistics, college tuition costs have increased an average of 7.7 percent annually for each of the last 5 years. The increased cost of a college education affects the number of scholarships IHS is able to award**.** In FY 2010, IHS expects that the increase of $1,243,000 for the Scholarship Program in the FY 2009 appropriation will help to offset the anticipated tuition and fee cost increases.

Loan Repayment Program

The FY 2010 LRP budget from IHP funding is $20,197,964, an increase of $2,000,000 from FY 2009 budget of $18,197,964. The approximate administrative cost of $961,533 leaves approximately $19,236,431 available for continuation of current loan repayment contracts and new awards.

IHS anticipates approximately 430 requests for LRP contract extensions in FY 2010 due to the LRP FY 2008. At an anticipated LRP one-year contract cost of $24,163 in FY 2009 and $25,023 in FY 2010, the anticipated 430 contract extension requests will cost approximately $10,759,890. This would leave approximately $8,476,541 for approximately 176 new LRP two-year contract awards (at an average cost for a two-year contract in FY 2009 anticipated to be $46,830 and $48,145 in FY 2010).

Externship Program

The Extern Program, Section 105, received $1,181,932 in FY 2008 and remains unchanged in FY 2010. This funding would provide approximately 135 summer externships (at an average cost of approximately $8,762). This budget provides for student externships for scholarship recipients to work at IHS and Tribal sites during non-academic periods.

Quentin N. Burdick American Indians Into Nursing Program

The Nursing program, Section 112, received $1,713,624 in FY 2009 and remains unchanged in FY 2010.

Indians Into Medicine (INMED) Program

The INMED program, Section 114, received $1,126,253 in FY 2009 and remains unchanged in FY 2010.

American Indians Into Psychology Program

The INPSYCH program, Section 217, received $757,386 in FY 2009 and remains unchanged in FY 2010.

OUTCOMES

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
42: **Scholarships:** Proportion of Health Professionals Scholarship recipients placed in Indian health settings within 90 days of	FY 2008: 61% (Target Exceeded)	69%	75%	+6%

graduation..				
Program Level Funding ($ in millions)	**$36.3**	**$37.5**	**$40.7**	**+$3.2**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

The performance goal refers to placement of scholars within 90 days of completion of their health professions degree or training. The IHP works with scholars, discipline chiefs and sites to assist in the placement of available scholarship recipients in health facilities, i.e., hospitals and clinics.

The IHS Scholarship Program's goal was to increase the 90 day placement rate by 5 percent (from 52 percent in FY 2007 to 57 percent in FY 2008) for new scholarship graduates. This goal was exceeded, with the percentage of new graduates serving at a site within 90 days of graduation increasing by 9 percent in FY 2008 (from 52 percent in FY 2007 to 61 percent in FY 2008)

The Scholarship Program continues to improve program performance, as demonstrated by a 41 percent overall increase in the 90-day placement rate from FY 2004 to FY 2008. The performance target for FY 2010 is 75 percent placement rate within 90 days of graduation. Increased efficiency in placing health profession scholarship recipients can and will help improve the health care delivery system at Indian health facilities, and the workload of health professional contributes towards the accomplishment of clinical and preventive health services.

OUTPUTS

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Number of Scholarship Awards – Total				
Section 103	50	45	30	(15)
Section 103P	46	48	33	(15)
Section 104	241	252	285	33
Number of Externs (Section 105)	133	134	135	1
Number of Loan Repayments Awarded – Total (Section 108)b/				
New Awards (2 Year Awards)	337a/	187	176	(9)
Contract Extensions (1 Year Awards)	174	350	430	80
Continuation Awards (Funded in Previous Fiscal Year)	228	337	187	(150)
Number of Grants Awarded – Total (see Below)	10	10	10	0
Program Level Funding ($ in millions)	**$36.291**	**$37.5**	**$40.743**	**$3.243**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

a/ The $5 million program increase for the Loan Repayment Program in FY 2008 will allow for approximately 116 new awards; The additional $5 million also included in FY 2009 and FY 2010 budget calculations but much is used to support contract extensions in FY 2009 and FY 2010.
b/ Loan repayment figures do not show data from non-IHP funding ($4,981,727 in H&C funding - 47 new awards and 25 extensions in FY 2008).

GRANTS AWARDS TABLES

	FY 2008	FY 2009	FY 2010
Indians into Nursing (Section 112)*			
Number of Awards	5	5	5
Average Award	$350,000	$337,000	$337,000
Range of Awards	$264,000-$360,000	$300,000-$350,000	$300,000-$350,000
Indians Into Medicine (Section 114)*			
Number of Awards	2	2	2
Average Award	$514,125	$514,125	$514,125
Range of Awards	$300,000-$728,250	$300,000-$728,250	$300,000-$728,250
Indians Into Psychology (Section 217)*			
Number of Awards	3	3	3
Average Award	$246,000	$247,333	$250,000
Range of Awards	$246,000	$246,000-$250,000	$250,000

* Almost half of all IHS IHP grant funds are not competitively awarded

Area Allocation

The Indian Health Professions program funds are administered from Headquarters.

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

TRIBAL MANAGEMENT GRANT PROGRAM

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$2,490,000	$2,586,000	$0	$2,586,000	$0
FTE	0	0	0	0	0

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

FY 2010 Authorization.....Expired 2000

Allocation Method.....Discretionary competitive grants to Tribes and Tribal organizations

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Tribal Management grant funds have been made available to tribes since 1976, with the initial passage of the Indian Self-Determination and Education Assistance Act, (ISDEAA) P.L. 93-638 and as amended, August 18, 2000. A Tribal Management Grant (TMG) award provides a Tribe the opportunity to assess, plan, or improve its capacity to assume Programs, Services, Functions and Activities (PSFA) of the IHS if it so chooses.

The TMG Program is a national competitive grant program that awards grants annually to Federally-recognized Tribes and qualified Tribal Organizations. The TMG Program began shortly after passage of P.L. 93-638. 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 operation evaluation; 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 Indian Health Service (IHS) programs, services, functions, or activities. All of these activities improve the management capacity of Tribes to take on additional PSFA provided by the IHS. The IHS distributes the total appropriated amount into two parts – grant awards and program operations.

There are approximately 224 Tribes that are currently Title I contractors and 322 Tribes that are Title V compactors of a total 562 Federally-recognized Tribes. The Title I Tribal contractors include a number of those Tribes directly served by federally-operated health service facilities that have made a decision to contract for funds to operate such IHS

programs as alcohol and substance abuse, community health representative, emergency medical service, and other support and ancillary programs. These Title I contractors, many of whom consider themselves as direct service tribes (DST) have chosen not to compact all PSFA of the IHS. Other Title I Tribal contractors continue to pursue additional PSFA as their capacity grows and may eventually transition to Title V compact status. Title I contractors are those tribes that contracted PSFA under P.L. 93-638 ISDEAA and Title V compactors are those tribes that have compacted PSFA under Title II of P.L. 103-413 Self Governance to redesign and reallocate funds to meet tribal health priorities and needs.

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. Specific outcomes, as a result, of feasibility studies, evaluation studies and management infrastructure grants are:

- The establishment of Tribal Health Boards which serve as health advisory committees to Tribal Councils;
- Training of Health Boards;
- Through Tribal health board initiatives and recommendations Tribal leaders are prepared to meet their communities' health needs;
- Tribal leaders also ensure compliance through implementation of policy and procedure manuals in key areas such as quality assurance, medical records, and information technology systems.

The TMG program provides an opportunity for Tribes to evaluate Federal programs and plan for the possibility of assuming operational control of a Federal program by contracting under the provisions of the ISDEAA. However, it must be recognized that the award of a self-determination contract or compact in and of itself should not be regarded as a measure of success of the TMG program. The Federal policy of self-determination recognizes the rights of Tribes to make a decision to contract to operate a Federal program or to decide to continue to have the Federal government administer a program on its behalf. This is the hallmark of a TMG award in that it provides a Tribe the opportunity to assess, plan, or improve its capacity to assume PSFA of the IHS if it so chooses. A Tribe then can make informed choices based upon the use of the TMG award to (1) build its capacity to take over PSFA of the IHS or (2) to improve the current capability to administer or manage those PSFA it is currently responsible for and not contract additional PSFA in order to eventually compact.

This grant program is highly competitive and over time has resulted in a greater focus from the TMG program office to provide training sessions to assist Tribes (including previous applicants not selected for funding) to prepare their grant proposals for a more competitive submission and environment.

With the conversion to electronic submission of grant applications on www.grants.gov in 2005, the IHS anticipated that the tribal entities would be submitting fewer applications until knowledge of the electronic application process and experience in electronic

submission increased to a comfortable level. The drop in numbers in the output table adequately reflects and captures the higher submission of paper applications in 2004 and 2005. In 2005, paper and electronic applications were accepted. In FY 2006, electronic submission was deemed mandatory by IHS. Training and technical assistance was provided by IHS to meet this need. However, the decrease in submissions is evident in the output table for years FY 2006, 2007 and 2008. It is anticipated that as the comfort level and familiarity increase for electronic submission that the numbers will gradually increase.

The award amounts and number of grants awarded by the TMG program varies annually based on the type of grant applications received and determined fundable. Grants are awarded for single year or multi-year projects dependent upon the number, dollar amounts and type of fundable applications. New grant awards are awarded each year after the multi-year non-competing continuation award funds are set aside for the previous year's multi-year grants.

FUNDING HISTORY

Fiscal Year	Amount
2005	$2,343,000
2006	$2,394,000
2007	$2,438,000
2008	$2,490,000
2009 Recovery Act	$0
2009 Omnibus	$2,586,000

BUDGET REQUEST

The FY 2010 budget request for the Tribal Management Grant Program is $2,586,000 at the same FY 2009 Omnibus level.

OUTPUTS TABLE

Measure	FY 2008	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Feasibility Studies	0	2	3	+1
Planning Grants	2	2	3	+1
Evaluation Studies	0	2	2	0
Management Structure – (Capacity Building and Developmental) Includes Continuations	23	17	17	0
Program Level Funding ($ in millions)	**$2.490**	**$2.586**	**$2.659**	**$0**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

1/ TMG is not required to submit actual performance targets

The above table consists of the current 4 components of the Tribal Management Grant Program. The Management Structure (capacity-building and developmental) component of the Tribal Management Grant Program varies in the number of awards based on the inclusion of non-competing continuations along with new awards. Management structure allows for the enhancement and development of infrastructure such as management and

accounting systems; electronic health records development, conversion, and recordkeeping; and accreditation to meet the standards of either the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the Accreditation Association for Ambulatory Health Care (AAAHC). These grants also assist Tribal organizations in correcting deficiencies in their management and internal control and financial and accounting systems revealed by the single audit act – OMB Circular A-133 Audits of States, Local Governments and Non-Profit Organizations.

GRANTS AWARDS TABLES

	FY 2008	FY 2009	FY 2010
Number of Awards 1/	26	29	30
Average Award	$91,905	$86,200	$85,774
Range of Awards	$50,000 - $236,250	$25,000 - $104,958	$50,000 - $100,000

Area Allocation

The Tribal Management Grant funds are administered from Headquarters.

1/ Included partial awards.

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

	FY 2008	FY 2009*		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$63,624,000	$65,345,000	$0	$68,720,000	+$3,373,000
FTE	330	348	0	357	+9

Authorizing Legislation.....25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001

FY 2010 Authorization.....Expired 2000

Allocation Method..... Direct Federal, P.L. 93-638 Self-Determination Contracts, Grants, and Self-Governance Compacts, Competitive Grants

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Service (IHS) Headquarters provides leadership, oversight, and executive direction to 12 regional offices to ensure that comprehensive health care services are provided to American Indians/Alaska Natives (AI/ANs). In addition, Headquarters actively administers the Agency's accomplishment of the HHS strategic goals and activities, while simultaneously maintaining the special Tribal-Federal relationship based in treaty and law.

The Headquarters operations are set forth by statute and administrative requirements by the Department of Health and Human Services (DHHS), the Administration, Congress, and field operations, i.e., 12 Area Offices and 163 Service Units. Headquarters actively works with the DHHS to formulate and implement national health care priorities, goals, and objectives. The IHS Headquarters continues to work 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, which includes IHS direct, Tribally operated programs, and urban Indian health programs (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 163 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 2008 Enacted	FY 2009 Omnibus	FY 2010 PB
Headquarters (56.5%)	$35,495,642	$36,919,925	$38,826,798
Title I Contracts (non-add)	*2,215,143*	*2,240,506*	*2,428,049*
Title V Compacts (non-add)	*5,286,566*	*5,757,635*	*5,818,683*
Area Offices (12) (43.5%)	28,128,358	28,425,075	29,893,202
Title I Contracts (non-add)	*832,267*	*841,796*	*914,531*
Title V Compacts (non-add)	*7,862,449*	*7,756,843*	*8,606,700*
BA	**$63,624,000**	**$65,345,000**	**$68,720,000**

The Direct Operations budget supports the 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 HHS Performance Objectives. For FY 2010, IHS activities will continue to focus on GPRA and program assessment performance objectives.

Significant activities include the establishment of performance plans that cascade throughout the agency and provide for performance accountability at all levels of the agency. The Direct Operations budget also supports leadership and oversight for the accomplishment of the performance measures that are included in the IHS FY 2009 Annual Performance Plan. The measures address many of the administrative aspects of providing health care to AI/AN population and comply with the requirements of GPRA and other Departmental goals of achieving equivalent and improved health status for all Americans. In addition, management improvements will be guided by the Department's Performance Objectives and the priorities of the Secretary of Health and Human Services.

Headquarters, through this activity, will continue to develop and expand its crosscutting collaborations and partnerships with other Federal agencies and outside organizations to meet many performance measures and objectives. A FY 2010 performance goal for Direct Operations is to continue the implementation of a human capital strategy to assist managers with succession planning activities. Twenty-seven percent of IHS employees will be eligible for retirement in 2011. 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.

FUNDING HISTORY

Fiscal Year	Amount
2005	$61,649,000
2006	$62,194,000
2007	$63,631,000
2008	$63,624,000
2009 Recovery Act	$0
2009 Omnibus	$65,345,000

BUDGET REQUEST

The FY 2010 budget request for direct operations is $68,720,000 an increase of $3,375,000 over the FY 2009 Omnibus level. This increase represents $1,232,000 for pay increases and inflation and $2,143,000 ($143,000 for new Tribes and $2,000,000 for administrative functions) for program increases.

Area Allocation – Direct Operations

Discretionary SERVICES	**FY 2008 Actual**	**FY 2009 Omnibus**	**FY 2010 Estimate**	**FY 2010 +/- FY 2009**
Aberdeen	$2,480,952	$2,548,061	$2,679,665	+$131,605
Alaska	4,549,136	4,672,188	4,913,501	+241,314
Albuquerque	1,321,350	1,357,092	1,427,185	+70,092
Bemidji	1,407,267	1,445,333	1,519,983	+74,650
Billings	2,269,026	2,330,402	2,450,765	+120,363
California	1,491,942	1,532,298	1,611,440	+79,142
Nashville	1,610,907	1,654,481	1,739,933	+85,452
Navajo	3,105,536	3,189,539	3,354,275	+164,736
Oklahoma	3,623,373	3,721,383	3,913,589	+192,206
Phoenix	3,066,168	3,149,107	3,311,755	+162,648
Portland	2,518,748	2,586,879	2,720,489	+133,610
Tucson	683,809	702,305	738,579	+36,273
Headquarters	35,495,786	36,455,931	38,338,841	+1,882,910
Total	**$63,624,000**	**$65,345,000**	**$68,720,000**	**+$3,375,000**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Indian Health Service
Services: 75-0390-0-1-551
SELF-GOVERNANCE

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$5,836,000	$6,004,000	$0	$6,066,000	+$62,000
FTE	11	11	0	12	+1

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

FY 2010 Authorization ..... Expired 2000

Allocation Method..... Direct Federal, Cooperative Agreements and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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 Office of Tribal Self-Governance (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, with Tribal representatives, has developed formula methodologies for identification of tribal shares for all Indian Tribes. Tribal shares are those program and administrative funds that Tribes are eligible for and can elect to take from Headquarters and Area organizational levels of the IHS. Currently, $1.843 billion of the IHS budget is under Tribal Health Administration of which approximately $1.242 billion will be transferred to tribes in support of Tribal Self-Governance with 125 compacts and 146 funding agreements in FY 2010. The remaining balance is used to administer Title I, Urban Health and Contract Support Costs.

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

- Agency performance measure achievement through various Tribal pilot projects throughout the country which are funded through the Self-Governance budget;

- Funding for ambulances to all Indian tribes and tribal organizations;
- Funding for third party infrastructure demonstration project with a tribe;
- Funding to an Indian tribal organization to provide technical assistance, coordination of meeting dates, locations, etc. in development of a annual report to Congress;
- Funding of a pilot project to explore alternative methods for providing direct care services to individuals within a three State area;
- Funding of Interagency Agreement between IHS and U.S. Department of Veterans Affairs to provide support and training to Community Health Representatives, first responders, modular curriculum development/online training, and specialty field training/support for suicide prevention and response.

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

FUNDING HISTORY

Fiscal Year	Amount
2005	$5,586,000
2006	$5,668,000
2007	$5,763,000
2008	$5,836,000
2009 Recovery Act	$0
2009 Omnibus	$6,004,000

BUDGET REQUEST

The FY 2010 budget request for Self-Governance is $6,066,000, an increase of $62,000 over the FY 2009 Omnibus level. This increase represents $53,000 for pay increases and $9,000 for inflation.

The Self-Governance budget will support the provision of technical assistance to approximately 392 federally recognized Indian tribes and tribal organizations compacted with the Indian Health Service (IHS); fund up to 16 Indian Tribes with Planning and Negotiation Cooperative Agreements; continue to fund the Government Performance and Results Act (GPRA) projects; and address tribal shares funding needs in IHS Areas and Headquarters for any Indian tribe(s) newly entering self-governance**.** The total funding for Self-Governance will provide:

- $2.7 million (or 45 percent) for the operating budget of the OTSG; 12 FTEs, including payroll costs, travel, supplies, rents/communications and contractual services; reimbursement travel cost (other than OTSG staff), TDY's to the OTSG; planning and negotiation cooperative agreements.

- $3.3 million (or 55 percent) for a reserve fund, i.e. shortfalls; these funds were appropriated to fund shortfalls in cases where there cannot be a direct transfer of

funds from IHS to the Indian tribes to fund self-governance compacts without jeopardizing the support provided by IHS to other Indian tribes. Therefore, the **reserve funds** are used for:

(1) To ensure that funding of tribal shares under Self-Governance compacting does not adversely affect 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: severance pays, Reduction In Force (RIF) costs, settlements and assessments costs; assistance with the purchase of ambulances; assistance with incidents caused by natural disasters (eg., mud slides caused by too much rain)
(3) To support special projects that enhance Self-Governance Activities: Government Performance Results Act (GPRA) Projects; development of a curriculum to be used for the training of future Agency Lead Negotiators (ALN) within the IHS; Self-Governance Communication Education Tribal Consortium continued agreement; eligibility services project; EMS services; travel/logistics of Advisory committees, workgroups; other trainings; SG Report card; Educational Brochure on SG.

The Self-Governance budget addresses the following elements of the HHS Strategic Plan: Chapter 2, Goal 1, Objective 1.3.1; Chapter 3, Goal 2; and, Chapter 6;.the IHS Strategic Plan: Goal 2, Objective 2.4; Goal 3, Objectives 3.1 – 3.2; and, the OMB Tribally Operated Health Programs (TOHP) program assessment performance measures and follow-up actions.

OUTCOMES

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
TOHP-1: Percentage of TOHP clinical user population included in GPRA data.	FY 2008: 73% (Target Unmet)	74%	78%	+4%
TOHP-E: **Tribally Operated Health Programs:** Hospital admissions per 100,000 diabetics per year for long-term complications of diabetes.	FY 2006: 149.7 (Target Unmet)	146.7	146.7	0
Program Level Funding ($ in millions)	**$0**	**$6.0**	**$6.1**	**+$0.1**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	FY 2008	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Increase Program Training Projects	6	6	6	0
Develop Tribal Health Information Technology Infrastructure Sites/Projects	7 (Target unmet)	10	10	0
Develop & support IHS Chronic Care initiatives at Tribal site: Screening Projects	1 (Target unmet)	3	3	0
Third Party Infrastructure Demonstration Project with a Tribe.	New Output Measure	0	1	1
Program Level Funding ($ in millions)	**2.0 M**	**2.5 M**	**3.5M**	**1**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

Area Allocation

The Self-Governance funds are administered from Headquarters.

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

CONTRACT SUPPORT COSTS

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$267,398,000	$282,398,000	$0	$389,490,000	+$107,092,000
FTE	0	0	0	0	0

Authorizing Legislation .....Indian Self-Determination and Education Act, P.L. 93-638, as amended, Section 106(a)(2), a(3), a(5), and a(6)

FY 2010 Authorization .....Expired 2000

Allocation Method..... P.L. 93-638 Self-Determination contracts and compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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 (specifically, contract support costs were first identified in the 1988 amendments to the ISDEAA). In FY 2009, approximately $1.805 billion of the Agency's appropriation will be under Tribal Health Administration primarily through Title I and V of the ISDEAA. The ISDEAA also provides that contract support costs (CSC) be added to the program amount. 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 administrative 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 CSC policy, in existence since 1992, governs the administration and allocation of CSC, and was developed through extensive consultation and participation of Tribes. The most recent revision of the CSC Policy was in April 2007, and established it as a permanent Chapter within the IHS Manual (Part 6, Chapter 3, TN-2007-05), effective for the fiscal year (FY) 2007 through FY 2010 funding periods.

The revised policy modified the CSC allocation methodology associated with new or expanded awards under the ISDEAA, P.L. 93-638, as amended. Allocations are now made at the average level of CSC funding paid to all existing P.L. 93-638 awards. The IHS CSC policy conforms to applicable OMB Circular A-87 and A-122 cost principles.

The IHS continues to review the soundness of its allocation policies concerning CSC and to take steps to assure that CSC provided to Tribes is reasonable and does not duplicate other funding provided to Tribes by the IHS under self-determination agreements. The IHS provides specific technical assistance to Tribes on calculating CSC and reviews each Tribal request that is submitted for CSC using a protocol to ensure that the CSC that are approved are consistent throughout the IHS system and not duplicative of other funding provided to Tribes.

This ongoing review of CSC allocation policies and technical assistance ties in directly with HHS Strategic Goals and Objectives – FY 2007-2012 (Goal 1: Objective 1.3; Improve health care quality, safety, cost, and value.

Since calendar year 2006, Tribally-operated health programs (TOHP) continue work to address follow-up recommendations from the findings of the TOHP program assessment. The CSC accounts for 16 percent of the total funding provided to TOHP, yet, is a key element of cost affecting the overall performance of TOHP. TOHP received a rating of Adequate on the TOHP program assessment. Generally, this rating describes a program that needs to set more ambitious goals, achieve better results, improve accountability or strengthen its management practices. The TOHP program assessment found that TOHPs maintain or improve the overall health of American Indians and Alaska Natives (AI/AN) 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 percent over the past decade. However, performance information is only available for programs that voluntarily report the data, or 76 percent of AI/ANs served in 2008. By law, the government cannot require Tribal programs to submit performance data (Indian Self-Determination and Education Assistance Act (ISDEAA) Public Law 93-638, as amended, Section 514). This restriction makes it difficult to identify deficiencies and assist Tribes in improving program performance. Tribes are also not required to inform the IHS 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.

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 FY 2007 and subsequent years. This guidance requires that Tribes and the IHS reach agreement concerning the unavailability of Indian Self-Determination (ISD)/CSC funding and the obligation of the IHS to fund CSC pursuant to the appropriations "cap" on CSC. If there is not 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 instances where

[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 plaintiff Tribes full funding of their contract support cost requirements pursuant to their ISDEAA contracts with the Federal Government in fiscal years 1995, 1996, and 1997.

CSC funding may not be available in order for the IHS to enter into new contracts or compacts under the Indian Self-Determination and Education Assistance Act. If the Tribe and the IHS could not reach agreement, the proposal to contract for the new and expanded programs, services, functions, and activities (PSFA) would be declined.

FUNDING HISTORY

Fiscal Year	Amount
2005	$263,683,000
2006	$264,730,000
2007	$269,730,000
2008	$267,398,000
2009 Recovery Act	$0
2009 Omnibus	$282,398,000

BUDGET REQUEST

The FY 2010 budget request for Contract Support Cost is $389,490,000, an increase of $107,092,000 over the FY 2009 Omnibus level; a significant increase of 38%. This increase represents $2,674,000 for non-medical inflation and $104,418,000 in program increases. The increase is projected to be applied against existing CSC shortfalls associated with ongoing contracts and compacts. The proposed increase will make significant progress in addressing the CSC needs of tribally operated programs to improve quality of care for AI/ANs.

OUTPUTS

Measure	FY 2008	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
The total direct program contracted or compacted by Tribes. [2]	$1372.0	$1,536.0	$1,747.9	+$211.9
Program Level Funding ($ in millions)	**$267.3**	**$282.3**	**$389.4**	**$107.1**
ARRA Level Funding ($ in millions)[3]	**$0**	**$0**	**$0**	**$0**

Area Allocation – Contract Support Costs

Discretionary SERVICES	FY 2008 Actual	FY 2009 Omnibus	FY 2010 Estimate	FY 2010 +/- FY 2009
Aberdeen	$10,634,808	$11,053,667	$14,302,376	+$3,248,709
Alaska	87,010,640	90,403,498	136,042,793	+ 45,639,295
Albuquerque	9,049,183	9,238,140	11,456,736	+ 2,218,596
Bemidji	12,527,658	14,175,587	21,099,156	+ 6,923,569
Billings	9,008,857	9,098,117	10,297,905	+ 1,199,788
California	26,844,796	27,614,246	38,455,645	+ 10,841,399
Nashville	16,545,678	16,733,501	19,276,657	+ 2,543,156
Navajo	12,622,457	15,298,585	23,173,006	+ 7,874,421
Oklahoma	34,007,405	37,872,058	52,284,462	+ 14,412,404
Phoenix	14,297,839	14,788,818	18,267,594	+ 3,478,776
Portland	33,449,895	34,676,107	42,712,030	+ 8,035,923
Tucson	1,398,782	1,445,676	2,121,640	+ 675,964
Headquarters	0	0	0	0
Total	**$267,398,000**	**$282,398,000**	**$389,490,000**	**+$107,092,000**

[2] The total number of Tribes/Tribal Organizations contracting or compacting is 331
[3] The spread of ARRA is unknown.

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

PUBLIC AND PRIVATE COLLECTIONS

	FY 2008 Actual	FY 2009 Estimate	FY 2010 Estimate
Medicare:			
Federal	$123,597,000	$125,633,000	$125,633,000
Tribal [1]	6,986,000	6,986,000	6,986,000
Tribal [2]	34,085,000	34,085,000	34,085,000
Subtotal:	164,598,000	166,704,000	166,704,000
Medicaid:			
Federal	438,542,000	440,372,000	440,372,000
Tribal [1]	22,217,000	22,217,000	22,217,000
Tribal [2]	75,181,000	75,181,000	75,181,000
Subtotal:	535,940,000	537,770,000	537,770,000
Medicare/Medicaid Total:	700,538,000	704,474,000	704,474,000
Private Insurance	94,042,000	94,042,000	94,042,000
TOTAL:	**$794,580,000**	**$798,516,000**	**$798,516,000**
FTE	4,204	4,204	4,204

[1] Represents CMS Tribal collection estimates.

[2] Represents estimates of Tribal collections due to direct billing that began in FY 2002-05.

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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. Public and Private Collections are a significant part of the IHS and Tribal budgets, and support increased access to quality health care services for American Indian and Alaska Native (AI/AN). Third party revenue represents up to 50 percent of operating budgets at many facilities. IHS has had legislative authority to bill Medicare and Medicaid (M&M) since 1976.

Medicare/Medicaid -- The FY 2008 collections are actual results and the 2009 total is adjusted using the 2008 M & M rate increase. The FY 2010 collection estimates assume continuation of the FY 2009 collections at this time. Completing cost reports to set the CY 2010 M&M rates is priority.

During FY 2009 and FY 2010, IHS will continue to place a priority on development of a third party interface with the new Unified Financial Management System. The IHS focus will continue to strengthen business office policies and management practices, including internal controls, patient benefits coordination, provider documentation training, certified procedural coding training and electronic claims processing. Priority efforts include the

continued development of modifications to third party billing and accounts receivable software to improve effectiveness and to ensure system integration with its business processes and compliance with Health Insurance Portability and Accountability Act (HIPAA), National Provider ID and M&M regulations. As part of long term planning goals, during FY 2009 and FY 2010 IHS will be evaluating through GSA commercial off the shelf Practice Management Software for possible replacement of existing third party billing and accounts receivable software.

IHS will continue to work with the Centers for Medicare and Medicaid Services (CMS) and the State Medicaid agencies to improve each program's capability to identify patients who are eligible to enroll in M&M programs. IHS will also continue to work with the CMS and the Tribes on a number of issues, including third party coverage, claims processing, denials, training and documentation of services.

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 facility accreditation and improve the delivery and access to health care for AI/AN people.

Private Third Party Collection -- The FY 2009 and 2010 private insurance budget estimate remains at the FY 2008 collection level. During FY 2009 and FY 2010, IHS continues to enhance each health facility's capability to identify patients who have private insurance coverage, improve claims processing, provider documentation and coding that increases private insurance billing and collections.

The local Service Units utilize the funds collected to improve services like the purchase of medical supplies and equipment. In addition, the funds will improve local service unit business management practices. The IHS continues to make use of private contractors to pursue collections on outstanding claims from private payers.

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

Type of Obligation	FY 2008 Estimate	FY 2009 Estimate	FY 2010 Estimate
Personnel Benefits & Compensation	$331,400,000	$338,037,000	$338,037,000
Travel & Transportation	4,261,000	4,219,000	4,219,000
Transportation of Things	3,841,000	3,798,000	3,798,000
Comm./Util./Rent	11,906,000	11,812,000	11,812,000
Printing & Reproduction	386,000	384,000	384,000
Other Contractual Services	148,849,000	147,645,000	147,645,000
Supplies	105,921,000	103,625,000	103,625,000
Equipment	18,790,000	18,592,000	18,592,000
Land & Structures	24,036,000	23,811,000	23,811,000
Grants	6,411,000	7,772,000	7,772,000
Insurance / Indemnities	245,000	242,000	242,000
Interest/Dividends	65,000	110,000	110,000
Subtotal	$656,111,000	$660,047,000	$660,047,000
Tribal Collections	$138,469,000	$138,469,000	$138,469,000
Total Collections	**$794,580,000**	**$798,516,000**	**$798,516,000**

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

SPECIAL DIABETES PROGRAM FOR INDIANS

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$150,000,000	$150,000,000	$0	$150,000,000	$0
FTE	0	0	0	0	0

Authorizing Legislation ..... 111 Stat. 574, 1997 Balanced Budget Act (P.L. 105-33), Consolidated Appropriation Act 2001 and amendment to Section 330C (c)(2)(c) Public Health Service Act through Senate Bill 2499 (passed the Senate 12/18/07) to extend funding through FY 2009 and the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) Title III Special Diabetes Program for Indians.

FY 2010 Authorization ..... through 2011

Allocation Method.....Grants, Interagency agreements, and Contracts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Congress established the initial Special Diabetes Program for Indians (SDPI) through the Balanced Budget Act of 1997. Support for the SDPI was augmented through the Consolidated Appropriations Act of 2001, House Resolution 5738 of 2003, House Resolution 2764 of 2007 and House Resolution 6331 of 2008. As a result, the SDPI now operates with a budget of $150 million per year (through FY 2011).

The IHS Division of Diabetes Treatment and Prevention (DDTP) provides leadership, programmatic, administrative and technical oversight to the SDPI grant program. The mission of the IHS DDTP is to develop, document, and sustain a public health effort to prevent and control diabetes in American Indians and Alaska Natives (AI/ANs). This mission is accomplished by promoting collaborative strategies for the prevention of diabetes and its complications to over 1.6 million AI/ANs through its extensive diabetes network. The diabetes 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 local Community-directed and 66 Demonstration Project IHS, Tribal and Urban Indian SDPI grant programs. The 66 SDPI demonstration grant programs, awarded in FY 2004, are comprised of 30 cardiovascular disease (CVD) risk reduction demonstration projects and 36 diabetes prevention demonstration projects.

This extensive diabetes network supports the SDPI grant programs by providing 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 and training. 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. 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.

Target Audience

Congress authorized the initial SDPI appropriation in 1997 in response to alarming trends documenting a disproportionately high rate of type 2 diabetes in 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 in particular for the growing disparity in **prevalence** between the AI/AN population and the US general population.

AI/AN communities suffer a disproportionately high rate of type 2 diabetes. The Centers for Disease Control and Prevention (CDC) recently reported that, after adjusting for population age differences, national survey data (2004-2006) for people aged 20 years or older indicate that 6.6 percent of non-Hispanic whites, 7.5 percent of Asian Americans, 10.4 percent of Hispanics, 11.8 percent of non-Hispanic blacks and 16.5 percent of AI/ANs had diagnosed diabetes.

Diabetes is the fourth leading cause of death among AI/ANs, and the diabetes **mortality** rate among AI/ANs is three to four times that of non-AI/ANs. Heart disease, the leading cause of AI/AN mortality, appears to be more often fatal among AI/ANs than in other populations. In 2005, of AI/AN age 35 years or older with diabetes, nearly 70 percent had hypertension. Hypertension in people with diabetes, particularly if it is uncontrolled, significantly increases their likelihood of developing diabetes complications.

In many tribal communities, the complications of diabetes lead to much higher incidence rates of blindness, vascular insufficiency leading to amputation, and kidney failure leading to dialysis than in the general U.S. population. 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). AI/ANs have the highest rate of premature deaths from heart disease of all races, with 36% of deaths from heart disease classified as premature; the rate is nearly 2.5 that for Whites.

There has been some good news recently. Since 1999, the incidence of kidney failure leading to dialysis has declined 18 percent among AI/AN population with diabetes over age 45 years (a 29 percent decrease was seen in those aged 45-64 years and a 13 percent decrease in those age 65 years and older). This improvement was seen despite the continued rise in diabetes prevalence in the same time period, and was attributed to the reduction in risk factors and improvements in diabetes care practices in Indian communities as shown by our yearly IHS Diabetes Care and Outcomes Audit.

Distribution Method

In the Balanced Budget Act of 1997, Congress established the SDPI to "establish grants for the prevention and treatment of diabetes" to address the growing problem of diabetes in AI/ANs. The entities eligible to receive these grants included IHS programs, tribes and tribal organizations, and urban Indian organizations.

The IHS distributed this funding to over 300 such entities according to legislative intent through a process that included a formal tribal consultation, development of a formula for distribution of the funds to eligible entities, and a formal grant application and administrative process. These programs were allowed to use this funding to design and carry out interventions that will best address the problem of diabetes in individual communities. Depending on community needs, these programs incorporate a wide range of proven diabetes treatment and prevention strategies, such as patient education, quality diabetes care services, as well as physical activity, nutrition and weight loss activities. $1 million was also set-aside for the CDC Native Diabetes Wellness Program (formerly known as the National Diabetes Prevention Center).

Special Diabetes Program for Indians – Total Yearly Costs 2004-2011

CATEGORY	(Dollars in Millions)
Original Diabetes Grants – now called Community-directed Diabetes Programs (297 Tribal and IHS grants in FY 1998)	$104.8
Administration of Community-directed SDPI grants (Includes administrative funds to IHS Areas, Tribal Leaders Diabetes Committee, Div of Diabetes, Grants Operations, evaluation support contracts, etc.)	4.1
Urban Indian Health Program community-directed diabetes programs (36 grants)	7.5
Demonstration Projects (66 grants)	23.3
Administration of Demonstration Project Diabetes Grants (Includes administrative funds 1) to support the limited dissemination activities, 2) to HQ, 3) to support contracts, etc.)	0.9
Demonstration Project Coordinating Center	3.2
Funds to strengthen the Data Infrastructure of IHS	5.2
Native Diabetes Wellness Center (CDC)	1.0
TOTAL:	**$150.0**

Strategy

The SDPI has brought Tribes together over these past 12 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.

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 2007 on the economic burden of diabetes in the U.S., estimated that it costs $11,744 per year to care for one person with diabetes compared with $5,095 per year for persons without diabetes. A recent IHS analysis, supported by the SDPI, demonstrated that in the Indian health system it costs $7,003 per year to care for an AI/AN person with diabetes compared with $2,205 for a AI/AN person without diabetes, a three-fold difference. Among AI/ANs with diabetes,

those who also have CVD cost $12,693 per year, a two-fold increase. Early on in the SDPI program the Indian health care system recognized that it would have to make careful choices about where to invest these funds and knew these choices would best be made locally.

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 for AI/ANs with diabetes 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. However, the greatest long-term benefit will most likely be from the diabetes primary prevention activities now becoming commonplace in AI/AN communities.

Demonstration Projects

In FY 2004 the IHS, in response to Congressional direction, developed and implemented a SDPI competitive Demonstration Project. The focus of the competitive Demonstration Project is on: 1) primary prevention of type 2 diabetes in those adults at risk for developing diabetes and 2) reduction of cardiovascular risk in AI/AN adults diagnosed with type 2 diabetes. Sixty-six grants were awarded and this 5-year project was launched in November 2004. These 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.

Preliminary results from these Demonstration Projects are promising. When the rigorous evaluation and analysis of the SDPI Demonstration Projects is complete in FY 2010, the IHS will better understand how best to implement the successful interventions in the diverse settings of AI/AN communities.

Strengthening the Diabetes Data Infrastructure

The IHS has used administrative funding from the SDPI to strengthen the diabetes data infrastructure of the Indian health system by improving diabetes surveillance and evaluation capabilities. These funds also support the development and implementation of the IHS Electronic Health Record, the electronic patient and data management system used in many Indian health facilities. As a result of these data infrastructure improvements, the Indian health system has been better able to identify and track American Indians and Alaska Natives with diabetes. This improvement in diabetes surveillance will allow for the measurement of the long-term outcomes of age-specific prevalence of diabetes and of CVD in people with diagnosed diabetes.

Technical assistance, provider networks, clinical monitoring and grant evaluation activities at the Headquarters and Area office levels have also been strengthened. In addition, support for the Area Diabetes consultants, who serve a crucial role in coordinating these functions at the Area level, was made stronger. SDPI funding for the past 11 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.

Milestones accomplished and challenges faced during current year

The SDPI provides funding for diabetes treatment and prevention services in 399 Tribal, IHS and urban Indian Health programs. Yearly SDPI grantee assessments are conducted within the yearly SDPI Progress Report. These assessments have shown significant improvements in care and community services provided over time when compared to the baseline SDPI assessment in 1997, as evidenced by:

- Improved Elements of Diabetes Care:
  - 68 percent more grant programs have diabetes teams – health professionals who work together to provide diabetes care.
  - 36 percent more grant programs have diabetes clinics that offer special medical appointments for people with diabetes.
  - 65 percent more grant programs use a diabetes registry to keep track of people with diabetes in their communities.
- Promoting Healthy Lifestyles:
  - 57 percent more grant programs offer nutrition services for adults.
  - 38 percent more grant programs have access to a registered dietitian.
  - 72 percent more grant programs offer community walking and running programs.
  - 53 percent more grant programs have a physical activity specialist.
- Addressing the threat of childhood obesity and diabetes:
  - 76 percent more grant programs have type 2 diabetes prevention programs for youth.
  - 29 percent more grant programs offer nutrition services for children and youth.
  - 69 percent more grant programs have community-based physical activity programs.
  - 52 percent more grant programs have safe environments for physical activity.
- Efforts to Support Behavior Change:
  - 71 percent more grant programs offer organized diabetes education activities.
  - 56 percent more grant programs offer culturally-appropriate diabetes education.
  - 55 percent more grant programs work with social service programs.
  - Greater availability of depression screening and a variety of therapies to help patients cope with stress and depression.
- Weight Management Activities.
  - 65 percent more grant programs offer adult weight management programs.
  - 64 percent more grant programs offer weight management programs for children and youth.

AI/AN communities have used SDPI funds to make quality diabetes practices common place in local health facilities.

- Key Clinical Outcome Measures Have Improved:
  - The mean long-term blood sugar control level (A1C) overall decreased 12 percent from A1C=9.00 percent (1996) to A1C=7.93 percent (2008).
  - The incidence of new cases of kidney failure leading to dialysis among AI/AN has declined 18 percent for the entire adult diabetic population:

  - 29 percent decrease in those aged 45-64 years
  - 13 percent decrease in those aged 65 years and older
- The mean LDL cholesterol level decreased 19 percent from 118 mg/dl (1996) to 95.3 mg/dl (2008).

Building Programs Based on Best Practices. There are 18 IHS Diabetes Best Practice Models that focus on successful diabetes prevention, treatment and education practices that have been shown to be successful in AI/AN communities. These Best Practices are based on findings from the latest diabetes scientific research, evidence-based outcomes studies, and the extensive experience of Indian health professionals. The best practice models have been used by SDPI 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.

Tribal Consultation. The Tribal Leaders Diabetes Committee, established in 1998, 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 recommendations to the Director of IHS on diabetes-related issues pertinent to AIAN, as well as to CDC and NIH-NIDDK.

Strengthen IHS Data infrastructure. SDPI funds support the development and implementation of the IHS Electronic Health Record and the IHS Diabetes Management System (a software program that is part of the RPMS system) in all 12 Areas of the IHS and, as a result, the Indian Health system has been better able to identify and track AIAN with diabetes and improve clinical services.

SDPI Grant Program Evaluation. The CDC's *Framework for Public Health Evaluation*, provides a framework for ongoing analysis of the SDPI Community-directed grant programs. In addition, the IHS is conducting a comprehensive evaluation of the SDPI Targeted Demonstration Projects to answer questions on program effectiveness and outcomes based on solid, statistically accurate, and timely data. Preliminary analyses reveal:

Diabetes Prevention Demonstration Project: As of December 31, 2008, 36 programs have recruited 3451 participants with pre-diabetes to receive education to promote weight loss through increased physical activity and reducing fat grams and calories in their diets with a modified version of the 16-session Diabetes Prevention Program Curriculum. Of these participants, 2878 completed both the baseline and follow-up assessments, providing data to assess of whether key clinical characteristics had improved after completing the 16-session Diabetes Prevention Program curriculum. As of December 31, 2008, the average weight loss of participants was 8.6 Lbs which represented a 3.9 % reduction from baseline for the group mean. Both systolic and diastolic blood pressure decreased by 0.7% on average and HDL increased by 2.3% from baseline (both represent an improvement). Average fasting blood glucose decreased by 3.3 percent from baseline to follow-up. Other clinical indicators showed similar improvements. The percent of

participants who met the program goal of more than 150 minutes per week of physical activity increased from 23 percent at baseline to 55 percent at follow up.

Healthy Heart Demonstration Project: As of December 31, 2008, 30 programs have recruited 3564 participants with diabetes to participate in an intensive, clinic-based case management approach to reduce their risk factors for cardiovascular disease (CVD). Of these participants, 2799 completed baseline and first annual follow-up assessments. The primary outcomes that are assessed at the annual assessment include reduction in blood pressure, changes in HbA1C and lipids, aspirin use, increased physical activity, nutrition, weight loss, and less smoking. As of December 31, 2008, the overall group showed improvements in almost all cardiovascular disease risk factors. For example, the percentage of participants meeting the LDL goal (< 100 mg/dl) improved by about 10% from baseline (54%) to both annual assessments (65% and 66% for 1st and 2nd annual respectively). The percentage meeting the blood pressure goals showed similar improvements. Furthermore, the percent of participants taking daily aspirin increased by more than 10% from baseline (71%) to both annual assessments (84% and 85% respectively). The percent of participants who met the goal of >= 150 minutes of physical activity per week also increased significantly from baseline (27%) to 1st annual (37%) and 2nd annual assessment (45%). Additionally, participants reported eating healthy foods more often and unhealthy food less often at both annual assessments comparing to baseline.

Tribal Management of Local Grant Programs. Eighty-one percent of the SDPI Community-directed Diabetes Programs are Tribal programs.

Collaborations and Partnerships. The IHS has developed and built upon collaborations and partnerships with federal and private organizations resulting from the SDPI. These include:

- Joslin Vision Network (JVN) Tele-ophthalmology Project;
- NIDDK/CDC/TLDC/Tribal Colleges collaboration on the Diabetes Education in Tribal Schools project;
- National Indian Health Board (NIHB);
- Tribal Epidemiology Centers;
- National Congress of American Indians and Native American Boys and Girls Clubs;
- Head Start Bureau;
- Committee on Native American Child Health (CONACH);
- American Diabetes Association;
- Juvenile Diabetes Research Foundation (JDRF);
- American Indian Higher Education Consortium;
- CDC's State Diabetes Control Programs;
- National Diabetes Education Program (NDEP)

Challenges

In its entire history, the IHS had never been faced with creating and managing such a large grant program. In response to this challenge, the IHS DDTP has mobilized an

extensive network to undertake one of the most strategic and concerted diabetes treatment and prevention efforts to date and have demonstrated the ability to design, manage and measure a complex, long-term project to address this chronic condition.

Despite the progress made, significant diabetes-related challenges remain in AI/AN communities such as:

- Significant number of vacancies for professional health care positions hinder staffing of programs especially in rural areas.
- Finding adequate space to set-up programs and conduct program activities.
- Being located in remote areas making access to clinical services a significant challenge.
- Additional needs for training and technical assistance for
  - Grant writing and planning.
  - Assessment and planning at the community level.
  - Grant program management and leadership skills.
  - Grant program evaluation – statistics, data analysis and research on program impacts and outcomes.
  - Implementing diabetes prevention strategies that have been proven to work
  - Implementing prevention of diabetes complications strategies that are known to work.

FUNDING HISTORY

Fiscal Year	Amount
2005	$150,000,000
2006	$150,000,000
2007	$150,000,000
2008	$150,000,000
2009 Recovery Act	$0
2009 Omnibus	$150,000,000

BUDGET

The FY 2010 budget for Special Diabetes Program for Indian is $150,000,000 to maintain current service levels. Tribal consultation will be conducted on the new SDPI extension and, based on the final decisions of the IHS Director and Administration priorities; the activities will be continued or modified appropriately.

OUTCOMES

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Diabetes: A1c Measured[1]: Proportion of patients who have had an A1c test. IHS-All	FY 2008: 79%	N/A	N/A	N/A
Tribally Operated Health Programs	FY 2008: 76%	N/A	N/A	N/A
1: **Diabetes: Poor Glycemic Control**: Proportion of patients with diagnosed diabetes that have poor glycemic control (A1C > 9.5). IHS-All[2]	FY 2008: 18/17% (Target Unmet)	18%	16%	-2%
1: Tribally Operated Health Programs	FY 2008: 14%	15%	13%	-2%

	(Target Unmet)			
2: **Diabetes: Ideal Glycemic Control**: Proportion of patients with diagnosed diabetes with ideal glycemic control (A1c <7.0) IHS-All[2]	FY 2008: 39/32% (Target Exceeded)	30%	32%	+2%
2: Tribally Operated Health Programs	FY 2008: 34% (Target Exceeded)	32%	34%	+2%
3: **Diabetes: Blood Pressure Control**: Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<130/80). IHS-All[2]	FY 2008: 36/38% (Target Unmet)	36%	39%	+3%
3: Tribally Operated Health Programs	FY 2008: 36% (Target Unmet)	34%	38%	+4%
4: **Diabetes: Dyslipidemia Assessment:** Proportion of patients with diagnosed diabetes assessed for Dyslipidemia (LDL cholesterol). IHS-All[2]	FY 2008: 75/63% (Target Exceeded)	60%	64%	+4%
4: Tribally Operated Health Programs	FY 2008: 61% (Target Exceeded)	58%	62%	+4%
Program Level Funding ($ in millions)	**$150.0**	**$150.0**	**$150.0**	**+$0**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

[1]*There is no measure or goal; this information is provided for context.*
[2]*ForPoor Glycemic Control, a reduction in the rate represents improvement.*

OUTPUTS

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Proportion of SDPI yearly grantee assessments completed[1]	94%	90	90	0
Proportion of SDPI grantees using at least one of the 18 Diabetes Best Practices[2]	82%	50	50	0
Proportion of patients with diagnosed diabetes assessed for DM education# provided [3](yearly audit).	61%	61	61	0
Program Level Funding ($ in millions)	**$150.0**	**$150.0**	**$150.0**	**$0**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

1 Newly developed target for FY 2010
[2] This is a new measure for 2008. Baseline will be established. This assessment will evaluate use of its current 18 formal IHS Diabetes Best Practices. Other programs choose to implement different Diabetes Best Practices. IHS intends to add these additional Best Practices to its formal list of Diabetes Best Practices over time.
[3] Many new programs participated in the audit assessment in 2006 so the expected target was lowered in 2006.

AREA ALLOCATION

The Special Diabetes Program does not allocate funds by Area.

SDPI Community-Directed Grant Programs by State and FY 2009 Annual Funding Amounts in Notices of Award			
State	**State Name**	**Total Number of SDPI Grant Programs**	**Financial Assistance Award FY 2009**
AK	Alaska	25	$8,963,599
AL	Alabama	1	186,868
AZ	Arizona	32	26,359,794
CA	California	45	8,307,826
CO	Colorado	3	728,212
CT	Connecticut	3	283,935
FL	Florida	2	411,650
IA	Iowa	2	518,266
ID	Idaho	4	759,471
IL	Illinois	1	226,282
KS	Kansas	7	695,810
LA	Louisiana	4	307,903
MA	Massachusetts	1	142,066
ME	Maine	5	429,697
MI	Michigan	13	2,172,877
MN	Minnesota	13	3,401,552
MS	Mississippi	2	1,350,679
MT	Montana	19	5,582,611
NC	North Carolina	2	1,143,625
ND	North Dakota	7	2,643,997
NE	Nebraska	4	1,326,504
NM	New Mexico	32	6,938,491
NV	Nevada	19	3,260,720
NY	New York	4	1,159,580
OK	Oklahoma	41	18,387,863
OR	Oregon	15	2,134,513
RI	Rhode Island	1	114,858
SC	South Carolina	1	120,669
SD	South Dakota	14	5,439,117
TN	Tennessee	3	84,609
TX	Texas	4	589,207
UT	Utah	8	1,444,740
WA	Washington	34	3,541,903
WI	Wisconsin	14	2,949,032
WY	Wyoming	4	747,878
	TOTAL	**390 (includes sub-grantees)**	**$112,856,404**

SDPI Grant Demonstration Projects by State and FY 2009 Annual Funding in Notices of Award			
	State	**Total Number of SDPI Demonstration Programs**	**Total FY 2009 Financial Assistance Award**
AK	Alaska	5	$1,767,100
AZ	Arizona	6	2,309,800
CA	California	8	2,740,000
ID	Idaho	1	324,300
KS	Kansas	1	397,100
MI	Missouri	1	324,300
MN	Minnesota	5	1,694,300
MS	Mississippi	1	397,100
MT	Montana	4	1,370,000
ND	North Dakota	1	324,300
NE	Nebraska	1	324,300
NM	New Mexico	7	2,488,500
NY	New York	2	648,600
OK	Oklahoma	7	2,634,100
OR	Oregon	2	794,200
SD	South Dakota	4	1,370,000
UT	Utah	1	397,100
WA	Washington	6	2,018,600
WI	Wisconsin	3	972,900
	Total	**66**	**$23,296,600**

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

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$374,646,000	$390,168,000	$415,000,000	$394,757,000	+$4,589,000
M&I	*$52,889,000*	*$53,915,000*	*$100,000,000*	*$53,915,000*	*$0*
Sanitation	*$94,253,000*	*$95,857,000*	*$68,000,000*	*$95,857,000*	*$0*
HCFC	*$36,584,000*	*$40,000,000*	*$227,000,000*	*$29,234,000*	*-$10,766,000*
FEHS	*$169,638,000*	*$178,329,000*	*$0*	*$193,087,000*	*+$14,758,000*
Equipment	*$21,282,000*	*$22,067,000*	*$20,000,000*	*$22,664,000*	*+$597,000*
Quarters[1]	*$6,288,000*	*$6,288,000*	*$0*	*$6,288,000*	*$0*
FTE	1,071	1,082	0	1,082	0

[1] Quarters funds are not BA but are rents collected for quarters which are returned to the service unit for maintenance and operation costs. They fall under the Program Authority.

SUMMARY OF THE BUDGET REQUEST

The Indian Health Facilities programs include project, program support, medical equipment, and quarters return activities. Project activities include Maintenance and Improvement (M&I), Sanitation Facilities Construction (SFC), and Health Care Facilities Construction (HCFC). The program support activity is Facilities and Environmental Health Support. Medical Equipment and Staff Quarters are also separate activities.

The FY 2010 budget request of $394,757,000 and 1,082 FTE's is an increase of $4,589,000 above the FY 2009 Omnibus level.

Maintenance & Improvement (+$0) – Specific objectives include:

- Providing routine maintenance and repairs for facilities;
- Achieving compliance with buildings and grounds accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations or other applicable accreditation bodies;
- Providing improvements to facilities for enhanced patient care;
- Ensuring that health care facilities meet building codes and standards; and
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., energy conservation, seismic, environmental, handicapped accessibility, and security.

Sanitation Facilities Construction (+$0) – Types of sanitation facilities projects:

- projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the BIA-Home Improvement Program (HIP), Tribes, individual homeowners, or other nonprofit organizations,
- projects to serve existing housing,
- special projects (studies, training, or other needs related to sanitation facilities construction), and emergency projects.

Health Care Facilities Construction (-$10,766,000) – The request continues the construction of:

- Barrow, Alaska Hospital;
- Kayenta, Arizona Health Center; and
- San Carlos, Arizona Health Center.

Facilities and Environmental Health Support (+$14,758,000) – provides for:

- personnel who provide facilities and environmental health services throughout the Indian Health Service, and operating costs associated with provision of those services and activities; and
- divided into sub-activities to align with project and equipment accounts.

Equipment (+$597,000) – provides for:

- routine replacement medical equipment to over 1,600 Federally and Tribally-operated health care facilities,
- new medical equipment in tribally-constructed health care facilities, and
- TRANSAM which is surplus Department of Defense medical equipment and ambulance programs.

Quarters (+$0) – rents collected to be used for:

- operation, management, and general maintenance of quarters, including temporary maintenance personnel services, security guard services, and
- repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (stoves, water heaters, furnaces, etc.).

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

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$52,889,000	$53,915,000	$100,000,000	$53,915,000	$0
FTE	0	0	0	0	0

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

FY 2010 Authorization ..... Indefinite

Allocation Method.....Direct, Federal P.L. 93-638 Self Determination contract and Self-Governance compact programs for Maintenance and Improvement (M&I) routine and project funds is formula based; environmental compliance funds are competitively allocated to Federal and tribal health care facilities; and demolition funds are competitively allocated to Federal facilities.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Maintenance and Improvement (M&I) supports the maintenance and improvement of IHS and Tribal health care facilities which are used to deliver health care services. The HHS and IHS are committed to sustaining the real property necessary to meet the mission and goals of the IHS. This request also moves towards a strategy of improving the condition of IHS health care facilities to condition standards set by HHS.

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

Annual health care space supported with M&I funds:

FY	Supported Space (Square Meters)
2005	1,003,689
2006	1,054,888
2007	1,112,112
2008	1,132,220
2009	1,156,237

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

The accreditation of facilities demonstrates the high level of quality of services being provided to American Indian and Alaska Native communities. In 2008, all IHS and Tribally-operated hospitals were accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certified by the Centers for Medicare and Medicaid Services (CMS). Also, most large clinics and many smaller clinics were accredited by JCAHO or the Accreditation Association for Ambulatory Health Care, and most youth regional treatment facilities were either accredited by JCAHO or the Commission on Accreditation of Rehabilitation Facilities.

An essential component of these accreditation standards is a viable and proactive maintenance and repair operation with adequate funding levels. Facilities Engineering Program Plans (FEPPs) establish annual M&I workload targets and help determine the most prudent use of available resources. FEPPs are prepared by IHS Area Offices, service units, and Tribal programs to identify delineate, and plan facilities related activities and projects to be accomplished during the upcoming fiscal year with M&I funds. Funds in the M&I line item account are used primarily to maintain and improve health care facilities and are identified for allocation as routine maintenance and project funds. Staff quarters operation, maintenance, and improvement costs are primarily funded with rent collections called Quarters Return (QR) funds. M&I funds may be used in conjunction with QR funds at locations with few quarters or where QR funds are insufficient to ensure appropriate quarters maintenance. New Executive Orders on asset management and environmental management related to facilities may affect the cost of facilities operations.

Status of Facilities

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

These surveys, together with routine observations by facilities personnel, identify deficiencies that are included in the Backlog of Essential Maintenance, Alterations, and Repair (BEMAR) database. The identified BEMAR for IHS and reporting Tribal facilities as of April 24, 2009 was $476,052,000. The following table summarizes the BEMAR by category:

BEMAR [1]

PUBLIC LAW

Life Safety Compliance	$20,681,000
General Safety	14,675,000
Environmental Compliance [2]	13,860,000
Handicapped Compliance	13,846,000
Energy Conservation	26,135,000
Seismic Mitigation [3]	50,862,000
Sub Total	**$140,059,000**

IMPROVEMENTS

Patient Care	$92,544,000
Program Deficiencies	43,414,000
Sub Total	**$135,958,000**

MAINTENANCE & REPAIR [4]

Architectural M&R	$27,524,000
Structural M&R	32,317,000
Mechanical M&R	67,834,000
Electrical M&R	17,844,000
Utilities M&R	12,137,000
Grounds M&R	21,502,000
Painting M&R	6,564,000
Roof M&R	14,313,000
Sub Total	**$200,035,000**

GRAND TOTAL $476,052,000

[1] The M&I allocation will be distributed for routine maintenance and for projects; projects are intended to reduce identified BEMAR deficiencies.

[2] These types of projects include air quality improvement, asbestos remediation, lead-based paint, and contaminated soil remediation.

[3] The Earthquake Hazard Reduction Program Act required IHS to survey and estimate the cost associated with compliance to seismic construction standards. This survey was completed in the fall of 1998 and added $149,127,000 in seismic deficiencies. Since that time some seismic deficiencies have been corrected as part of larger projects, thus reducing the backlog.

[4] Staff quarters operation, maintenance, and improvement costs are funded through rents collected, called Quarters Return (QR) funds. The M&I funds may be used in conjunction with QR funds at locations where QR funds are insufficient to ensure appropriate quarters maintenance.

The IHS and tribes conduct detailed facility assessments to identify deficiencies that make up the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). To identify potential projects for the Recovery Act, a substantial number of new deficiencies were identified in both tribally and federally owned facilities that increased overall BEMAR. For IHS and reporting tribal facilities, BEMAR is $476,052,000 as of April 24, 2009.

Under the American Recovery and Reinvestment Act, $100 million was appropriated to the M&I activities, not all of which are BEMAR related. As the result of these funds, anticipate that BEMAR will be reduced by an estimated $80 million at Federal and tribal facilities. More details will be

M&I Funds Allocation Method

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

Routine Maintenance Funds - Amounts are calculated using the IHS M&I distribution formula, which is based on the modified University of Oklahoma methodology to calculate routine maintenance costs. Routine M&I funds can be used to pay non-personnel costs for the following activities in IHS and Tribally-owned health care facilities: emergency repairs, preventive maintenance activities, maintenance supplies and materials, building service equipment replacement, upkeep activities, training, and local projects. These funds support facilities activities that are generally classified as those needed for 'sustainment' of the existing facilities. In FY 2009, approximately $47 million, identified as M&I routine maintenance, was provided to the IHS Area Offices and Tribes for daily maintenance activities and local projects to maintain the current state of health care facilities. The Building Research Board of the National Academy of Sciences (NAS) (*Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings, 1990*) has determined that approximately two to four percent of current replacement value of supported buildings is required to maintain (i.e., 'sustain') facilities in their current condition. The current IHS investment strategy fully funds sustainment to maintain the facilities in their current condition.

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

equipment, and to accommodate new treatment methodologies. In FY 2009, approximately $3.8 million, identified as M&I project, was provided to the IHS Area Offices and Tribes for projects to reduce the BEMAR deficiencies and to improve healthcare facilities to meet changing healthcare delivery needs. The Healthcare Financial Management Association published the findings of a study that found that in the commercial (non-government) healthcare sector, hospitals spend an average of approximately five percent of a facility's value each year on restoration and modernization to maintain a reasonable backlog of maintenance and repair.

Environmental Compliance Funds - The IHS places a high priority on the implementation of the Greening the Government Executive Orders and meeting Federal, State, and local legal/regulatory environmental requirements, including allocating funding to address findings and recommendations from environmental audits. Many IHS and Tribal facilities were constructed before the existence of current environmental laws and regulations. Since IHS is required to comply with current Federal, State, and local environmental regulations, the use of environmental assessments to identify and evaluate potential environmental hazards is important. These assessments form the basis of the IHS facilities environmental remediation activities. The IHS has currently identified approximately $14 million in environmental compliance tasks and included them in the BEMAR database. Tribally-owned health care facilities receive assessments upon request by a Tribe.

Demolition Funds - The IHS has a number of Federally-owned buildings that are vacant, excess, or obsolete which are no longer needed. The number currently is estimated at over 100 buildings. Many of these buildings are safety and security hazards. Demolition of some of these buildings, in concert with transferring others, reduces hazards and liability. Demolition Fund may be augmented with environmental compliance funds as available for demolition of the Federal buildings to the extent that the proposed action reduces hazards, environmental concerns, or liability to the Indian Health Service.

FUNDING HISTORY

Fiscal Year	Amount
2005	$49,203,808
2006	$51,633,011
2007	$54,688,000
2008	$52,889,000
2009 Recovery Act	$100,000,000
2009 Omnibus	$53,915,000

BUDGET REQUEST

The FY 2010 budget request for Maintenance and Improvement is $53,915,000, which is the same as FY 2009 Omnibus level. There are no FTE's associated with this program.

This level of funding will assist the IHS in meeting the real property asset management requirements and goals as outlined in the Executive Order 13327, *Federal Real Property Asset Management*; Executive Order 13423, *Strengthen Federal Environmental, Energy, and Transportation Management*; and *Energy Independence and Security Act of 2007*; with the end product of improving the condition of existing facilities by eliminating the maintenance and repair backlog, demolition of excess buildings, and thereby raising the Condition Index. The requested funding will also aid in improving the efficiency of IHS and tribal facilities and addressing the most frequently cited area for improvement, which is the physical plant safety and efficiency. The average age of IHS health care facilities is greater than 30 years.

The total funding for M&I may provide:

- Approximately $49.4 million as M&I routine maintenance.
- Approximately $1 million identified as M&I project[1] provided to the IHS Area Offices and Tribes for projects to reduce the BEMAR deficiencies and to improve healthcare facilities' Condition Index (CI) to meet changing healthcare delivery needs.
- Approximately $3 million for environmental compliance projects and approximately $500,000 for demolition projects.

Under the American Recovery and Reinvestment Act, $100 million was appropriated to the M&I activities. As the result of these funds, anticipate that BEMAR will be reduced by an estimated $80 million at Federal and tribal facilities.

OUTCOMES

Program has no outcomes.

OUTPUTS

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
1**:** Improvement to facility condition index. *(Output)*	FY 2008: 87.2 (Target Exceeded)	87.6	88.0	+0.4
Program Level Funding ($ in millions)	**$0**	**$53.9**	**$53.9**	**+0**
ARRA Level Funding ($ in millions)	**$0**	**$100**	**$0**	**$0**

The CI reflects Government-owned facilities and selected Tribally-owned facilities that choose to maintain their deficiencies within our database system.

GRANTS AWARDS

Program has no grants awards.

[1] Program Level Funding is approaching sustainment with estimated funding for projects to address raising the Condition Index of assets dropping to less than a million dollars in FY2010.

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

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$94,253,000	$95,857,000	$68,000,000	$95,857,000	$0
FTE	164	166	0	166	0

Authorizing Legislation..... 25 U.S.C. 13 Snyder Act, P.L. 85-568, Transfer Act, 42 U.S.C. 2001, P.L. 86-121, Indian Sanitation Facilities Act; and Title III of P.L. 94-437, Indian Health Care Improvement Act, as amended.

FY 2010 Authorization…. P.L. 86-121, Indian Sanitation Facilities Act and Title III of P.L. 94-437, Indian Health Care Improvement Act, as amended which expired 2000.

Allocation Method..... Direct Federal, P.L. 93-638 Self-Determination Contracts, Memorandum of Agreements, and Self-Governance Compacts.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Sanitation Facilities Construction (SFC) is an integral component of the IHS disease prevention activity. The Indian Health Service (IHS) has carried out the program since 1959 using funds appropriated for SFC to provide potable water and waste disposal facilities for AI/AN people. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other environmentally-related diseases have been dramatically reduced, by about 80 percent since 1973. The IHS physicians and health professionals credit many of these health status improvements to IHS' provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations.

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

Sanitation facilities projects are carried out cooperatively with the tribes who are to be served by the facilities. Tribal involvement has been the keystone of the Sanitation

Facilities Program since its inception in FY 1959. Projects start with a Tribal Project Proposal and are funded through execution of an agreement between the Tribe and IHS. In these agreements the Tribes agree to assume ownership responsibilities, including operation and maintenance.

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

The Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L. 94-437) directed the IHS to identify the universe of Indian sanitation facilities needs for existing Indian homes. As of April 24, 2009, the list of all documented projects totaled almost $3 billion with those projects considered economically and technically feasible totaling almost $1.7 billion. Typically, it's those projects with exceptionally high capital costs that are considered economically infeasible if their cost per home exceeds an established allowable unit cost per home for a particular geographical area. Technical feasibility relates to operability and sustainability of the proposed system. As of the end of FY 2008, there were about 220,000 AI/AN homes in need of sanitation facilities, including nearly 35,000 AI/AN homes without potable water.

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

With completion of all projects approved through FY 2008, approximately 300,000 AI/AN homes will have been provided sanitation facilities since 1960. Experience shows that 60 to 70 percent of the actual construction is performed by Indian Tribes/firms.

The SFC program is a contributing factor in accomplishing the goals of the IHS Strategic Plan including: Goal 1: Build and Sustain Healthy Communities: Objective 1.2) Develop public health infrastructure with Tribes to sustain and support AI/AN communities. The SFC Program also supports the HHS Strategic Objective(s) 2.1: Preventing the spread of infectious diseases, 2.2: Protecting the public against injuries and environmental threats, and 2.4 Preparing for and responding to natural and man-made disasters. SFC projects provide resources for building and sustaining healthy communities through disease prevention; achieving parity in access by attempting to increase the number of AI/AN homes with potable water to 94 percent by 2015; providing compassionate quality health care through the provision of sanitation; and embracing innovation through prevention activities and increased partnerships with other federal agencies, states and tribes. Safe drinking water supplies and adequate waste

disposal facilities are essential preconditions for most health promotion and disease prevention efforts, as well as being a major factor in the quality of life of Indian people.

In FY 2008, the IHS provided service to 21,811 homes, which exceeds the performance target: to provide sanitation facilities projects to serve 21,800 AI/AN new or like-new and existing homes with water, sewage disposal, and/or solid waste water facilities. The SFC program has exceeded all Government Performance and Results Act (GPRA), IHS, Departmental and Program assessment performance measures.

In FY 2009, of the $95,857,000 appropriated for sanitation facilities, $47,500,000 will be used to address the backlog of existing homes. This included funding to serve solid waste needs identified on the Sanitation Deficiency System (SDS)[1] (included in the solid waste funding was approximately $500,000 to clean up open dumps evaluated by an interagency task force, the members of which included the Bureau of Indian Affairs, the Environmental Protection Agency (EPA), the Department of Agriculture and others). The remainder of the FY 2009 appropriation was used to provide $47,357,000 for sanitation facilities for new/like-new Indian homes and $1,000,000 for special projects, and emergency projects. In addition the SFC Program was appropriated $68,000,000 in the American Recovery and Reinvestment Act (ARRA) which was also used to provide essential sanitation facilities to the backlog of existing homes. The ARRA funds will fund projects of the Sanitation Deficiency System(SDS) list in the same manner as other projects are funded off SDS. The CJ states this as "In addition the SFC Program was appropriated $68,000,000 in ...ARRA... which was also used to provide essential sanitation facilities to the backlog of existing homes." We do not expect any impact on the 2010 measures because any additional homes served will impact the 2009 measures and the durations should not be impacted until after 2011. More detail will be available on Recovery.gov.

In cooperation with the Office of Management and Budget (OMB) a Common Measure was developed in 2002 with the Rural Utility Service (RUS), the Bureau of Reclamation (BOR), the EPA, and the IHS to allow direct comparisons between rural water programs within the federal government. The Common Measures agreed upon were the number of connections and the population served per million dollars of total project cost. It was recognized that BOR and IHS are direct service programs to a specific population, and EPA and RUS are grant/loan programs that can leverage funding with both of these programs mostly providing strictly upgraded services. SFC has leveraged its project funds yearly gaining up to 100 percent in matching projects contributions from other federal (EPA, RUS), state, tribal, and local entities. The IHS compared favorably in the OMB common measure of direct comparisons between federal rural water programs by servicing more than seven times the number of homes per dollar of funding than comparable programs.

[1] The sanitation Deficiency System (SDS) is an inventory of the sanitation deficiencies of American Indian and Alaska Native communities; those sanitation deficiencies include needed water, sewer, and solid waste facilities for existing American Indian and Alaska Native homes.

An efficiency measure based on the average project duration is evaluating SFC expertise in advancing project discipline. For Sanitation Facilities Construction projects completed during Calendar 2011 and the years thereafter, the average project duration from the execution of the Project Memorandum of Agreement (MOA) to the Construction Completion date as tracked by the Sanitation Facilities Project Data System shall be at 4 years or less. Project duration or the average length of time to complete project construction from the time the project is funded is a measure of actual performance since project schedule is under a project manager's control. This time length has been slowly increasing from 2.5 years in 1993 to over 4 years at the end of 2007. Several factors have contributed to this growth in project duration including increased administrative requirements, more involved environmental reviews, increased complexity of designs and decreases in staff resources. It is expected that the project duration will increase to at least 4.3 years prior to returning to 4 years. Reversing this trend is a protracted undertaking marked by gradual progress due to the sheer number of existing projects already underway, many of which already have durations in excess of four years. All reductions in the length of time a project takes to complete will yield cost savings in both construction inflation costs and project related staffing costs.

Based on the FY 2008 data, 10% of AI/AN homes are without a safe and reliable water supply. A marginal cost analysis for the SFC Program was requested by the OMB in conjunction with OMB A-11, Section 221, Budget and Performance Integration. The OMB approved the analysis and its findings in June of 2006. The marginal cost estimates related the level of SFC funding to the percent of AI/AN homes with potable water for a ten year period. According to the marginal cost curves the SFC funding would need to be increased to raise the percent of AI/AN homes that have access to safe drinking water. The marginal cost analysis for the SFC Program recommendations validated the existing IHS strategic goal and Program assessment goal for the SFC Program to increase the number of AI/AN homes with potable water to 94 percent by 2015. The Tribes through tribal consultation, other federal agencies through the Johannesburg MOU, and EPA within their strategic plan are all committed to SFC long term strategic goal. The marginal cost estimates related the level of SFC funding to the percent of AI/AN homes with potable water for a 10-year period.

FUNDING HISTORY

Fiscal Year	Amount
2005	$91,767,000
2006	$94,003,000
2007	$94,253,000
2008	$94,253,000
2009 Recovery Act	$68,000,000
2009 Omnibus	$95,857,000

BUDGET REQUEST

The FY 2010 budget request for Sanitation Facilities Construction is $95,857,000, which is equal to the FY 2009 Omnibus level. The budget request for Sanitation Facilities Construction supports essential sanitation facilities including water supply, sewage, and solid waste disposal facilities to American Indian/ Alaska Native (AI/AN) homes and communities. The SFC Program is a preventative health program that yields positive benefits in excess of the program costs.

This level of funding will be allocated as follows, with projects budgeted to include full costs for pre-planning, design, construction costs, and associated overhead:

1) $1,500,000 will be reserved at IHS Headquarters for special projects and for distribution to the Areas as needed to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situations that require immediate attention to minimize potential threats to public health. Emergency and special funds remaining at the end of the fiscal year will be distributed to the Areas to address the priority list of needs. The additional $500,000 is for funding special projects in 3 Areas a year to collect homeowner data and other demographic information to strengthen verification mechanisms within the SFC Community Deficiency Profiles (CDP) in an effort to increase transparency, accuracy, and accountability of the CDP data. This data initiative will be funded over 4 years to collect this data in all twelve IHS Areas.

2) Approximately $47,000,000 of the total FY 2010 SFC appropriation will be reserved to serve new and like-new homes. Some of these funds may also be used for sanitation facilities for the individual homes of the disabled or sick with a physician referral indicating an immediate medical need for adequate sanitation facilities in their home. As needed, amounts to serve new and like-new homes will be established by Headquarters after reviewing Area requests. Priority will be given to projects intended to provide sanitation facilities for the first time to homes in categories B, C, and D (new homes and homes receiving major renovation bringing the homes up to like new condition) under the BIA Housing Improvement Program (HIP). (NOTE: Homes in BIA/HIP Category A are considered existing homes. Category A homes needing service will be included in the SDS.)

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

3) Approximately $48,000,000 of the amount appropriated in FY 2010 will be distributed to the Areas for prioritized projects to serve existing homes, based on a formula that considers, among other factors, the cost of facilities to serve existing homes that: (a) have not received sanitation facilities for the first time; or (b) are served by substandard sanitation facilities (water and/or sewer). Another distribution formula element is a weight factor that favors Areas with larger numbers of American Indian and Alaska Native (AI/AN) homes without water supply or sewer facilities, or without both. Up to $5,000,000 will be used for projects to clean up and

replace open dumps on Indian lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994.

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

OUTCOMES

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009 Omnibus
35/SFC-1: **Sanitation Improvement:** Number of new or like-new and existing AI/AN homes provided with sanitation facilities	FY 2008: 21,811 (Target Exceeded)	37,500	21,811	+311
35A/SFC-2: Percent of existing homes served by the program at Deficiency Level 4 or above as defined by 25 USC 1632	FY 2008: 42% (Target Exceeded)	43%	42%	-1%
SFC-E: Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion *(Efficiency)*	FY 2007: 4.1 years (Target Not Met)	4.1 years	4.0 years	-.1 year
SFC-3: Percentage of AI/AN homes with sanitation facilities[1]	FY 2008: 90% (No target until 2010)	N/A	90%	N/A
Program Level Funding ($ in millions)	**$94**	**$96**	**$96**	**$0**
ARRA Level Funding ($ in millions)	**$0**	**$68**	**$0**	**$0**

1. Includes approximately 15,370 homes to be served with ARRA funding.
Targets in FY 2009 are revised to reflect funds provided in the Recovery Act.

OUTPUTS

Program has no outputs

GRANTS AWARDS

Program has no grants awards.

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

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$36,584,000	$40,000,000	$227,000,000	$29,234,000	$-10,766,000
FTE	0	0	0	0	0

HEALTH CARE FACILITIES CONSTRUCTION PROJECTS
(Dollars in Thousands)

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
		Omnibus	Recovery Act (2)	Pres.Budget Request	
BA	$36,584	$40,000	$227,000	$29,234,000	$10,766,000
Chandler, AZ PIMC System -SE ACC		4,000			-$4,000
Barrow, AK, Hosp	12,664			15,234	+$15,234
Nome, AK		10,000	2/		-$10,000
Outpatient Facilities					
Eagle Butte, SD	17,212		2/		$0
Fort Yuma, CA, HC	2,208	-			$0
Kayenta, AZ HC		12,000		7,000	-$5,000
San Carlos, AZ		14,000		7,000	-$7,000
Youth Regional Treatment Centers (Section 704)					
	0	-			$0
Joint Venture Construction Program (Section 818e)					
	0	-			$0
Small Ambulatory Program (Section 306)					
	2,500	-			$0
Dental Facilities Program					
	2,000	-			$0

1 The Inpatient and Outpatient health care facilities, Staff Quarters, and SAP projects are shown in priority order within their subcategory, but they are not prioritized against the other project categories that are listed. For example, the Barrow, AK Inpatient project does not have a higher priority than the Eagle Butte, SD project.

2 The distribution amounts are yet to be determined.

Authorizing Legislation.....25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001; and the Indian Health Care Improvement Act, P.L. 94-437, as amended.

FY 2010 Authorization.....Indefinite

Allocation Method..... Direct Federal, P.L.93-638 Self-Determination Contracts, and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Purpose - The IHS Health Care Facilities Construction (HCFC) funds are to provide optimum availability of functional, modern IHS and tribally operated health care facilities and, where no suitable housing alternative is available, staff housing that offer access to the IHS health care delivery system. The IHS capital improvement program, funded through this budget activity, is authorized to construct health care facilities and staff quarters; renovate/construct Youth Regional Treatment Centers for substance abuse; support tribal construction of facilities under the Joint Venture Construction Program; provide construction funding for Tribal small ambulatory care facilities projects; and provide funding to replace or provide new and replacement dental units.

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

To determine the locations where new and replacement facilities are most critically needed, the IHS has developed comprehensive priority system methodologies for health care facilities and staff quarters construction. The IHS Headquarters periodically solicits from the IHS Areas proposals for urgently needed new or replacement health care facilities, essential staff quarters projects, and replacement/new dental units. These proposals are evaluated and ranked. Program justification documents are prepared for those scoring highest. Once justified and approved, projects are placed on the appropriate construction priority list and proposed for funding in the order in which planning documents are approved and progress is achieved.

History - During FY 1990, in consultation with the Tribes, the IHS revised its Health Facilities Construction Priority System (HFCPS) methodology. The HFCPS ranks proposals using factors reflecting the total amount of space needed; age and condition of the existing facility, if any; degree of the isolation of population to be served in the proposed facility; and availability of alternate health care resources. There are three phases to the HFCPS. During FY 1991, Phase I of the methodology was applied to 149 IHS Area-generated proposals to construct new or replacement health care facilities. Based on the Phase I result, the IHS proceeded with Phase II of the methodology, by submitting the 28 highest ranked proposals to a more detailed analysis. During FY 1992, the IHS consulted with Tribes about incorporating additional flexibility into the HFCPS in order to give consideration to new concepts, such as low acuity beds in health centers, as directed by the Congress in the FY 1992 Conference Report on IHS appropriations. Few Tribes urged the IHS to make changes to the HFCPS. In FY 1993, 23 of the 28 proposals considered in Phase II were advanced to Phase III. IHS Area Offices were asked to develop Program Justification Documents (PJDs) for each of the 23 proposed

facilities. In FY 2008, the last of these PJDs were approved, and the projects were placed on the Healthcare Facilities Construction Priority Lists.

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

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

For the IHS Joint Venture Construction Program (JVCP), the Department of the Interior and Related Agencies Appropriations Act for FY 1991 (P.L. 101-512) authorized and partially funded a "joint venture demonstration program" to equip, supply, operate, and maintain up to three health centers. Under this demonstration, these health centers were to be selected on a competitive basis from those Tribal applicants agreeing to provide an appropriate facility for use as a health center for a minimum of 20 years, under a no cost lease. A subsequent update to the Indian Health Care Improvement Act, P.L. 94-437, incorporated authorization for the Joint Venture Construction Program as a part of Section 818. Beginning in FY 2003, Congressional language directed that staff quarters, if needed, were to be part of the health care facility under the Joint Venture Construction Program. The costs for facility design and construction and staff quarters, if any were to be borne by participating Tribes. The IHS was to be responsible for all costs associated with staffing, initially equipping, and operating the facilities.

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

Recent Accomplishments - The efficiency measure for the IHS Health Care Facility Construction program for FY 2008 was to complete construction of two health care facilities. One Health Care facility was completed ahead of schedule in FY 2007. The other facility was delayed to FY2009 due to P.L. 93-638 Tribal contract negotiations.

In FY 2008, the program selected two Joint Venture construction projects, the Vinita Health Center in Vinita, Oklahoma, and the Santee Health Center in Santee, Nebraska. The Santee Health Center was awarded upon approval of the Joint Venture Agreement

between the IHS and the Santee Sioux Nation. The IHS is working with the Cherokee Nation of Oklahoma to develop approvable planning documents, which are required before the IHS can enter into a Joint Venture Agreement. The HHS Strategic Objectives, 1.2 and 1.3, and the IHS Strategic Objectives, 1 and 2 cannot be realized without replacing small and antiquated facilities with appropriately sized facilities, adequate staffing, and state-of-the-art equipment. Sufficient resources, facilities, and equipment together with a culturally competent, highly skilled work force are fundamental to achieving health care access and health status parity with the U.S. general population. The ability to affect health status in any community involves increasing access to quality healthcare.

FUNDING HISTORY

Fiscal Year	Amount
2005	$88,597,000
2006	$37,779,000
2007	$25,664,000
2008	$36,584,000
2009 Recovery Act	$227,000,000
2009 Omnibus	$40,000,000

BUDGET REQUEST

The FY 2010 budget request for Health Care Facility Construction is $29,234,000, which is a decrease of $-10,766,000 from the FY 2009 Omnibus level.

Barrow Hospital: +$15,234,000 -- These funds will be used to continue construction of the Barrow Hospital, which received initial design and construction funding in 2005. The replacement hospital will provide space to support a modern and adequately staffed health care delivery program, which will improve access to the medical services needed to maintain and promote the health status and overall quality of life for the residents of the Barrow Service Area. The IHS health care services for this region are provided in the Samuel Simmonds Memorial Hospital, which is operated by the Arctic Slope Native Association, Ltd., under a Public Law (P.L.) 93-638 compact, with support services being provided by the Ukpeagvik Inupiat Corporation, under a P.L. 93-638 contract. The IHS also contracts with the North Slope Borough to provide community based services. The proposed new replacement hospital will have health care services for inpatient acute care nursing and labor and delivery (8 beds); endoscopy and outpatient surgery; ambulatory care; emergency and urgent care; ancillary for diagnostic imaging and laboratory; dental; optometry; audiology; physical therapy; community health, including public health nursing, nutrition; health education, alcoholism, and community health representative program; environmental health; and mental health and social services. The proposed 9 326 gross square meters (GSM) replacement hospital will serve a projected user population of 6,142 generating 26,760 primary care provider visits and 40,167 outpatient visits. The IHS planned facility includes only IHS supported health care programs.

Kayenta Health Center: + $7,000,000 – These funds will be used to continue construction of the Kayenta Health Center and associated staff quarters, which received initial design funding in FY 2005. The proposed new Kayenta replacement health center will provide space to support a modern and adequately staffed health care delivery program that will improve access to the medical services needed to maintain and promote the health status and overall quality of life for the residents of the service area. The health care programs and services provided at this facility include a level III emergency and urgent care unit with the support of the Tribal emergency medical services (EMS); a 10-bed short stay nursing unit that provides sub-acute care; a three-bed low-risk birthing center, which will allow this health center to function as an IHS alternative rural hospital. Additionally, this health center will have comprehensive ambulatory care, ancillary services, preventive community health services, behavioral health services, service unit administration, and facility support services. The proposed 16 638 gross square meters (GSM) new health center has been planned for a projected user population of 19,253 generating 53,796 primary care provider visits and 107,431 outpatient visits. The existing facility will be disposed of in accordance with established regulations and procedures after the replacement health center is operational.

San Carlos Health Center: + $7,000,000 -- Funds in this request will be used to continue construction of the San Carlos Health Center and associated staff quarters, which received initial design funding in FY 2005. The existing hospital at San Carlos will be replaced with a modern 16 721 gross square meters (GSM) health center that will have alternative rural hospital capabilities. The replacement facility will be a modern, technologically advanced facility with the required staff to provide an expanded level of health care services specifically designed to meet the health care needs of the San Carlos Service Unit's projected user population of 9,459 and 64,155 primary care provider visits. The facility will include eight acute care beds and two birthing beds for a total of ten. New services provided by at the facility will be a two-bed low risk birthing unit, physical therapy, telemedicine, podiatry, Ultra-sound, ambulatory procedures, CT, and mammography. The project will also include the construction of 43 new staff housing units.

OUTCOMES

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009 Omnibus
36 Health Care Facility Construction: Number of health care facilities construction projects completed.	FY 2008: 0[1] (Target Unmet)	1	TBD	N/A
HCFC-E **Health Care Facilities Construction:** Percent of health care facilities construction projects completed on time.	FY 2008: N/A	100%	100%	0
Program Level Funding ($ in millions)	**$36.58**	**$40.0**	**$29.0**	**$-11.0**
ARRA Level Funding ($ in millions)	**$0**	**$227.0**	**$0**	**$0**

1 The Phoenix Indian Medical Center Southwest Ambulatory Care Center project was delayed due to 638 Tribal contract negotiations. The project was completed in FY 2009.

OUTCOMES

Measure	Most Recent Result All FY 2008	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
HCFC-1 **Diabetes: Ideal Glycemic Control:** Proportion of patients with diagnosed diabetes with ideal glycemic control.	31/88 (Target Not met)	30	32	+2
	44/43 (Target Exceeded)	43	45	+2
	27/224 (Target Unmet)	26	28	+2
	40/30 (Target Exceeded)	39	41	+2
	29/41 (Target Exceeded)	28	30	+2
	31/37 (Target Unmet)	30	32	+2
HCFC-2 **Pap Smear Rates:** Proportion of eligible women who have had a Pap screen within the previous three years.	63/51 (Target Exceeded)	62	63	+1
	39/24 (Target Exceeded)	38	39	+1
	45/242 (Target Unmet)	44	45	+1
	61/5 (Target Exceeded)	60	61	+1
	62/10 (Target Exceeded)	61	62	+1
	81/21 (Target Exceeded)	80	81	+1
HCFC-3 **Mammogram Rates:** Proportion of eligible women who have had mammography screening within the previous two years.	51/93 (Target Exceeded)	50	52	+2
	47/25 (Target Unmet)	46	48	+2
	34/260 (Target Unmet)	33	35	+2
	68/17 (Target Unmet)	67	69	+2
	36/27 (Target Exceeded)	35	37	+2
	89/21 (Target Exceeded)	87	89	+2
HCFC-4 **Alcohol Screening (FAS Prevention}:** Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients.	45/39 (Target Exceeded)	45	48	+3
	74/8 (Target Exceeded)	74	77	+3
	69/211 (Target Exceeded)	69	72	+3
	74/7 (Target Exceeded)	74	77	+3
	53/7 (Target Exceeded)	53	56	+3
	65/16 (Target Unmet)	65	68	+3
HCFC-5 **Combined* immunization rates for AI/AN children patients aged 19-35 months[2]:** Immunization rates for AI/AN children patients aged 19-35 months.	95 (Target Exceeded)	94	95	+1
	97 (Target Exceeded)	96	97	+1
	84 (Target Exceeded)	83	84	+1
	90 (Target Exceeded)	89	90	+1
	77 (Target Unmet)	76	77	+1
	97 (Target Exceeded)	96	97	+1

HCFC-6 **Influenza vaccination rates among adult patients aged 65 years and older.**	67/111 (Target Exceeded)	66	67	+1
	62/35 (Target Unmet)	61	62	+1
	58/218 (Target Unmet)	57	58	+1
	89/-5 (Target Exceeded)	88	89	+1
	72/20 (Target Exceeded)	71	72	+1
	94/32 (Target Exceeded)	93	94	+1
HCFC-7 **Pneumococcal vaccination rates among adult patients aged 65 years and older.**	83/111 (Target Exceeded)	82	83	+1
	84/35 (Target Exceeded)	83	84	+1
	81/215 (Target Exceeded)	80	81	+1
	100/-5 (Target Exceeded)	99	100	+1
	85/20 (Target Exceeded)	84	85	+1
	96/32 (Target Unmet)	95	96	+1
HCFC-8 **Tobacco Cessation Intervention[2,3]:** Proportion of tobacco-using patients that receive tobacco cessation intervention.	2 (Target Exceeded)	2	5	+3
	25 (Target Exceeded)	25	28	+3
	18 (Target Exceeded)	18	21	+3
	18 (Target Unmet)	18	21	+3
	7 (Target Exceeded)	7	10	+3
	24 (Target Exceeded)	24	27	+3
HCFC-9: Percent reduction of the YPLL rate within 7 years of opening the new facility. *(Outcome)*	N/A	-10% (A) (2013)	-10% (B) (2014)	N/A
HCFC-10: Percent increase in the proportion of diagnosed diabetics demonstrating ideal blood sugar control within 7 years of opening the new facility[1] *(Outcome)*	N/A	+10% (A)	+10% (B)	N/A

Measures are reported by facility in ascending order (i.e. Facility A, B, C, D, E, F).
[1]First figure in results column is performance measure results; second is increased access from baseline.
[2]Rate changes prior to 2006 are not comparable due to CRS logic changes; increase in access rates could not be calculated.
[3]In FY 2005, this measure tracked the proportion of patients ages 5 and above who are screened for tobacco use. Prior to 2004, measure was Support local level initiatives directed at reducing tobacco usage.

The group of measures above outline clinical performance and access to care for eight clinical performance topics and include: diabetes Glycemic control, cancer screening (breast and cervical), Alcohol screening to prevent Fetal Alcohol Syndrome, Tobacco Cessation and immunizations (childhood and adult). Overall trends for these measures show moderate improvement but variations across facilities and across measures were noted. High cost measures such as Glycemic control, cancer screenings, and tobacco cessation can be attributed to the varied results across measures. In addition, increases in access to care (i.e., service population) have been observed for all measures and are not unique to one individual facility. Due to the inflation of the service population, clinical results can have an artificial appearance of declining performance. With that said, over inflation of the denominator (or increase in the service population) can dilute the true performance result (i.e. the overall number of patients being served has increased). All in all, the biggest attribute noted for these performance measures are the vast gains in access to quality healthcare across all topic areas outlined above.

GRANTS AWARDS

Program has no grants awards.

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

	FY 2008	FY 2009		FY 2010	FY 2010
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	+/- FY 2009 Omnibus
BA	$169,638,000	$178,329,000	$0	$193,087,000	+$14,758,000
FS	*$90,424,000*	*$96,038,000*	*$0*	*$108,831,000*	*+$12,793,000*
EHS	*$64,576,000*	*$67,022,000*	*$0*	*$68,142,000*	*+$1,120,000*
OEHE	*$14,638,000*	*$15,269,000*	*$0*	*$16,114,000*	*+$845,000*
FTE	907	916	0	916	0

Authorizing Legislation.....25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001

FY 2010 Authorization.....Indefinite

Allocation Method..... Direct Federal, P.L. 93-638 Self-Determination Contracts, Self-Governance Compacts, and competitive cooperative agreements

SUMMARY OF PROGRAMS

The Indian Health Facilities programs, managed throughout including at IHS Headquarters by the OEHE and also carried out by Area, Field, and Service unit staff, provide an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs both directly and indirectly support all of the IHS facilities performance measures.

Services are delivered directly by Federal or Tribal employees or contractors. In addition to staffing costs, funds appropriated for this activity are used to pay for utilities in IHS health care facilities, certain non-medical supplies and personal property, and biomedical equipment repair.

The OEHE Headquarters staff, and facilities and environmental health-related programs in IHS Area Offices and District Offices, provide support for a diverse range of projects and activities. Area facilities and environmental health personnel include architects, engineers, environmental health officers, real property and staff quarters management specialists, biomedical technicians, facilities planners, injury prevention specialists, institutional environmental health officers, construction inspectors, utility operations consultants, draftspersons, and land surveyors.

FUNDING HISTORY

Fiscal Year	Amount
2005	$141,669,000
2006	$150,709,000
2007	$165,272,000
2008	$169,638,000
2009 Recovery Act	$0
2009 Omnibus	$178,329,000

BUDGET REQUEST

The FY 2010 budget request for Facilities and Environmental Health Support is $193,087,000 an increase of $14,758,000 over the FY 2009 Omnibus level. This increase represents:

Pay Costs +$2,783,000 – will fund pay increases for Federal and Tribal employees.

Inflation +$300,000 – will fund non-medical inflation costs.

Population Growth +$2,675,000 – will fund costs associated with the annual population growth projected to be 1.5%.

Staffing New Facilities +$8,425,000 - will fund 4 new facilities to expand access to care in locations where existing capacity is most overextended.

Program Increase +$575,000 -The Facilities & Environmental Health Support (FEHS) provides funding for the overall management of the environmental health and engineering programs, including real property asset management of all, IHS facilities, technical services and support for capital investments, budget formulation, long range planning, national policy development and implementation and liaison with the Department, Congress, Tribes, and other Federal agencies. This funding request will provide additional support for the overall management of the environmental health and engineering program.

Facilities Support (FS): (+$12,793,000)

- Provides funding for staff, management, operation, and maintenance of real property and building systems, medical equipment technical support, and planning and construction management support for new and replacement facilities projects.

Environmental Health Support (EHS): (+$1,120,000)

- Provides funding for engineers, environmental health officers, environmental health technicians, engineering aides, injury prevention specialists, and institutional environmental health officers.

Office of Environmental Health and Engineering (OEHE): (+$845,000)

Provides funding for real property asset management across the IHS facilities and environmental health programs, including technical services and support for capital investments, budget formulation, and long range planning, national policy development and implementation and liaison with the Department, Congress, Tribes, and other Federal agencies.

Below is a list of new or expanded facilities showing the Facilities Support funding requirements. Operating cost is based on a percentage of the total new staffing cost for all sub-sub-activities within a healthcare facility.

Facility	Amount	Tribal Positions
Absentee Shawnee Health Center (JV), Shawnee, OK	$245,000	1
Santee Sioux Health Center (JV), Santee, NE	$1,306,000	4
Carl Albert Hospital (JV), Ada, OK	$6,294,000	8
Lake County Tribal Health Consortium (JV), Lake County, CA	$491,000	1
Santee Sioux Health Center (JV), Santee NE *	$89,000	1
Grand Total:	**$8,425,000**	**15**

*Environmental Health Support

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

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$90,424,000	$96,038,000	$0	$108,831,000	+$12,793,000
FTE	486	490	0	490	0

Authorizing Legislation.....25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001

FY 2009 Authorization.....Indefinite

Allocation Method..... Direct Federal, P.L. 93-638 Self-Determination Contracts, Self-Governance Compacts, and competitive cooperative agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

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

The IHS owns approximately 912,000 square meters of facilities (buildings and structures) and 743 hectares of Federal and trust land. The nature of space varies from sophisticated medical centers to residential units and utility plants. Facilities range in age from less than one year to more than 156 years. The average age of our health care facilities is 30 years.

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

Space Occupied by IHS and Tribal Health Care Programs - FY 2008				
Type of Facility	Federally Owned	Direct Federal Lease	GSA Assigned	Tribal *
Hospitals and Health Centers	446,000 M^2	88,000 M^2	-0-	280,000 M^2
Staff Quarters	320,000 M^2	0 M^2	-0-	0 M^2
Other	146,000 M^2	16,000 M^2	57,000 M^2	312,000 M^2
Total	912,000 M^2	104,000 M^2	57,000 M^2	592,000 M^2

(FY 2008 end of year)

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

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

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

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

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

- **Facilities Planning and Construction** -- Some IHS Areas have facilities planning and construction-monitoring components that assist in the planning and construction management of new and replacement health care facility and staff quarters projects.

The need for new and replacement facilities is determined by applying the IHS Health Facilities Construction and Quarters Construction Priority System methodologies. Area staffs develop initial proposals for new and replacement facilities, prepare Program Justification Documents, Program of Requirements Documents, and Project Summary Documents for projects. While construction is underway, Area facilities management staff may be supplemented with construction management personnel to oversee Federal interests in the construction of new and replacement facilities.

In addition, the functions of these facility and realty positions support new real property asset management requirements as required by Executive Order 13327, *"Real Property Asset Management*"; Executive Order 13423, *"Strengthen Federal Environmental, Energy, and Transportation Management"*; *Energy Independence and Security Act of 2007*; and HHS Program Management objectives. These management actions are to ensure management accountability, to ensure the efficient and economic use, to recognize the importance, and to respond to the current condition of Federal real property.

The IHS places a high priority on the implementation of the Greening the Government Executive Orders and meeting Federal, State, and local legal/regulatory environmental requirements, including allocating funding to address findings and recommendations from environmental audits. The costs associated with implementation of these requirements compete against other Facilities Support requirements within the existing budget levels. Starting in FY 2004, a national effort was initiated to execute a new cycle of environmental assessments with emphasis on direct building and grounds related deficiencies with sufficient data to initiate projects to address pending environmental deficiencies. The IHS then annually sets aside Maintenance and Improvement funds in the amounts of approximately $3 million for environmental compliance projects and $500,000 for demolition projects.

In conjunction with improved management practices, energy conservation measures, and projects, IHS reduced the energy related utility consumption for IHS managed facilities from 2,190,000 British Thermal Unit per Square Meter (BTU/SM) in 2003 to 1,964,000 BTU/SM in 2008. These efforts help stem the growth in the cost of utilities, which is primarily due to space increases and inflation. IHS will continue all of these functions in FY 2009. However, this will only partially address the overall impact of expected increases in energy cost. During the period FY 2003 through FY 2008, total utility costs have increased 62 percent from $15.5 million to $25.1 million and total utility costs per Gross Square Meters increased 60 percent from $25/GSM to $40/GSM. The IHS continues to aggressively investigate options to reduce energy costs through energy-savings performance contracts, utility energy-efficiency service contracts, and other contractual platforms for achieving conservation goals.

FY	Cost	BTU/SM	Cost/GSM
2004	14,800,000	2,150,000	$ 25
2005	18,500,000	1,930,000	$ 30
2006	21,800,000	1,797,000	$ 33
2007	21,900,000	1,923,000	$ 35
2008	25,100,000	1,964,000	$ 40

BUDGET REQUEST

The FY 2010 budget request for Facilities Support is $108,831,000. It is an increase of $12,793,000 above the FY 2009 Omnibus level.

This request will facilitate the IHS progress towards the real property asset management requirements and goals as outlined in the Executive Order 13327, *"Federal Real Property Asset Management"*; Executive Order 13423, *"Strengthen Federal Environmental, Energy, and Transportation Management"*; *Energy Independence and Security Act of 2007*; and the HHS Real Property Asset Management Plan.

This level of funding will provide:

Area Offices, service units and certain Tribal health care entities with funding for staff, utilities, program supplies and equipment to maintain the health care buildings and grounds, and to service approximately $320 million worth of medical equipment. Facilities supported include hospitals, health centers, staff quarters, health stations and school health clinics, and youth regional treatment centers. ‘

OUTCOMES

Program has no outcomes.

OUTPUTS

Program has no outputs

GRANTS AWARDS

Program has no grants awards.

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT
ENVIRONMENTAL HEALTH SUPPORT

	FY 2008	FY 2009		FY 2010	FY 2010
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	+/- FY 2009 Omnibus
BA	$64,576,000	$67,022,000	$0	$68,142,000	+$1,120,000
FTE	353	357	0	357	0

Authorizing Legislation.....25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001

FY 2009 Authorization.....Indefinite

Allocation Method..... Direct Federal, P.L. 93-638 Self-Determination Contracts, Self-Governance Compacts, and competitive cooperative agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The program provides funding for IHS Area, District and Service Unit environmental health staffs which include engineers, environmental health officers, environmental health technicians, engineering aides, injury prevention specialists, and institutional environmental health officers. American Indians and Alaska Natives face hazards in their environment that contribute to their health status, including: communities in remote/isolated locations that expose residents to severe climatic conditions, hazardous geography, and extreme isolation; increased exposure to disease carrying insects and rodents; limited availability of housing and extensive use of sub-standard housing; unsanitary methods of sewage and garbage disposal; and unsafe water supply.

Division of Sanitation Facilities Construction (SFC) staff manages and provides professional engineering services to construct over 400 sanitation projects annually at a total cost of over $190 million[1]. These services include management of staff, pre-planning, consultation with Tribes, coordination with other federal, State and local governmental entities, identifying supplemental funding outside of IHS, developing local policies and guidelines with Tribal consultation, developing agreements with Tribes and others for each project, providing project design, project construction, assuring environmental and historical preservation procedures are followed, assisting Tribes where the Tribes provide construction management, and assisting Tribes with operation and

[1] Does not include approximately 150 projects with at total cost of approximately $160 million funded under the American Recovery and Reinvestment Act.

maintenance of constructed facilities. In accordance with the Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L. 94-437) the SFC staff annually updates its inventory of sanitation facilities deficiencies for existing Indian homes. This is carried out with extensive consultation with Tribes. The SFC staff also develops and updates an inventory of all open dump sites on Indian lands as required under the Indian Lands Open Dump Cleanup Act (P.L. 103-399). Both of these inventories are widely used by other governmental agencies in their evaluation and funding of sanitation projects. Consistent with the 1994 Congressional set aside for "… tribal training on the operation and maintenance of sanitation facilities," $1,000,000 of these support funds are used to provide for continued operation and maintenance training. The SFC staff provides technical assistance, training and guidance to Indian families and communities regarding the operation and maintenance of essential water supply and sewage disposal facilities.

To accomplish its goals, the **Division of Environmental Health Services (DEHS)** is a consultative public health advisor to Tribes. The DEHS staff lead in the assessment and identification of environmental hazards and risk factors facing Tribal groups and partner with Tribal groups in the development of sound public health strategies to prevent or mitigate environmental hazards. Strategies employed by DEHS staff include: maintaining surveillance of disease and injury incidence in communities; investigation of disease and injury incidents; identifying environmental hazards in community facilities and institutions such as food service establishments, Head Start Centers, community water supply systems, and health care facilities; and providing training, technical assistance and project funding to develop the capacity of Tribal governments to address their environmental health issues. The DEHS is administered through the following three program emphasis areas:

- **General Environmental Health** staff are the lead environmental health professionals providing environmental health services to Tribes in issues of water quality, waste disposal, hazardous materials management, food sanitation, community injury prevention, institutional environmental health, vector control, occupational safety and health, and other environmental health issues.

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

- **Injury Prevention Program** staff take the lead in developing public health strategies to reduce the burden of injury experienced by AI/AN. AI/ANs die from injuries and poisonings at a rate 2.5 times the U.S. All Races rate. Treatment of injuries

(hospitalizations and ambulatory cases) cost an estimated $350,000,000 per year in direct health care costs to IHS, Tribes, and Contract care facilities. The IHS Injury Prevention Program has developed effective strategies and initiatives to reduce the burden of injury experienced by AI/AN, including: surveillance of community-based injuries; development of targeted prevention programs based on surveillance data; developing community coalitions to address their injury issues; developing the capacity of community coalition members through injury prevention practitioners training; funding competitively awarded cooperative agreement to develop Tribal injury prevention infrastructure; and evaluation program initiatives. In FY 2009, 22 of the 31 Tribal projects to develop Tribal infrastructure are continuing best practices as community-based IHS Tribal Injury Prevention Cooperative Agreements. The program awards consisted of 22 five-year programs and 8 three-year projects. In FY 2008 and 2009, the 8 three-year projects will be completed. There were no new awards in FY 2006 – FY 2009. The next award cycle is expected to be announced in FY 2010 after the 22 five-year programs have been completed.

- The **Institutional Environmental Health** (IEH) program is comprised of staff with specialized skills to quantify, evaluate, and respond to unique environmental and safety hazards found in health care, educational, childcare, correctional, and industrial facilities.

  The IEH program staffs are knowledgeable of and provide support in the following disciplines: infection control, industrial hygiene, radiation protection, hazardous materials and waste, safety management, ergonomics, fire/life safety, emergency management, public health preparedness, security, and environmental compliance. Also, IEH program staffs perform evaluations and management system reviews of IHS and Tribal health care facilities seeking accreditation and/or certification. Maintaining accreditation ensures that IHS continues to have access to third party funding.

  The IEH program utilizes a web-based occupational health incident reporting system called “WebCident” in IHS healthcare facilities. WebCident is used to report injuries, illnesses, hazardous conditions, security, and property-related incidents experienced by visitors, patients, and others, as appropriate. WebCident is used to prepare required Occupational Safety and Health Administration logs, identify, document and track hazardous conditions, report trends to assist with the development of targeted prevention strategies. DEHS continues to support the expansion of WebCident to all IHS and Tribal health care facilities and refine the program from feedback provided by users. Data developed through WebCident will be used to reduce occupational injuries/illnesses and associated workers’ compensation claims, and reduce/eliminate hazards to employees, patients, visitors, and others.

TRIBAL HEALTH PROGRAMS

The IHS Area, District and Service unit environmental health personnel also train Tribal employees to provide environmental health services, under contract with IHS wherever a

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

Area, District and Service unit environmental health personnel work with Tribes/Tribal organizations to encourage maximum participation in planning health services delivery programs. Also, they provide technical assistance to the Tribal officials who carry out administrative/management responsibilities associated with operation of federally supported programs. Their support of self-determination for Tribal organizations will continue. However, the extent to which there is participation in the self-determination process depends on, and is determined by, the individual Tribes/Tribal organizations.

BUDGET REQUEST

The FY 2010 budget request for Environmental Health Support is $68,142,000. It is an increase of $1,120,000 above the FY 2009 Omnibus level.

The request funds the costs of personnel who accomplish environmental health services, injury prevention activities, and sanitation facilities construction activities, at the IHS Area, District, and Service unit levels and pays operating costs associated with provision of those services and activities.

Environmental Health Services staff will utilize WebEHRS to identify environmental health risk factors. Multiple interventions will be implemented in FY 2009 to address each identified risk factor.

OUTCOMES

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
27: **Injury Intervention:** Occupant protection restraint use	FY 2008: Survey/11 Areas (Target Met)	1 Pilot/Area	TBD	N/A
34: **Environmental Surveillance:** Identification and control of environmental health risk factors[1]	FY 2008: Baseline established in 12 Areas (Baseline)	3 Interventions/ Area	TBD	N/A
Program Level Funding ($ in millions)	**$65**	**$67**	**$68**	**+$1**

[1] Prior to FY 2008 this measure tracked the number of environmental health programs with an automated web-based environmental health surveillance data collection system

Past trends for the Injury Intervention measure have shown positive outcomes in meeting set targets. The FY 2007 target was to implement three community injury prevention projects and report them using an automated tracking system, and the target was met. The FY 2008 target was for each Area to conduct a seat belt observation survey in 1 site to get a baseline usage rate for

that site. The target was met. All 11 Areas conducted seat belt usage surveys to get baseline rates**.** In FY 2009, the measure was 1 pilot project in 11 Areas (implementing a comprehensive intervention designed to increase restraint use) per Area. In FY 2010 the target is yet to be determined. . The original, pilot project in each Area will be continued.

Past trends for the Environmental Surveillance measure have shown an increase in the number of environmental health programs with automated web-based environmental health surveillance data collect system (WebEHRS). The FY 2007 target of 29 was met and a result of 32 was achieved. Because this system is now in wide use, the FY 2008 target was to set a baseline rate for identifying and addressing environmental risk factors in communities in 11 of the Areas. This target was exceeded. Twelve Areas identified baseline risk factors. The FY 2009 target is for each of Area to implement at least three interventions to address one of the environmental risk factors identified in FY 2008. The FY 2010 measure is yet to be determined. .

OUTPUTS

Program has no outputs.

GRANTS AWARDS

Program has no grants awards.

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

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

	FY 2008	FY 2009		FY 2010	FY 2010
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	+/- FY 2009 Omnibus
BA	$14,638,000	$15,269,000	$0	$16,114,000	+$845,000
FTE	68	69	0	69	0

Authorizing Legislation.....25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001

FY 2009 Authorization.....Indefinite

Allocation Method..... Direct Federal, P.L. 93-638 Self-Determination Contracts, Self-Governance Compacts, and competitive cooperative agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

In addition, these positions support new real property asset management requirements as required by Executive Order 13327, Real Property Asset Management; and HHS Program Management objectives. These actions are to ensure management accountability and to ensure the efficient and economic use of Federal real property,

while recognizing the importance of these assets and responding to their current condition.

In FY 2009, OEHE Support funded personnel and developed and utilized data systems to distribute resources to Area offices for facilities and environmental health activities. Also, technical guidance, information, and training were provided throughout the IHS system in support of the Facilities Appropriation. Some of the activities and accomplishments include approval of Program Justification Documents and Program of Requirements, announcement and selection of Joint Venture and Small Ambulatory projects, and awarding contracts for health care facilities construction.

OEHE continued to coordinate between a centralized approach to facilities management and infrastructure outside of the IHS to the geographical challenges of the Indian Health System. The coordination effort of a decentralized management structure throughout the IHS is complex. Health care delivery decisions are made locally and infrastructure needs are community based to avoid inappropriate decisions to be made from a distance which may adversely affect Indian communities.

BUDGET REQUEST

The FY 2010 budget request for Office of Environmental Health and Engineering Support is $16,114,000, which is an increase of $845,000 above the FY2009 Omnibus level.

OEHE collects and reports facility the data for the IHS to HHS. This information is consolidated at the HHS level for all Operating Divisions of HHS and reported to the Office of Management and Budget. OEHE continues to coordinate the requirements of HHS and the mission of the IHS. Targets and measurements are documented in the HHS Real Property Asset Management Plan.

OUTCOMES

Program has no outcomes.

OUTPUTS

Program has no outputs

GRANTS AWARDS

Program has no grants awards.

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

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$21,282,000	$22,067,000	$20,000,000	$22,664,000	+$597,000
FTE	0	0	0	0	0

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

FY 2010 Authorization ..... Indefinite

Allocation Method..... Direct Federal, and P.L. 93-638 Self Determination contracts and Self-Governance compacts for replacement medical equipment that is formula based; Equipment funds for tribally-constructed health care facilities are competitively allocated; and TRANSAM and ambulance purchase programs are Federally managed.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

This sub-activity supports maintenance, replacement, and the purchase of new biomedical equipment at IHS and Tribal health care facilities.

- The IHS and Tribal health programs manage laboratory, x-ray, and biomedical equipment valued at approximately $320 million. Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment to assure the best possible health outcomes. The average life expectancy for today's medical device is approximately six years depending on the intensity of use, maintenance, and technical advances. In FY 2009, the medical equipment program distributed over $16 million to IHS and tribal health programs to purchase new medical equipment, including replacement of existing equipment used in diagnosing and treatment of illnesses. Allocation of medical equipment funds is formula based. The remaining equipment funds are allocated as for new medical equipment in tribally-constructed health care facilities ($5 million) and for the TRANSAM and ambulance programs ($1 million).

Annual health care space supported with replacement medical equipment funds:

FY	Supported Space (Square Meters)
2005	1,051,075
2006	1,098,403
2007	1,155,452
2008	1,174,901
2009	1,199,346

This budget activity also funds equipment for replacement clinics built by Tribes using other funding sources. These equipment funds are competitively allocated where tribes and tribal organizations are invited to apply for these equipment funds during the annual application period.

Tribally-constructed health care facilities supported annually with equipment funds:

FY	Project Awards
2004	49
2005	31
2006	27
2007	32
2008	19
2009	15

Using these funds, 15 awards - see table below - were made to tribal organizations that funded and constructed clinics or clinic additions. Tribes plan on spending in excess of $74 million in construction projects using non-IHS funding sources to access these equipment funds. As a result, approximately 71,000 individual patients will be treated with updated medical equipment in these tribally-funded construction projects.

Bristol Bay Dental Clinic	Sokaogon Chippewa HC	Narragansett Health Clinic
Nunapitchuk Health Clinic Project	Polson Health Center	Grand Ronde Dental Clinic
Ouzinkie Health Clinic	Toiyabe Dialysis Unit	Lummi Nation Dental Clinic
Tyonek Health Clinic	Shingle Springs Health Center	Makah Tribal Health Clinic
Zia Pueblo Health Center	Yuki Trails Clinic	Bad River Clinic

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The program funds are used to acquire new and like-new excess medical equipment for the Department of Defense (DoD) or other sources through the TRANSAM (i.e., Transfer of DoD Excess Medical and Other Supplies to Native Americans or TRANSAM) program and to procure ambulances for IHS and tribal emergency medical services programs.

Such program activities support HHS strategic objective(s) 2.4: Prepare for and respond to natural and man-made disasters; 1.3: Improve health care quality, safety, cost and

value. These activities also support IHS strategic goal 2: providing accessible, quality health care.

FUNDING HISTORY

Fiscal Year	Amount
2005	$17,336,756
2006	$20,947,214
2007	$21,619,214
2008	$21,282,000
2009 Recovery Act	$20,000,000
2009 Omnibus	$22,067,000

BUDGET REQUEST

The FY 2010 budget request for Equipment is $22,664,000, which is an increase of $597,000 above the FY 2009 Omnibus level for non-medical inflation ($12,000) and medical inflation ($585,000).

- $16.7 million for routine replacement medical equipment to over 1,600 Federally and Tribally-operated health care facilities,
- $5 million for new medical equipment in tribally-constructed health care facilities, and
- $1 million for the TRANSAM and ambulance programs.

Under the American Recovery and Reinvestment Act, $20 million was appropriated to Equipment activities. Medical equipment at many IHS and Tribal health care sites is out of date or inadequate, especially at sites with high volumes of patients. Recovery Act funds ($8.5 million) will be used to mitigate some of the most pressing needs. Recovery Act funds ($5 million) also will be used to replace approximately 62 ambulances at IHS and tribal emergency medical services programs. Many of the existing ambulances are beyond their useful life and need replacement. Ambulances beyond their useful life have higher costs to maintain, lower availability, and lower reliability for emergency transport. Conversely, newer units have lower maintenance costs, higher availability, and better reliability for meeting communities' most urgent needs. The remaining Recovery Act funds ($6.5 million) will procure Computed Tomography (CT) Scanners that will improve diagnostic capability.

OUTCOMES - Program has no outcomes.

OUTPUTS - Program has no outputs.

AWARDS GRANTS - Program has no awards grants.

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

	FY 2008	FY 2009		FY 2010	FY 2010 +/- FY 2009 Omnibus
	Appropriations	Omnibus	Recovery Act	Pres. Budget Request	
BA	$6,288,000	$6,288,000	$0	$6,288,000	$0
FTE	0	0	0	0	0

Authorizing Legislation ..... Public Law 98-473, as amended

FY 2010 Authorization ..... Indefinite

Allocation Method..... Quarters Return (QR) funds are collected from tenants of quarters that are operated by direct Federal and P.L. 93-638 Self Determination contract and Self-Governance compact programs. These funds are distributed and used at the locality in which they are collected.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

Staff quarters' operation, maintenance, and improvement costs are funded with Quarters Return (QR) funds. An estimated $6,288,000 in QR funds will be collected from tenants of quarters during FY 2009. These funds will be used for the operation, management, and general maintenance of quarters, including temporary maintenance personnel services, security guard services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (stoves, water heaters, furnaces, etc.). In certain situations, M&I funds may be used, in conjunction with QR funds, to ensure adequate quarters maintenance; e.g., locations with few quarters where QR funds are not enough to pay for all required maintenance costs.

FUNDING HISTORY

Fiscal Year	**Amount**
2005	$ 6,200,000
2006	$ 6,288,000
2007	$ 6,288,000
2008	$ 6,288,000
2009 Recovery Act	$0
2009 Omnibus	$ 6,288,000

BUDGET REQUEST

The FY 2010 budget request for Quarters is $6,288,000, which is the same as the 2009 Omnibus level. Rental rates are established in accordance with OMB A-45.

OUTCOMES

Program has no outcomes.

OUTPUTS

Program has no outputs.

AWARDS

Program has no awards grants.

FY 2010 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2009 Omnibus	FY 2010 Estimate	FY 08 +/- FY 2009
DIRECT OBLIGATIONS			
Personnel Compensation:			
Full-Time Permanent(11.0)……	402,258	415,473	13,215
Other than Full-Time Permanent(11.3)……	24,329	25,081	752
Other Personnel Comp.(11.5)……	53,041	54,705	1,664
Military Personnel Comp (11.7)……	98,190	98,623	433
Special Personal Services Payments (11.8)……	177	179	2
Subtotal, Personnel Compensation..…	577,995	594,061	16,066
Civilian Personnel Benefits(12.1)……	129,918	134,133	4,215
Military Personnel Benefits (12.2)	45,500	45,705	205
Benefits to Former Personnel(13.0)……	7,148	7,148	0
Subtotal, Pay Costs……	**760,561**	**781,047**	**20,486**
Travel(21.0)……	44,904	47,291	2,387
Transportation of Things(22.0)……	11,935	12,817	882
Rental Payments to GSA(23.1)……	13,133	14,202	1,069
Rental Payments to Others(23.2)……	1,306	1,421	115
Communications, Utilities and Miscellaneous Charges(23.3……	36,172	40,430	4,258
Printing and Reproduction(24.0)……	571	614	43
Other Contractual Services:			
Advisory and Assistance Services(25.1)……	3,362	3,604	242
Other Services(25.2)……	135,208	160,859	25,651
Purchases from Govt. Accts.(25.3)……	70,479	77,946	7,467
Operation and Maintenance of Facilities(25.4)..	7,046	7,474	428
Research and Development Contracts(25.5)…..	0	0	0
Medical Care(25.6)……	324,414	565,172	240,758
Operation and Maintenance of Equipment(25.7)	7,055	7,603	548
Subsistence and Support of Persons(25.8)……	65,941	66,065	124
Subtotal, Other Contractual Current.....….	**613,505**	**888,723**	**275,218**
Supplies and Materials(26.0)……	102,685	111,811	9,126
Equipment (31.0)……	16,500	17,483	983
Land & Structures (32.0)……	8,033	8,045	12
Investments & Loans (33.0)……	0	0	0
Grants, Subsidies, & Contributions (41.0)……	1,971,476	2,110,380	138,904
Insurance Claims & Indemnities (42.0)……	221	236	15
Interest & Dividends (43.0)……	122	125	3
**Subtotal Non-Pay Costs.....…… **	**2,820,563**	**3,253,578**	**433,015**
Total, Direct Obligations……	**3,581,124**	**4,034,625**	**453,501**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
Salaries and Expenses
(Budget Authority - Dollars in Thousands)

Object Class	FY 2009 Omnibus	FY 2010 Estimate	Increase or Decrease
Personnel Compensation:			
Full-Time Permanent (11.0)	402,258	415,473	13,215
Other than Full-Time Permanent (11.3)	24,329	25,081	752
Other Personnel Comp. (11.5)	53,041	54,705	1,664
Military Personnel Comp. (11.7)	98,190	98,623	433
Special Personnel Services Payments (11.8)	177	179	2
Subtotal, Personnel Compensation	577,995	594,061	16,066
Civilian Personnel Benefits (12.1)	129,918	134,133	4,215
Millitary Personnel Benefits (12.2)	45,500	45,705	205
Benefits to Former Personnel (13.0)	7,148	7,148	0
Total, Pay Costs	**760,561**	**781,047**	**20,486**
Travel (21.0)	19,016	20,276	1,260
Transportation of Things (22.0)	11,935	12,817	882
Rental Payments to Others (23.2)	1,306	1,421	115
Communications, Utilities & Misc. Charges (23.3)	36,172	40,430	4,258
Printing and Reproduction (24.0)	571	614	43
Other Contractual Services:			
Advisory and Assistance Services (25.1)	3,362	3,604	242
Other Services (25.2)	135,208	160,859	25,651
Purchases from Govt. Accts. (25.3)	70,479	77,946	7,467
Operation and Maintenance of Facilities (25.4)	7,046	7,474	428
Operation and Maintenance of Equipment (25.7)	7,055	7,603	548
Subsistance and Support of Persons (25.8)	65,941	66,065	124
Subtotal, Other Contractual	289,091	323,551	34,460
Supplies and Materials (26.0)	102,685	111,811	9,126
Total, Non-Pay Costs	**460,776**	**510,920**	**50,144**
Total Salaries & Expenses	1,221,337	1,291,967	70,630
Direct FTE	9,687	9,797	110

INDIAN HEALTH SERVICE
Detail of Full-Time Equivalents (FTE)

	FY 2008 Actual	FY 2009 Estimate	FY 2010 Estimate
Headquarters			
Office of the Director	29	29	29
Office of Tribal Self-Governance	10	10	10
Office of Tribal Programs	9	9	9
Office of Urban Indian Health Programs	2	2	2
Office of Clinical and Preventive Services	87	87	87
Office of Information Technology	6	6	6
Office of Public Health Support	38	38	38
Office of Resource Access and Partnerships	13	13	12
Office of Finance and Accounting	27	27	24
Office of Management Services	108	108	106
Office of Environmental Health and Engineering	75	75	74
Sub-Total, Headquarters	403	403	396
Area Offices			
Aberdeen Area Office	1,849	1,865	1,870
Alaska Area Office	653	659	660
Albuquerque Area Office	1,007	1,015	1,017
Bemidji Area Office	439	442	444
Billings Area Office	868	875	877
California Area Office	91	91	91
Nashville Area Office	190	192	191
Navajo Area Office	4,319	4,355	4,357
Oklahoma City Area Office	1,759	1,777	1,867
Phoenix Area Office	2,479	2,529	2,541
Portland Area Office	544	549	549
Tucson Area Office	389	392	393
Sub-Total, Area Offices	14,586	14,741	14,858
TOTAL FTES	14,989	15,144	15,254

Average GS Grade

2007.....	8.2
2008.....	8.2
2009.....	8.1

INDIAN HEALTH SERVICE
DETAIL OF PERMANENT POSITIONS

	2008 Actual	2009 Estimate	2010 Estimate
ES-5	2	2	2
ES-4	3	3	3
ES-3	4	4	4
ES-2	5	5	5
ES-1	5	5	5
Subtotal	19	19	19
Total - ES Salaries	$3,472,667	$3,619,344	$3,691,731
GS/GM-15	422	422	422
GS/GM-14	377	377	377
GS/GM-13	368	369	370
GS-12	858	860	863
GS-11	1,237	1,240	1,244
GS-10	543	544	546
GS-9	1,223	1,229	1,233
GS-8	277	278	278
GS-7	963	967	970
GS-6	1,193	1,196	1,199
GS-5	2,087	2,093	2,099
GS-4	1,156	1,159	1,162
GS-3	215	216	216
GS-2	47	47	47
GS-1	1	1	1
Subtotal	10,967	10,999	11,028
Total - GS Salaries	$518,019,367	$541,609,205	$553,975,970
Assistant Surgeon General CO-08	4	4	4
Assistant Surgeon General CO-07	5	5	5
Director Grade CO-06	468	468	468
Senior Grade CO-05	577	577	577
Full Grade CO-04	551	551	551
Senior Assistant Grade CO-03	387	387	387
Assistant Grade CO-02	108	108	108
Junior Grade CO-01	18	18	18
Subtotal	2,118	2,118	2,118
Total - CO Salaries	$239,823,221	$249,952,784	$254,951,840
Ungraded	1,256	1,256	1,260
Total - Ungraded Salaries	$24,850,705	$25,900,340	$26,418,347
Average ES level	ES-02		
Average ES salary	$182,772		
Average GS grade	8.1		
Average GS salary	$56,406		

Indian Health Service

Programs Proposed for Elimination or Consolidation

The Indian Health Service has no programs slated for elimination, reduction, or consolidation in FY 2010 budget plan.

INDIAN HEALTH SERVICE
Summary of Reimbursements, Assessments, and Purchases
FY 2007

April 20, 2009

		Object Class								FY 2007	FY 2008	FY 2009	FY 2010
		11.1 & 12.1	21.0	22.0	23.2 & 23.3	24.0	25.3	26.0	31.0	Actual	Estimate	Estimate	Estimate
Type of Funding	**Reimbursement for Services Purchased within HHS**												
SSF	Service & Supply Fund				182,606		38,669,629			38,852,235	22,103,139	31,053,388	30,098,000
SSF	HHS Consolidated Acquisition System (HCAS) Operations and Maintenance						0			0	0	96,000	96,000
SSF	Unified Financial Management System (UFMS) Operations and Maintenance						21,683,071			21,683,071	12,068,000	1,679,000	1,679,000
SSF	UFMS Assessment/Analysis for 12.0 Upgrade						0			0	-	95,000	316,000
JFA & OS TAP	Office of General Counsel	1,291,019	103,944	39		1,680	956,102	2,881	44,890	2,400,556	2,453,368	2,502,436	2,552,484
JFA	HSPD-12 Implementation						345,922			345,922	345,694	331,068	331,068
JFA	HCAS						0			0	1,060,195	1,718,379	0
JFA	HHS Enterprise						1,152,000			1,152,000	1,152,000	893,000	774,000
	Total, Reimbursements	**$1,291,019**	**$103,944**	**$39**	**$182,606**	**$1,680**	**$62,806,725**	**$2,881**	**$44,890**	**$64,433,784**	**$39,182,396**	**$38,368,271**	**$35,846,552**
	Government-wide Administrative Functions												
JFA	Tri-Council (CFOC, CIOC, PEC)						13,867			13,867	35,561	59,774	60,969
JFA	Federal Employment Services						57,581			57,581	86,774	88,770	90,545
JFA	Radio Spectrum						135,000			135,000	135,161	138,270	141,035
JFA	President's Council on Bioethics						18,454			18,454	18,454	17,480	0
	Total, GAF	**$0**	**$0**	**$0**	**$0**	**$0**	**$224,902**	**$0**	**$0**	**$224,902**	**$275,950**	**$304,294**	**$292,549**
	HHS-wide Assessments												
JFA	Quality of Work Life						14,661			14,661	0	0	0
JFA	Safety Management Information						3,006			3,006	0	0	0
JFA	Safety, Health & Environmental Programs						18,326			18,326	0	0	0
JFA	Energy Program Review						17,104			17,104	0	0	0
JFA	IT Access for the Disabled						49,846			49,846	46,426	71,359	71,359
JFA	Media Outreach						2,550			2,550	0	58,694	58,694
JFA	Federal Executive Board-Dallas						30,328			30,328	0	0	0
OS TAP	Audit Resolution						54,000			54,000	57,000	55,000	56,000
OS TAP	Information Technology Service Center *(Under SSF as of FY 09)*						3,310,000			3,310,000	3,346,000	0	0
OS TAP	Web Communications						1,448,000			1,448,000	1,557,000	1,794,000	1,937,000
OS TAP	Small Business Center						176,000			176,000	179,000	178,000	178,000
OS TAP	Tracking Accountability Government Grants System						76,000			76,000	77,000	13,000	16,000
OS TAP	Departmental Contract Information System						184,000			184,000	188,000	192,000	242,000
OS TAP	Acquisition Integration Modernization						254,000			254,000	259,000	259,000	294,000
OS TAP	High Performing Organizations and Competitive Sourcing Reporting						40,000			40,000	40,000	40,000	42,000
OS TAP	Commissioned Corps Force Management						6,507,000			6,507,000	6,477,000	8,373,000	8,541,000
JFA	Regional Health Administrators						582,350			582,350	577,407	577,407	589,190
JFA	Motor Vehicle Management Information System						8,000			8,000	8,000	33,000	175,000
JFA	Secretarial Protective Operations Staff						0			0	0	65,000	66,000
JFA	(Environmental) Compliance and Process Tracking System						0			0	0	11,000	11,000
JFA	Health Services Research Library						530,000			530,000	525,000	545,000	572,000
JFA	Office of Global Health Affairs						13,404			13,404	13,404	13,404	13,404
JFA	Media Monitoring and Analysis						0			0	0	58,694	58,694
	Total, Assessments	**$0**	**$0**	**$0**	**$0**	**$0**	**$13,318,575**	**$0**	**$0**	**$13,318,575**	**$13,350,237**	**$12,337,558**	**$12,921,341**
	Grand Total	**$1,291,019**	**$103,944**	**$39**	**$182,606**	**$1,680**	**$76,350,202**	**$2,881**	**$44,890**	**$77,977,261**	**$52,808,583**	**$51,010,123**	**$49,060,442**

Object Class Description:
11.1 & 12.1 – Salaries & Benefits
21.0 -- Travel
22.0 -- Transportation of Things
23.2. & 23.3– Rental Payments, Communications, Utilities
24.0 -- Printing & Reproduction
25.3 -- Purchases of goods and servics from Gov't Accounts
26.0 -- Supplies & Materials
31.0 -- Equipment

FY 2010 HHS Enterprise Information Technology Fund e-Gov Initiatives

The **IHS** will contribute **$761,899** of its **FY 2010** budget to support Department enterprise information technology initiatives as well as E-Government initiatives. Operating Division contributions are combined to create an Enterprise Information Technology (EIT) Fund that finances both the specific HHS information technology initiatives identified through the HHS Information Technology Capital Planning and Investment Control process and E-Government initiatives. These HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, **$147,619.23** is allocated to support the E-Government initiatives for **FY 2010**. This amount supports E-Government initiatives as follows:

FY 2010 HHS Contributions to E-Gov Initiatives*	IHS
Line of Business - Federal Health Architecture (FHA)	$73,691.04
Line of Business - Human Resources	$32,014.65
Line of Business - Grants Management	$1,100.18
Line of Business - Financial	$3,175.71
Line of Business - Budget Formulation and Execution	$2,111.85
Line of Business - IT Infrastructure	$3,556.80
Disaster Assistance Improvement Plan	$31,969.00
E-Gov Initiatives Total	**$147,619.23**

*The total for all HHS FY 2010 inter-agency E-Government and Line of Business contributions for the initiatives identified above, and any new development items, is not currently projected by the Federal CIO Council to increase above the FY 2009 aggregate level. Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

Lines of Business-Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology (HIT) Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs.

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital. HHS has been selected as a Center of Excellence and will be leveraging its HR investments to provide services to other Federal agencies.

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. An HHS agency, Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally, NIH is an internally HHS-designated Center of Excellence and has applied to be a GMLOB consortia lead. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Lines of Business-IT Infrastructure: This initiative provides the potential to leverage spending on commodity IT infrastructure to gain savings; to promote and use common, interoperable architectures that enable data sharing and data standardization; secure data interchanges; and, to grow a Federal workforce with interchangeable skills and tool sets.

Disaster Assistance Improvement Plan (DAIP): The DAIP, managed by Department of Homeland Security, assists agencies with active disaster assistance programs such as HHS to reduce the burden on other federal agencies which routinely provide logistical help and other critical management or organizational support during disasters.

Department of Health & Human Services
Indian Health Service
Number of Service Units and Facilities
Operated by IHS and Tribes, October 1, 2008

Apr 16, 2009

Type of Facility	TOTAL	IHS Total	TRIBAL Total	Title I [a]	Title V [b]	Other [c]
Service Units	**161**	61	100			
Hospitals	**45**	31	14	2	12	0
Ambulatory	**601**	93	508	193	306	9
Health Centers	288	61	227	112	113	2
School Health Centers	15	2	13	11	2	0
Health Stations	132	30	102	62	40	0
Alaska Village Clinics	166	0	166	8	151	7

[a] Operated under P.L. 93-638, Self Determination Contracts

[b] Operated under P.L. 106-260, Tribal Self-Governance Amendment of 2000

[c] Operated by a local government, not a tribe, for some Alaska Native villages through a standard procurement contract

[d] Classified "IHS" if any Federally owned and operated facility present in Service Unit. Classified "Tribal" if a funding agreement exists (Title I, Title V, Other, or any combination of these) to fund the facility's operations and it is principally controlled by a Tribal government or designated entity through operation and ownership.

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2007 Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**34,849**	**20,588**	**55,437**
Aberdeen	4,889		4,889
Alaska		12,286	12,286
Albuquerque	1,753		1,753
Bemidji	483		483
Billings	2,327		2,327
California			*
Nashville		1,274	1,274
Navajo	13,276	3,209	16,485
Oklahoma	5,279	3,209	8,488
Phoenix	6,151	610	6,761
Portland			*
Tucson	691		691

* No inpatient facilities in FY 2007

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	**4,549,675**	**6,162,250**	**10,711,925**
Aberdeen	716,803	86,965	803,768
Alaska	**	1,496,506	1,496,506
Albuquerque	421,657	73,622	495,279
Bemidji	253,838	768,442	1,022,280
Billings	488,990	155,903	644,893
California	**	480,182	480,182
Nashville	8,578	534,505	543,083
Navajo	1,010,104	258,116	1,268,220
Oklahoma	641,540	1,445,810	2,087,350
Phoenix	666,638	313,487	980,125
Portland	236,161	499,864	736,025
Tucson	105,366	48,848	154,214

** No IHS facilities in FY 2007

INDIAN HEALTH SERVICE
Immunization Expenditures 1/

	FY 2008 Estimate	FY 2009 Estimate	FY 2010 Estimate	Increase or Decrease
Infants and Children	$12,068,910	$12,575,804	$13,103,988	+$528,184
Adults	$1,671,086	$1,741,272	$1,814,405	+$73,133
HPV vaccine (Non-add)	$8,857,800	$8,857,800	$9,229,828	+$372,028
Monitoring		$100,000	$104,200	+$4,200
Total:	$13,739,996	$14,417,076	$15,022,593	+$605,517

1/The immunization estimates do not include the Hepatitis B and Haemophilus Immunization program (Alaska) budget line item

The Indian Health Service (IHS) patient care data system does not calculate itemized costs for the treatment of various conditions. Therefore, an indirect method was used for calculating immunization costs based on an estimated patient population and the amount of staff time for required immunizations, as well as the immunization costs not available through the Vaccines for Children program.

Immunization costs were categorized by two target populations; infants and children (3 to 27 months of age) and adults (≥65 years of age).

By combining these two groups, an estimate of $10,540,043 was calculated for the IHS immunization expenditures in FY 2004 with inflation costs added into the equation:

FY 2005 Estimated Costs = FY 2004 cost times 3.7 percent
FY 2006 Estimated Costs = FY 2005 cost times 3.3 percent
FY 2007 Estimated Costs = FY 2006 cost times 4.0 percent
FY 2008 Estimated Costs = FY 2007 cost times 4.2 percent
FY 2009 Estimated Costs = FY 2008 cost times 4.2 percent
FY 2010 Estimated Costs = FY 2009 cost times 4.2 percent

For FY 2008, **$8,857,800** was added for adult vaccine for Human Papilloma Virus (HPV) for females 19 – 26 years costs. The total cost does not include inflation, which may affect future estimated costs. The methodology was calculated based on the following assumptions:

1. 20 percent coverage of the 19 – 26 year old female user population (~23,855)
2. Cost of a 3 dose series of the vaccine at $360.00

Overall, the estimated costs for these immunizations are affected by:

1. Individuals outside these target groups are regular recipients of immunizations (e.g., HBg and influenza immunization for health care workers and those at specific risk for other vaccine-preventable diseases), however, there is not a methodology to estimate the size of these groups

2. There is not a methodology to estimate indirect costs or administrative overhead associated with the administration of immunizations, or operation of the immunization program

DEPARTMENT OF HEALTH AND HUMAN SERVICE
Indian Health Service
Drug Control Budget
FY 2010

	Budget Authority (in Millions)		
	2008 Final	**2009 Omnibus**	**2010 Request**
Drug Resources by Function			
Prevention	16.067	17.827	18.859
Treatment	71.422	75.761	79.950
Total Drug Resources by Function	**$87.489**	**$93.588**	**$98.809**
Drug Resources by Decision Unit			
Alcohol and Substance Abuse	84.082	90.181	95.402
Urban Indian Health Program	3.407	3.407	3.407
Total Drug Resources by Decision Unit	**$87.489**	**$93.588**	**$98.809**

Drug Resources Personnel Summary			
Total FTEs (direct only)	160	169	171
Drug Resources as a Percent of Budget			
Agency Budget	$ 4,297.047	$ 4,535.928	$ 4,989.429
Drug Resources Percentage	2.04%	2.06%	1.98%

Indian Health Service
Indian Self Determination

Indian Health Service Philosophy -- The Indian Health Service (IHS) has implemented the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, as amended, in the spirit by which the Congress recognized the special legal relationship and the obligation of the United States to American Indian and Alaska Native peoples. In keeping with the concept of tribal sovereignty, IHS policy implements the ISDEAA and maximizes opportunities for tribes to exercise their right to manage and operate IHS health programs, or portions thereof, under Title I and Title V, as well as those tribes who choose their health services to be provided directly by the IHS. The IHS recognizes that tribal decisions to contract/compact or not to contract/compact are equal expressions of self-determination.

Title I Contracts and Title V Self-Governance Compacts -- The IHS contracts/compacts with tribes and tribal organizations (T/TO) pursuant to the authority provided under Title I and Title V of the ISDEAA, as amended. This Act allows T/TO to enter into contracts/compacts with the Government to plan, conduct, and administer programs that are authorized under Section 102 of the Act. The IHS has been contracting with T/TO pursuant to the authority of P.L. 93-638 since its passage in 1975. Today, the IHS currently administers self-determination contracts under Title I and compacts authorized under Title V valued at more than $1.8 billion. The IHS currently administers contracts and Annual Funding Agreements (AFA) with 236 tribes or tribal organizations pursuant to Title I of the ISDEAA. The IHS currently administers compacts and Funding Agreements authorized under Title V of the ISEAA who meet certain criteria. To date, 75 Title V compacts and 96 Funding Agreements have been negotiated with 328 Tribes.

IHS and Tribally-Operated Service Unit and Medical Facilities -- The total dollars administered under ISDEAA contracts and compacts have nearly doubled in recent years and the scope of services managed and provided by tribal programs has also expanded greatly. Tribes have historically assumed control of community services first and then expanded into medical care. For example, the Community Health Representatives program and community-based components of the alcohol programs have been almost 100 percent tribally operated. The number of Tribally operated hospitals has now started to rise, and over 20 percent of the hospitals funded by IHS are managed by tribes. This trend is expanding their scope and is also reflected in the increasing number of ambulatory medical facilities now managed by tribes.

Self-Determination Implementation: Contract Support Cost Funding -- Because the rate of T/TO entering into self-determination contracts and compacts has been steadily increasing, the demand for contract support cost (CSC) funding to support T/TO in their contracting/compacting has also increased. The CSC funding is authorized pursuant to Section 106(a)(2) of the ISDEAA. This funding has been used by T/TO to develop strong, stable tribal governments capacity to professionally manage their contracts/ compacts and the corresponding services to their communities. Additionally, through the

funding of CSC, the IHS has helped in the development of T/TO who are maturing and now achieving greater levels of self-sufficiency in health care operations and administration.

The primary growth in CSC since 2003 can be attributed to the need to maintain the current level of services as annual program increases are included in ongoing contracts and compacts. Additional increased needs for CSC is attributed to the increased contracting and compacting of new or expanded programs, services, functions, or activities by T/TO under both Title I and V of the ISDEAA. The Agency has taken steps to ensure that funding provided is allowable, allocable, reasonable, and necessary and has recently adopted standards for the review and approval of CSC. This has proven beneficial in maintaining consistency in the determination of tribal CSC requirements. The T/TO support an appropriate share of administrative streamlining. The IHS has provided administrative shares of its budget to T/TO associated with their contracting and compacting activities since 1995.

Indian Health Service
Self Governance Funded Compacts FY 2008

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Alabama	**$3,748,000**	**$233,000**	**$119,000**	**$631,000**	**$4,731,000**
Poarch Band of Creek Indians	$3,748,000	$233,000	$119,000	$631,000	$4,731,000
Alaska	**$369,552,000**	**$29,416,000**	**$21,360,000**	**$63,659,000**	**$483,987,000**
Alaska Native Tribal Health Consortium	$102,614,000	$19,123,000	$3,502,000	$5,153,000	$130,392,000
Aleutian/Pribilof Islands Association, Inc.	$3,095,000	$741,000	$259,000	$516,000	$4,611,000
Arctic Slope Native Association	$7,550,000	$70,000	$932,000	$2,337,000	$10,889,000
Bristol Bay Area Health Corporation	$20,489,000	$901,000	$1,646,000	$5,393,000	$28,429,000
Chugachmiut	$3,863,000	$103,000	$209,000	$1,120,000	$5,295,000
Copper River Native Association	$1,980,000	$32,000	$159,000	$482,000	$2,653,000
Council of Athabascan Tribal Government	$1,767,000	$18,000	$62,000	$830,000	$2,677,000
Eastern Aleutian Tribes, Inc.	$2,931,000	$36,000	$140,000	$764,000	$3,871,000
Kenalitze Indian Tribe	$1,669,000	$14,000	$132,000	$315,000	$2,130,000
Ketchikan Indian Corporation	$4,805,000	$132,000	$752,000	$1,599,000	$7,288,000
Kodiak Area Native Association	$6,172,000	$88,000	$331,000	$1,122,000	$7,713,000
Maniilaq Association	$25,604,000	$972,000	$2,087,000	$7,555,000	$36,218,000
Metlakatla Indian Community	$5,670,000	$896,000	$373,000	$591,000	$7,530,000
Mount Sanford Tribal Consortium	$705,000	$2,000	$47,000	$172,000	$926,000
Native Village of Eklutna	$165,000	$1,000	$4,000	$19,000	$189,000
Norton Sound Health Corporation	$19,396,000	$779,000	$1,472,000	$3,978,000	$25,625,000
Seldovia Village Tribe	$965,000	$33,000	$29,000	$265,000	$1,292,000
Southcentral Foundation	$55,270,000	$1,263,000	$2,868,000	$11,216,000	$70,617,000
Southeast Alaska Regional Health Corporation	$34,239,000	$1,414,000	$2,371,000	$5,615,000	$43,639,000
Tanana Chiefs Conference	$28,295,000	$682,000	$1,300,000	$3,367,000	$33,644,000
Yakutat Tlingit Tribe	$294,000	$8,000	$23,000	$71,000	$396,000
Yukon-Kuskokwim Health Corporation	$42,014,000	$2,108,000	$2,662,000	$11,179,000	$57,963,000
Arizona	**$21,990,000**	**$3,397,000**	**$1,243,000**	**$3,018,000**	**$29,648,000**
Gila River Indian Community	$21,990,000	$3,397,000	$1,243,000	$3,018,000	$29,648,000
California	**$42,395,000**	**$1,875,000**	**$1,818,000**	**$10,621,000**	**$56,709,000**
Consolidated Tribal Health Project, Inc.	$3,274,000	$259,000	$79,000	$879,000	$4,491,000
Hoopa Valley Tribe	$4,483,000	$237,000	$192,000	$934,000	$5,846,000
Indian Health Council, Inc.	$6,864,000	$476,000	$217,000	$1,541,000	$9,098,000
Karuk Tribe of California	$2,472,000	$163,000	$70,000	$1,015,000	$3,720,000
Northern Valley Indian Health, Inc.	$2,001,000	$160,000	$53,000	$533,000	$2,747,000
Redding Rancheria	$5,481,000	$96,000	$432,000	$1,611,000	$7,620,000
Riverside-San Bernardino County Indian Health, I	$16,404,000	$385,000	$654,000	$3,749,000	$21,192,000
Susanville Indian Rancheria	$1,416,000	$99,000	$121,000	$359,000	$1,995,000
Connecticut	**$2,058,000**	**$26,000**	**$0**	**$31,000**	**$2,115,000**
Mohegan Tribe of Indians of Connecticut	$2,058,000	$26,000	$0	$31,000	$2,115,000
Florida	**$6,687,000**	**$397,000**	**$201,000**	**$1,101,000**	**$8,386,000**
Seminole Tribe of Florida	$6,687,000	$397,000	$201,000	$1,101,000	$8,386,000
Kansas	**$2,067,000**	**$100,000**	**$5,000**	**$233,000**	**$2,405,000**
Prairie Band of Potawatomi Nation	$2,067,000	$100,000	$5,000	$233,000	$2,405,000
Idaho	**$12,598,000**	**$836,000**	**$870,000**	**$1,632,000**	**$15,936,000**
Coeur D'Alene Tribe	$4,796,000	$280,000	$504,000	$881,000	$6,461,000
Kootenai Tribe of Idaho	$532,000	$22,000	$54,000	$58,000	$666,000
Nez Perce Tribe	$7,270,000	$534,000	$312,000	$693,000	$8,809,000
Louisana	**$1,045,000**	**$123,000**	**$83,000**	**$119,000**	**$1,370,000**
Chitimacha Tribe of Louisana	$1,045,000	$123,000	$83,000	$119,000	$1,370,000
Maine	**$2,828,000**	**$188,000**	**$128,000**	**$520,000**	**$3,664,000**
Penobscot Indian Nation	$2,828,000	$188,000	$128,000	$520,000	$3,664,000
Massachusetts	**$607,000**	**$47,000**	**$163,000**	**$218,000**	**$1,035,000**
Wampanoag Tribe of Gay Head	$607,000	$47,000	$163,000	$218,000	$1,035,000
Michigan	**$17,718,000**	**$1,105,000**	**$768,000**	**$1,627,000**	**$21,218,000**
Grand Traverse Band of Ottawa and Chippewa Ind	$2,455,000	$218,000	$50,000	$418,000	$3,141,000
Keweenaw Bay Indian Community	$2,696,000	$240,000	$92,000	$381,000	$3,409,000
Sault Ste. Marie Tribe of Chippewa Indians	$12,567,000	$647,000	$626,000	$828,000	$14,668,000
Minnesota	**$14,071,000**	**$960,000**	**$407,000**	**$1,021,000**	**$16,459,000**
Bois Forte Band of Chippewa Indians	$2,195,000	$159,000	$58,000	$299,000	$2,711,000
Fond du Lac Band of Lake Superior Chippewa	$7,397,000	$422,000	$276,000	$429,000	$8,524,000
Mille Lacs Band of Ojibwe	$3,435,000	$336,000	$60,000	$221,000	$4,052,000
Shakopee Mdewakanton Sioux Community	$1,044,000	$43,000	$13,000	$72,000	$1,172,000
Mississippi	**$14,336,000**	**$1,002,000**	**$945,000**	**$1,764,000**	**$18,047,000**
Mississippi Band of Choctaw Indians	$14,336,000	$1,002,000	$945,000	$1,764,000	$18,047,000
Montana	**$17,447,000**	**$1,325,000**	**$1,559,000**	**$3,001,000**	**$23,332,000**
Chippewa Cree Tribe of the Rocky Boy's Reservat	$8,777,000	$713,000	$875,000	$1,776,000	$12,141,000
Confederated Salish and Kootenai Tribes of Flathe	$8,670,000	$612,000	$684,000	$1,225,000	$11,191,000

Nevada	**$17,474,000**	**$1,023,000**	**$1,130,000**	**$2,981,000**	**$22,608,000**
Duck Valley Shoshone-Paiute Tribe	$6,371,000	$536,000	$580,000	$1,386,000	$8,873,000
Duckwater Shoshone Tribe	$994,000	$63,000	$148,000	$556,000	$1,761,000
Ely Shoshone Tribe	$1,139,000	$34,000	$46,000	$260,000	$1,479,000
Las Vegas Paiute Tribe	$3,051,000	$116,000	$100,000	$251,000	$3,518,000
Washoe Tribe of Nevada and California	$4,226,000	$188,000	$179,000	$259,000	$4,852,000
Yerington Paiute Tribe of Nevada	$1,693,000	$86,000	$77,000	$269,000	$2,125,000
New York	**$6,496,000**	**$308,000**	**$184,000**	**$466,000**	**$7,454,000**
St. Regis Mohawk Tribe	$6,496,000	$308,000	$184,000	$466,000	$7,454,000
North Carolina	**$17,863,000**	**$1,437,000**	**$787,000**	**$2,886,000**	**$22,973,000**
Eastern Band of Cherokee Indians	$17,863,000	$1,437,000	$787,000	$2,886,000	$22,973,000
Oklahoma	**$225,785,000**	**$13,318,000**	**$8,270,000**	**$23,324,000**	**$270,697,000**
Absentee Shawnee Tribe of Oklahoma	$6,199,000	$292,000	$611,000	$546,000	$7,648,000
Cherokee Nation	$63,888,000	$3,052,000	$1,246,000	$4,475,000	$72,661,000
Chickasaw Nation	$39,254,000	$2,222,000	$1,672,000	$6,043,000	$49,191,000
Choctaw Nation of Oklahoma	$49,816,000	$4,615,000	$2,526,000	$5,141,000	$62,098,000
Citizen Potawatomi Nation	$8,887,000	$1,048,000	$610,000	$1,368,000	$11,913,000
Kaw Nation	$1,022,000	$71,000	$152,000	$191,000	$1,436,000
Kickapoo Tribe of Oklahoma	$5,339,000	$72,000	$113,000	$849,000	$6,373,000
Modoc Tribe of Oklahoma	$47,000	$89,000	$4,000	$16,000	$156,000
Muscogee (Creek) Nation	$35,253,000	$1,643,000	$979,000	$2,895,000	$40,770,000
Northeastern Tribal Health System	$5,930,000	$56,000	$112,000	$749,000	$6,847,000
Ponca Tribe of Oklahoma	$3,114,000	$54,000	$122,000	$388,000	$3,678,000
Sac and Fox Nation	$5,572,000	$61,000	$94,000	$415,000	$6,142,000
Wyandotte Nation	$1,464,000	$43,000	$29,000	$248,000	$1,784,000
Oregon	**$19,975,000**	**$1,048,000**	**$1,817,000**	**$6,040,000**	**$28,880,000**
Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians of Oregon	$1,504,000	$66,000	$165,000	$371,000	$2,106,000
Confederated Tribes of Grand Ronde	$5,051,000	$240,000	$395,000	$2,363,000	$8,049,000
Coquille Indian Tribe	$1,622,000	$75,000	$173,000	$702,000	$2,572,000
Confederated Tribes of Siletz Indians of Oregon	$6,219,000	$184,000	$545,000	$1,243,000	$8,191,000
Confederated Tribes of the Umatilla Reservation	$5,579,000	$483,000	$539,000	$1,361,000	$7,962,000
Washington	**$39,760,000**	**$2,988,000**	**$2,061,000**	**$8,872,000**	**$53,681,000**
Jamestown S'Klallam Indian Tribe	$825,000	$59,000	$66,000	$265,000	$1,215,000
Kalispel Tribe of Indians	$792,000	$121,000	$18,000	$59,000	$990,000
Lower Elwha Klallam Tribe	$1,561,000	$95,000	$73,000	$291,000	$2,020,000
Lummi Indian Nation	$6,811,000	$587,000	$188,000	$1,395,000	$8,981,000
Makah Indian Tribe	$3,229,000	$323,000	$265,000	$310,000	$4,127,000
Muckleshoot Indian Tribe	$4,461,000	$202,000	$150,000	$0	$4,813,000
Nisqually Indian Tribe	$1,774,000	$91,000	$88,000	$491,000	$2,444,000
Port Gamble S'Klallam Tribe	$1,783,000	$177,000	$104,000	$453,000	$2,517,000
Quinault Indian Nation	$4,534,000	$401,000	$165,000	$1,709,000	$6,809,000
Shoalwater Bay Indian Tribe	$1,652,000	$79,000	$212,000	$633,000	$2,576,000
Skokomish Indian Tribe	$1,756,000	$84,000	$87,000	$347,000	$2,274,000
Squaxin Island Indian Tribe	$2,374,000	$173,000	$148,000	$898,000	$3,593,000
Suquamish Tribe	$1,319,000	$48,000	$113,000	$492,000	$1,972,000
Swinomish Indian Tribal Community	$2,188,000	$130,000	$133,000	$645,000	$3,096,000
Tulalip Tribes of Washington	$4,701,000	$418,000	$251,000	$884,000	$6,254,000
Wisconsin	**$12,984,000**	**$781,000**	**$266,000**	**$713,000**	**$14,744,000**
Forest County Potawatomi Community	$1,503,000	$147,000	$20,000	$72,000	$1,742,000
Oneida Tribe of Indians of Wisconsin	$11,481,000	$634,000	$246,000	$641,000	$13,002,000
Grand Total	**$869,484,000**	**$61,933,000**	**$44,184,000**	**$134,478,000**	**$1,110,079,000**

Indian Health Service
FY 2008 Self-Governance Funding Agreements
By Area

AREA	Tribal User Pop	Program Tribal Shares	Area Tribal Shares	Headqtrs Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	TOTAL
Alaska	117,492	373,733,000	12,337,000	12,899,000	21,359,000	63,659,000	483,987,000
Aberdeen	0	152,000	128,000	0	0	0	280,000
Bemidji	27,506	41,050,000	4,533,000	1,756,000	1,441,000	3,361,000	52,141,000
Billings	15,096	15,708,000	1,909,000	1,155,000	1,559,000	3,001,000	23,332,000
California	26,617	41,164,098	3,104,000	1,902	1,818,000	10,621,000	56,709,000
Nashville	38,310	51,839,000	5,602,000	1,988,000	2,611,000	7,736,000	69,776,000
Oklahoma	237,023	228,088,000	3,316,000	9,866,000	8,275,000	23,557,000	273,102,000
Phoenix	21,120	40,774,000	1,597,000	1,512,000	2,373,000	5,999,000	52,255,000
Portland	40,383	68,666,000	5,391,000	3,148,000	4,748,000	16,544,000	98,497,000
Total, IHS	523,547	861,174,098	37,917,000	32,325,902	44,184,000	134,478,000	1,110,079,000

Indian Health Service
Self-Governance
Fund Status Report --- FY 2008 Expenditure

30-Sep-08

	Date	Vendor/Description	Obligation	Adjustment	Balance
1	10/1/05	Beginning Balance			$5,763,403
2	10/1/06	Congressional Increases/Decreases		184,000	5,947,403
3	10/1/06	Adjustment needed to match FY 08 PresBdgt		(19,403)	5,928,000
4	1/1/07	Less Recission @ 1.56%		(92,477)	5,835,523
5	Recurring	OTSG Office expenses, salary, travel, etc.	1,185,404		4,650,119
6	10/1/05	Salish&Kootenai FA Neg 1995 User Pop	13,221		4,636,898
7	3/23/06	Choctaw 1995 Base Budget	21,058		4,615,840
8	10/3/06	Jamestown S'Klallam 1997 HQ TSA adj.	1,584		4,614,256
9	10/1/06	Mississipp Choctaw 1997 HQ TSA adj.	7,688		4,606,568
10	10/1/06	Penobscot 1997 HQ TSA adj	12,680		4,593,888
11	1/11/08	TSGAC (Lummi) trvl/logistics/meetings	95,000		4,498,888
12	1/11/08	PAO - Jamestown Tech wkgp logistics	70,000		4,428,888
13	1/23/08	SGCE cont. agmt Lummi Tribe passthru	150,000		4,278,888
14	1/23/08	SGCE reimb/travel Lummi Tribe passthru	22,752		4,256,136
15	12/21/05	GPRA Pilot Proj ANTHC	249,000		4,007,136
16	12/21/05	GPRA Pilot Proj USET	249,000		3,758,136
17	12/21/05	GPRA Pilot Proj Rocky Boy	42,000		3,716,136
18	12/21/05	GPRA Pilot Proj Kaw	42,000		3,674,136
19	12/21/05	GPRA Pilot Proj Mississippi Choctaw	42,000		3,632,136
20	2/22/08	SG Report Card	75,000		3,557,136
21	2/22/08	Educ. Brochure on SG	150,000		3,407,136
22	3/7/08	Cash Award to CA/D.Heffington per MLS	3,500		3,403,636
23	3/28/08	OKA Sal/Ben costs PKW 2nd yr agrmnt	166,000		3,237,636
24	4/23/07	Forest County Pilot Project	72,000		3,165,636
25	6/1/08	Ambulances	500,000		2,665,636
26	6/18/08	Transfer to Office Budget	100,000		2,565,636
27	7/23/08	OCAO for TS for Cherokee	800,000		1,765,636
28	7/23/08	SGCE reimb/travel Lummi passthru 08 add'l	28,219		1,737,417
29	8/15/08	Chickaloon Native Village -AK Plng Award	50,000		1,687,417
30	8/15/08	Knik Tribal Council -AK Neg Award	20,000		1,667,417
31	8/11/08	AK for ANTHC -trvl asst. w/GRPA Pilots	12,000		1,655,417
32	9/12/08	OK asst. w/SeverenceCosts-Cherokee Hastin	400,000		1,255,417
33	9/15/08	Reimb PHX area R.Tahsuda trvl - Albq - Taos	1,194		1,254,223
34	9/18/08	Reimb PHX area R.Tahsuda trvl - Albq - Taos	749		1,253,474
35	9/23/08	ANTHC/USET Coll.Init. w/GRPA projects	60,000		1,193,474
36	9/23/08	GPRA Pilot Proj ANTHC FY 09	249,000		944,474
37	9/23/08	GPRA Pilot Proj USET FY 09	249,000		695,474
38	9/30/08	Funds for Plng/Neg Awards trnfrd twice	70,000		625,474
39		To HQ	625,474		0
40					0

SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2010 CONGRESSIONAL JUSTIFICATION
ARRA and H.R. 1105 (March 2009)

American Recovery and Reinvestment Act (P.L. 111-5)

Item

Health Care Facilities Construction - The Indian Health Service is directed to use the funding provided for health care facilities construction to complete ongoing high priority facilities construction projects. For an additional amount for ''Indian Health Facilities'', for facilities construction projects, deferred maintenance and improvement projects, the backlog of sanitation projects and the purchase of equipment, $415,000,000, of which $227,000,000 is provided within the health facilities construction activity for the completion of up to two facilities from the current priority list for which work has already been initiated (page 57).

Action taken or to be taken

The ARRA funds will be used to complete construction of two health care facilities; for the facility in Nome, Alaska and one other not yet determined.

The Omnibus Appropriations Act (P.L. 111-8)

Item

Dental Services - The Service, and particularly the Director of Oral Health, is strongly encouraged to redouble its efforts to address the alarmingly high vacancy rates among health professionals, for example 31 percent among dental professionals, in the Indian Health Service. Therefore, an increase of $8,299,000 over the fiscal year 2008 enacted level has been provided for Dental Services in order to maintain current levels of care and provide for the staffing of new facilities (page 53).

Action taken or to be taken

The IHS Division of Oral Health (DOH) has been able to implement a number of recruitment incentives for oral health providers and as a result, the vacancy rate for oral health providers has dropped by 40% since August 2008 and the DOH continues to receive strong interest from dental students and oral health providers in current and projected vacancies.

Item

Fetal Alcohol Spectrum Disorders and Alcohol Screening - In addition, the Service is encouraged to participate in the Fetal Alcohol Spectrum Disorders and Alcohol Screening. Intervention and Referral Initiative (page 53).

Action taken or to be taken

The Division of Behavioral Health (DBH) currently funds the Fetal Alcohol Spectrum Disorders (FASD) Training Project which focuses on the needs of the IHS for continued research and training in the prevention of FASD. The FASD Training Project, which is

implemented through the University of Washington, in collaboration with the Northwest Portland Area Indian Health Board (NPAIHB), provides technical assistance and training to American Indian and Alaska Natives (AI/AN) Tribal FASD programs in their efforts to develop and implement more effective FASD prevention, intervention and treatment programs. The NPAIHB disseminates up-to-date FASD information to AI/AN communities and service providers who specialize in FASD issues. The NPAIHB also works to develop public awareness materials on FASD.

Item

Hospitals and Clinics Program - Within the resources available to the Hospitals and Clinics program the Service is encouraged to provide such assistance as may be necessary for the newly formed Nevada Indian Health Board to fully establish its operations (page 53).

Action taken or to be taken

IHS will provide requisite support to facilitate the Nevada Indian Health Board's understanding and compliance as a Tribal entity eligible for Federal grants funding in accordance with 25 USC 1603(e). 25 USC 1603(e) defines Tribal organizations as the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

Item

Health Professions - Within the amount provided for Indian Health Professions it is expected that the Service will fund the Indians Into Medicine (INMED), Recruitment/Retention of American Indians into Nursing (RAIN) and Indians into Psychology (INPSYCH) programs at no less than the current levels and manage them in the same manner as in prior years. The Service is also expected to use health professions program funding for loan repayment and scholarship programs to encourage increased recruitment and retention of health professionals (page 53).

Action taken or to be taken

The IHS uses health professions funding (in addition to Hospitals and Clinics funding) to recruitment and retention of health professionals. Providing marketing and outreach to students and recent graduates not only provides them information about the scholarship and loan repayment programs, but lets students know about job opportunities available after they complete their schooling/training.

Item

Indian Health Care Improvement Fund - The Indian Health Service is directed to use the Indian health Care Improvement Fund to bring the units with the highest level of need up to at least 40 percent before allocating funds to units with needs above 40 percent (page 53).

Action taken or to be taken

The purpose of the IHCIF is: (1) eliminating the deficiencies in health status and resources of all Indian tribes, (2) eliminating backlogs in the provision of health care services to Indians, and (3) meeting the health needs of Indians in an efficient and equitable manner. Funds are allocated in proportion to funding deficiency scores measured by the Federal Disparity Index – an index of comparability with the Federal Employees Health Plan. The FY 2008 and 2009 appropriations for the IHCIF raised all scores to at least 40 percent. The FY 2010 President's Budget recommends a significant increase of 13 percent over the FY 2009 Omnibus level to strengthen the Indian health system and improve the health of American Indians and Alaska Natives. The IHS plans to review the methodology, gather the latest data, and produce up-to-date deficiency scores by 2nd quarter, FY 2010.

Item

Health Professionals - The high vacancy rate of health professionals in the Indian Health Service has not been substantially alleviated by current recruitment and retention efforts. To the extent possible, the Service is encouraged to use the construction and improvement of staffing quarters as a vital tool to recruit and retain these health professionals (page 54).

Action taken or to be taken

The IHS uses a multifaceted recruitment and marketing effort to attract and retain health professionals. To the extent possible, in FY 2010, IHS will inform students and health professionals about new facilities, new housing and renovations to existing facilities and housing, using these updates as one of our marketing points.

Additionally, some funding for information technology will be utilized to improve recruitment development or upgrading websites and other applications necessary for recruitment of healthcare professionals including:

- Designing content for the specific audience
- Standardization of content requirements/appearance (e.g., having HIS Area Offices present similar topics/layout)
- Using new web technologies – Facebook/YouTube/MySpace etc.

Item

Funding for Facility Equipment and Construction - No resources have been provided for the joint venture and small ambulatory grants programs because all qualified projects on the existing list have been completed. These programs have broad support, and the Service is directed to initiate new solicitations for both in this fiscal year. As in the past, the Service is encouraged to provide additional credit to tribes that are willing to provide full funding for facility equipment in addition to providing full funding for facility construction when determining priorities for project funding under the joint ventures program for· hospitals and clinics (page 54).

Action taken or to be taken
The Indian Health Service will solicit for the Joint Venture Construction Program. The solicitation will indicate to the tribes that additional credit will be given to those applications that will fully fund equipment costs as well with design and construction costs and also if they are planning to construct a hospital or a health center.

The Small Ambulatory Program is in the process of establishing a new priority list. Both the Joint Venture Construction Program and the Small Ambulatory Program solicitations will be initiated this year.

Item
Mobile Dental Units – Within the overall amount provided for construction, the House and Senate Committees on Appropriations recommend $500,000 for new mobile dental units. There is a concern, however, that high dental vacancy rates have left newly constructed units unstaffed. The Service should attempt in the distribution of these funds to ensure that staffing will be available for new units and that construction can be initiated in an expeditious manner once funds are committed (page 54).

Action taken or to be taken
The IHS Division of Oral Health (DOH) has been able to implement a number of recruitment incentives for oral health providers and as a result, the vacancy rate for oral health providers has dropped by 40% since August 2008 and the DOH continues to receive strong interest from dental students and oral health providers in current and projected vacancies. In is anticipated that the DOH will be able to fill a majority of the currently vacant positions for oral health providers, which will address the concern expressed over staffing of mobile dental units. However in FY 2009, IHS is not funding additional dental units and in the future prior to allocating funds for acquisition of dental units under the Dental Unit program, the Indian Health Service will obtain assurance from applicants that staffing is available to provide services and that the acquisition of the dental unit will be accomplished in a timely manner.