DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

JAN 3 0 2007

This presentation of the Indian Health Service (IHS) fiscal year (FY) 2008 Congressional Justification represents our third fully integrated performance budget which supports the President's Management Agenda (PMA) and priorities, the Department's FY 2004-2009 Strategic Plan, and the Secretary's 500-Day Plan. Consistent with the Government Performance and Results Act of 1993 (GPRA), this justification includes the FY 2008 Annual Performance Plan and the FY 2006 Annual Performance report and is organized to provide an integrated presentation of our funding request and program performance.

Performance measurement and reporting continues as a mainstay of ongoing IHS performance management. Quarterly performance reporting is utilized to enhance efficient and effective coordination of IHS programs to further integrate a performance management culture across the Indian health care system. The Agency performance process is coordinated through our Performance Achievement Team, a group of key program and support function leaders who monitor agency performance and facilitate linkages between budget and program performance.

For FY 2008, the IHS provides a comprehensive set of 34 measures that represent health-care-related outcomes. This objective results-oriented information provides the IHS and our stakeholders with information to assess ongoing progress towards the Department's Strategic Plan and the 2006-2011 IHS Strategic Plan:

HHS Strategic Objectives:

- 3.4 Eliminate racial and ethnic health disparities.
- 3.6 Increase access to health services for American Indians and Alaska Natives (AI/AN).

IHS Strategic Goals:

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

Our FY 2008 budget request represents the best efforts of IHS and our stakeholders to continually strive to build and sustain healthy communities, foster collaboration and innovation across the Indian health network, and provide accessible quality health care.

Charles W. Grim, DDS

Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Director

THIS PAGE LEFT BLANK INTENTIONALLY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2008 Performance Budget Submission

TABLE OF CONTENTS

Facilities

Performance Detail

Supplemental

II. Special Requirements for Individual Operating Division

THIS PAGE LEFT BLANK INTENTIONALLY

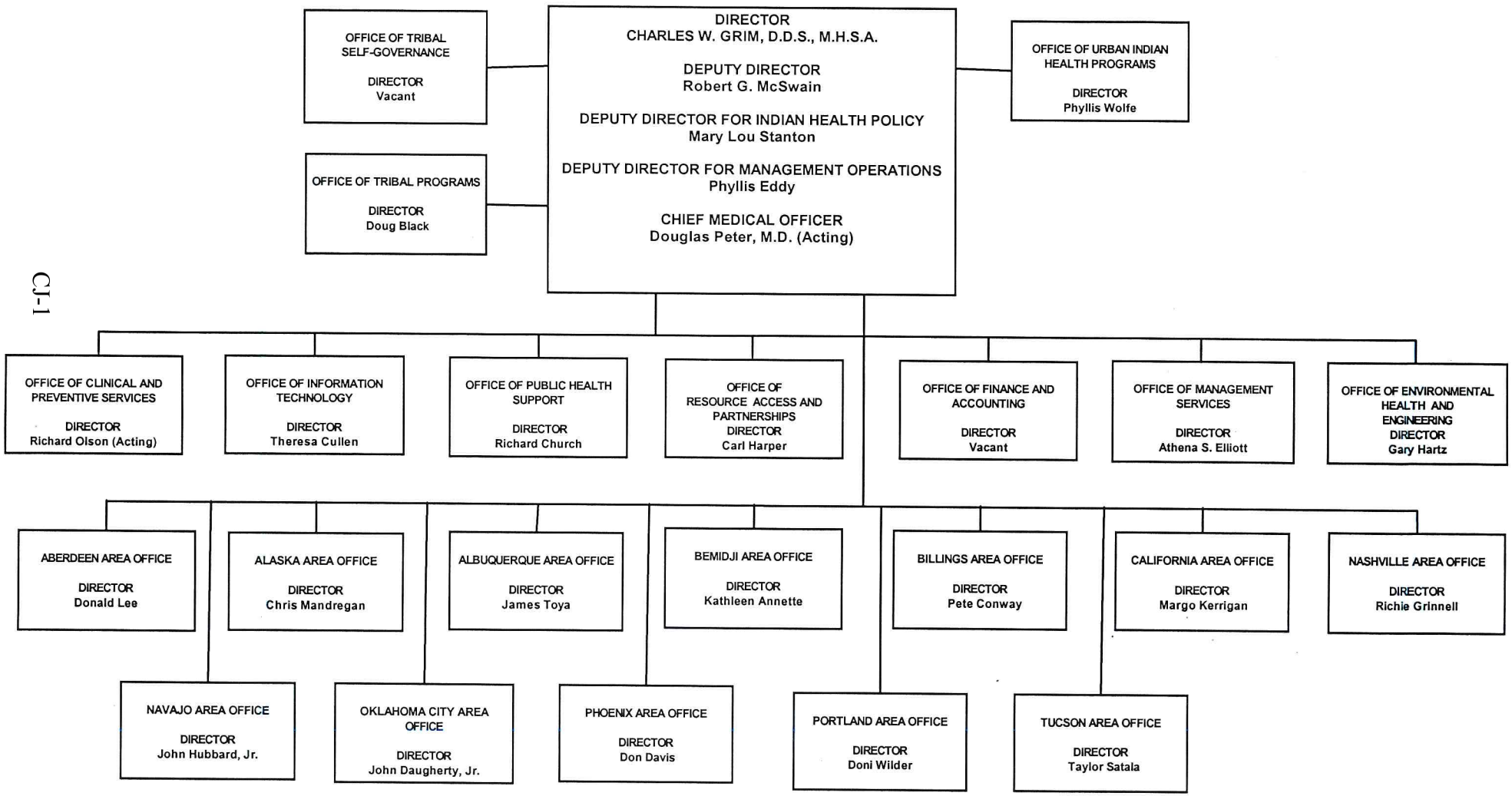
DEPARTMENT OF HEALTH AND HUMAN SERVICES

INDIAN HEALTH SERVICE

Approved: Charles W. Grim, DDS

Date: 1/23/07

CJ-1



THIS PAGE LEFT BLANK INTENTIONALLY

PERFORMANCE BUDGET OVERVIEW

Statement of the Indian Health Service 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.

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 (PHS).

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.

Strategic Goals

		IHS Strategic Goals		
		Build and sustain healthy communities	Provide accessible quality health care	Foster collaboration and innovation across the Indian Health Network
HHS Strategic Goals				
1	Reduce the major threats to the health and well-being of Americans	X	X	X
2	Enhance the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges	X		X
3	Increase the percentage of the Nation's children and adults who have access to health care services, and expand consumer choices	X	X	X
4	Enhance the capacity and productivity of the Nation's health science research enterprise			X
5	Improve the quality of health care services	X	X	X
6	Improve the economic and social well-being of individuals, families, and communities, especially those most in need	X	X	X
7	Improve the stability and healthy development of our Nation's children and youth	X	X	
8	Achieve excellence in management practices			X

The Department-wide and IHS Strategic Plans provide the framework for carrying out the Federal commitment for raising the health status of American Indians and Alaska Natives (AI/AN). The broader HHS Plan outlines the goals for improving the health of all Americans while the IHS Plan is more specific in its goals and describes in detail the strategic actions necessary for achieving the HHS objectives for the AI/AN population as an HHS division. The entire IHS budget supports programs and activities that are critical to achieving these objectives.

In particular, the HHS objectives 3.4 (Eliminate racial and ethnic health disparities) and 3.6 (Increase access to health services for AI/ANs) provide the broad framework on which the IHS Strategic Plan is based and on which the IHS budget is focused. To

accomplish these objectives, the IHS Strategic Plan outlines three overarching goals: (1) Build and Sustain Healthy Communities, (2) Provide Accessible, Quality Health Care, (3) Foster Collaboration and Innovation Across the Indian Health Network. The Plan includes long-term outcomes that are used as indicators of accomplishment in meeting the goals. The Plan also includes existing agency performance measures which are cross-walked to HHS Strategic Plan, Department-Wide Objectives and the Secretary's 500-Day Plan, as well as performance reporting on these measures. The timeframes and targets for these measures are ambitious, as agreed upon with the Office of Management and Budget. The outlook for progress is discussed below under the Overview of Indian Health Service Performance.

The IHS has an integral role in supporting the Secretary's 500-Day Plan of securing the homeland; protecting life, family and human dignity; and improving the human conditions around the world. Over one-third of Commissioned Corps officers serve in the IHS and are able and ready to respond to disasters at a moment's notice based on our capabilities in health care and environmental health. In FY 2006, approximately 600 IHS Commissioned Officers were deployed in response to the hurricane related disasters in the Gulf Coast. Protection of life, family and human dignity are core values of the Indian Health system and IHS is supporting the First Lady's Initiative on Helping America's Youth. IHS is in the process of developing a multi-Departmental Call to Action on Indian youth that is responsive to the many at-risk youth in our communities. In order to improve the human conditions around the world, the IHS has deployed its staff and operating concepts on a worldwide basis to a variety of sites (e.g., Iraq, Afghanistan, Indonesia) to assist local and national governments in recovery and enhancing their health delivery systems.

Overview of Indian Health Service Performance

Historically, the IHS has succeeded in substantially improving the health status of the AI/AN population, primarily by focusing on preventive and primary care services and developing a community-based public health system. Examples can be seen in the dramatic decreases in mortality rates for certain health problems between 1972-74 and 2000-2002:

- Gastrointestinal disease mortality reduced 91 percent (9.3 to 0.8 per 100,000);
- Tuberculosis mortality reduced 80 percent (10.7 to 2.1 per 100,000);
- Cervical cancer mortality reduced 76 percent (19.0 to 4.5 per 100,000);
- Infant mortality reduced 66 percent (25.0 to 8.5 per 1,000);
- Unintentional injuries mortality reduced 60 percent (223.1 to 90.1 per 100,000); and
- Maternal mortality reduced 64 percent (34.8 to 12.5 per 100,000);
- Motor Vehicle fatalities reduced 57 percent (117.5 to 50.4 per 100,000);
- Homicide reduced 57 percent (26.6 to 11.4 per 100,000)

The average death rate from all causes for the AI/AN population dropped a significant 28 percent between 1972-1974 and 2000-2002.

However, population growth and economic factors are creating considerable pressure on AI/AN communities and the IHS system. From 1990 to 2000, the AI/AN population grew at a rate of 26 percent, while the total U.S. population grew by only 13 percent. Poverty and low educational attainment remain as critical external factors affecting the health status of AI/AN people. The 1999 unemployment rate for the AI/AN population was 2.1 times higher than the rest of the population; the percent of the population living in poverty was more than three times that of the non-Hispanic white population in 1999 (25.7 percent compared to 8.1 percent). Educational levels, which influence economic prospects, also reflect significant differences. The 2000 census reported that among people aged 25 and older who identified their race as AI/AN only, 11.5 percent had a bachelor's degree or higher compared with 24.4 percent of all people aged 25 and older; only 70.9 percent of AI/ANs had at least a high school diploma compared to 80.4 percent of all people in the 25 and older age range. This information is from www.census.gov.

The AI/AN population suffers disproportionately from a number of health problems. For example, the 2000-2002 death rate from alcohol abuse was more than 6.1 times higher among AI/ANs than the rates for all races in 2001, the death rate for diabetes was 3.3 times non-Hispanic whites, and the cervical cancer death rate was 3.8 times higher. One of the fastest growing health problems in the AI/AN community is that of diabetes. In 2002, AI/ANs were 2.2 times more likely to have diagnosed diabetes than non-Hispanic whites, and the death rate from diabetes in the AI/AN community has increased by 55 percent between 1972-1974 and 2000-2002.

AI/AN communities suffer a disproportionately high rate of type 2 diabetes. Between 1997 and 2003, the prevalence of diabetes increased by 41 percent in the population served by the IHS and represents a large increase in resource consumption for clinical care. To frame this problem from a more pragmatic perspective, by FY 2002 almost 15 percent of AI/ANs aged 20 years or older who were receiving care from IHS had diagnosed diabetes. And in some communities, as many as one-third of all patients we see over the age of 35 have a diagnosis of diabetes. Furthermore, between FY 1999 and FY 2006, IHS and Tribal pharmaceutical costs increased an average of 14.7 percent per year and a significant proportion of this increase was in response to the medications needed to treat diabetes and to try to prevent its significant complications. Treating blood pressure, dyslipidemia, and early kidney disease, in order to prevent complications from diabetes (such as heart disease, stroke and kidney failure) is just as important as treating the blood sugar level. Additionally, the diabetes epidemic is occurring in an increasingly younger population. Based on IHS diabetes prevalence data, the following increases in prevalence were documented between 1990 and 2002 by age groups:

25-34 years	132 percent
20-24 years	69 percent
15-19 years	106 percent

A recent article in Journal of the American Medical Association (July 2006) showed that early-onset of type 2 diabetes mellitus is associated with a substantially increased incidence of kidney failure requiring dialysis and mortality in middle age. The longer

duration of diabetes mellitus by middle age in individuals diagnosed younger than age 20 years largely accounts for these outcomes. It is crucial that we prevent diabetes in young people.

In addition, the AI/AN population data shows increasing rates of obesity that exceed U.S. all races. Data from 2004 indicate at least a 4 percent increase in obesity rates since FY 2000 and rates that are 5-8 percent higher than U.S. all races. In FY 2006 a baseline rate of 24 percent was established for the proportion of children, ages 2-5 years, with a Body Mass Index of 95 percent or higher, as part of the goal of planning effective programs for childhood weight control (see page CJ-227 in Detail of Performance Analysis). Costs of obesity care have been estimated to account for up to 7 percent of all health care expenditures in populations.

Despite these ongoing challenges, the agency has made significant progress on some important indicators. A 96.5 percent reduction in the rate of uncontrolled diabetes in the general AI/AN service population has occurred from 1998 to 2004. In 2005 the screening rate for diabetic nephropathy rose significantly. In 2006 the target of maintaining the number of patients assessed for nephropathy was substantially exceeded (see page CJ-208 in Detail of Performance Analysis). Furthermore, the measure will be modified in FY 2007 to meet American Diabetes Association Standards of Care. End stage renal disease or diabetic kidney disease is a significant and growing problem in Indian communities. Early identification of at-risk diabetic patients may help prevent or delay the need for costly care such as dialysis or renal transplant.

Significant progress was also made in improving the pneumococcal vaccination rate for non-institutionalized adults over 65 years of age from 65 percent in 2003 to 74 percent in 2006 (see page CJ-223 in Detail of Performance Analysis). The improvement and maintenance of pneumococcal vaccination rates is important because studies have shown that AI/AN people are at high risk for this disease; the 2000-2002 AI/AN death rate from pneumonia and influenza is 41 percent greater than the 2001 U.S. all-races death rate. Vaccination of the elderly against this disease is one of the few medical interventions that have been shown to improve health status and save on medical costs.

A significant accomplishment and evidence for effective performance management is demonstrated by the IHS commitment to a 10 percent increase in four different performance measures by the end of FY 2007, with performance maintained in FY 2008, for the “One HHS” 10 Department-wide management objectives. These include pneumococcal vaccination rates, screening women of child bearing age for alcohol abuse to help prevent Fetal Alcohol Syndrome, screening for intimate partner violence, and screening patients with diabetes for LDL cholesterol. FY 2006 data indicate increases in screening for alcohol abuse (21 percent increase), domestic violence (24 percent increase), LDL cholesterol assessment (7 percent increase), and pneumococcal vaccination (5 percent increase).

These results indicate our ability to impact targeted measures via performance management. Of concern is the issue that labor-intensive screening rates may be easier to

achieve as opposed to cost intensive interventions. It is worth noting that the agency is targeting measures that were not met in FY 2006 to improve overall performance, despite the fact that most clinically-based performance measures represent rates of coverage and the AI/AN population served increases about 1.6 percent each year. Furthermore, there are a number of additional factors that make the achievement of the proposed performance targets challenging. These include:

- Vacancy rates are now at or near all-time high levels for many provider groups and have a significant negative impact on the ability achieve performance targets;
- The IHS has experienced significant loss of services for the past two years associated with deployments of Commissioned Officer providers to health emergencies;
- Possible decreases in third-party collections despite Medicare and Medicaid rate increases because of changing eligibility requirements;
- The continued growth in the prevalence and incidence of diabetes in the AI/AN population and its associated co-morbidities and cost; and
- Improvements in data collection with reduced error rates and less lost data that historically contributed to performance improvements are now reaching a plateau.

In light of these issues, the proposed performance targets are indeed ambitious.

During FY 2006 the IHS decreased in overall achievement of performance measures to 82 percent compared to 83 percent in FY 2005, but improved from 72 percent in FY 2004. Additionally, IHS and Tribal programs made the following performance improvements over FY 2005:

- Increased the proportion of diabetic patients assessed for nephropathy by 17 percent,
- Increased the proportion of diabetic patients with ideal glycemic control by 3 percent,
- Increased the proportion of diabetic patients assessed for LDL by 13 percent,
- Increased the proportion of eligible women screened for alcohol-use by 155 percent,
- Increased the proportion of eligible women screened for domestic violence by 115 percent,
- Increased the proportion of children ages 19-35 months who have had recommended immunizations by 7 percent,
- Increased the proportion of eligible adults 65 or older receiving a pneumococcal vaccination by 7 percent, and
- Increased the proportion of eligible adults screened for cholesterol by 12 percent.

The IHS remains committed to improving efficiency and effectiveness through the appropriate use of technology and sharing of best practices. Accountability for performance measures are now part of the performance appraisal criteria at all levels. The Clinical Reporting System (CRS) software, which provides the capability for local programs to identify non-compliant patients for follow-up, has been deployed nationally. Area Government Performance and Results Act (GPRA) coordinators have been actively networking to share information and material on successful programs, as well as technical assistance to programs to identify ways of improving clinical business

processes. To this end, the IHS is supporting best practice conferences which offer training opportunities to providers and serve to integrate medical best practices and agency performance measures.

In addition, the IHS has restructured its approach to performance management at the national level. Since FY 2005 and through FY 2006, IHS performance oversight has been increasingly under the guidance of the Performance Achievement Team (PAT), a workgroup of key IHS program and support function leaders. Consistent with its charge, the PAT is serving to coordinate performance monitoring of the Agency and to expand and integrate the performance monitoring culture across the Indian health care system. Such efforts have resulted in more consistent and systematic review of budget and performance metrics in the context of the President's Management Agenda, GPRA and Program Assessment Rating Tool (PART). We believe this new structure will reduce redundancy in data collection and reporting, continue to move the overall IHS system toward a more consistent performance management corporate culture, and improve management efficiency.

Finally, the IHS has had overall success in documenting effectiveness in PART evaluations with all programs receiving a rating of "Adequate" or higher. For the FY 2008 funding cycle, all major programs within the IHS had undergone an assessment by the PART, therefore the IHS focus was on PART improvement plans. The Sanitation Facilities Construction Program is implementing a strategic plan, as recommended by an independent evaluation, and completed a marginal cost analysis in conjunction with OMB A-11, Section 221, regarding budget and performance integration. Federally Administered Activities continue to work on evidence-based strategies in the development of performance goals and measures. For example, specific strategies include model program development in the treatment of obesity and comprehensive planning that focuses on primary, secondary, and tertiary pediatric overweight interventions for distribution to field facilities. The Resource and Patient Management System (RPMS) continues to develop the capability to explain how system improvements will impact health outcomes, and developing budget requests which are explicitly tied to the accomplishment of annual and long term performance goals, such as maintaining the earned value variance and improving the RPMS Exhibit 300 score. The Urban Indian Health Program has developed baselines for 17 agency performance measures, with 100 percent of urban programs reporting. The Health Care Facilities Construction Program has developed facility-specific annual performance measures to assess the role new facilities play in expanding access to critical health services and the impact on health outcomes. The program has also revised the health care priority system methodology. For Tribally-Operated Health Programs (TOHP), data submission was a point of discussion and negotiation during all FY 2007 and 2008 contract or compact renewals for tribes not currently reporting performance data. A new methodology for changes in data collection and analysis was developed for the percentage of TOHP clinical user population included in GPRA data, and performance targets were incrementally adjusted. Collaboration continues between the CMS Tribal Technical Advisory Group members and IHS to explore methodologies regarding data extrapolation to better understand the linkage between funding and performance, and alternative accreditation options continue

to be discussed to identify cost-effective alternatives for facility accreditation for currently unaccredited programs to ensure access to quality health care.

Overview of Indian Health Service Budget

This budget submission proposes budget authority of $3.271 billion and program level funding of $4.127 billion, which is an increase of $212 million over the FY 2007 Continuing Resolution (CR) funding level of $3.059 billion in budget authority and $3.915 billion at program level.

Consistent with priorities for the past several years, this budget emphasizes support of the existing IHS and Tribal programs with additional funds included to maintain service coverage of the beneficiary population (+$129 million) and provide funds for staffing and operating costs of two new health facilities (+$19 million). Also, a net increase of $64 million is included to restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget and thus FY 2006 inflation levels. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current service levels cannot be maintained.

Tribal Consultation

Tribal consultation is fundamental to the IHS budget formulation process, and at its core are the priorities and recommendations developed by Tribes within each Area office as they reflect the differences in health problems and resource needs across IHS. Tribal representatives met to consolidate the 12 sets of Area priorities and recommendations into one national set, with the emphasis on maintaining the differences among the Areas to the extent possible. This budget request responds to their concerns by funding those items that Tribes have emphasized as critical funding needs in FY 2008, including pay raises, inflation, population growth, and new staffing for new facilities.

Director's Priorities

The IHS shares these concerns and in fact, during FY 2005, the Director launched three initiatives that are intended to achieve positive improvements in the health of Indian people. As discussed earlier, the major causes of death have shifted from infectious diseases and perinatal mortality to a much larger number of deaths attributable to intentional and unintentional injury (e.g., suicide, homicide, and motor vehicle crashes) and preventable chronic diseases including cardiovascular disease, diabetes, cancers of various organ systems, and even depression-related deaths. The morbidity associated with these diseases has shown a corresponding increase, undermining the quality of life of many AI/AN individuals and communities. There is a demonstrated correlation between the rise in behavioral health related diagnoses and chronic disease that must be addressed. For example, the scientific literature has documented that untreated depression leads to chronic diseases at twice the rate of people with treated depression.

Underlying depression can contribute to the rise of methamphetamine use in Indian Country and result in more violence and suicidal behavior among Indian youth.

There has also been a corresponding developing body of scientific literature that has demonstrated the outcome effectiveness and cost benefit of approaching these issues in ways quite different than the historical medical approach. These "best practices" have focused on multi-disciplinary patient and community-based approaches to prevention and treatment that are not as dependant upon hospital services and high-technology, procedure-oriented medicine. The IHS has embraced many of these newer approaches in the development and implementation of its internationally recognized program of services for diabetes care and prevention (see the report to Congress provided by IHS on the diabetes program activities and outcomes).

Thus, the Director has determined that the Indian health system will focus its programs and efforts on Health Promotion/Disease Prevention (HP/DP), Behavioral Health, and Chronic Disease management. These areas of emphasis target underlying risk factors for morbidity and mortality as well as the re-engineering of the IHS delivery system to incorporate the best practices documented in the scientific literature. The goal is to reduce the burden of preventable disease and elevate the health status of AI/AN people, thereby eliminating the disparities in health that exist between the AI/AN population and all other segments of the U.S. population.

This process requires significant re-education of communities and providers and the employment of newer techniques, and to a lesser degree, newer technologies. This effort requires long-term support from policymakers, providers, patients, and communities themselves. It requires significant partnerships among and between clinical medical practitioners, behavioral health providers, public health workers. It requires renewed partnerships among Federal programs and Tribal and State leaders. It requires new partnerships between academia and AI/AN communities and programs. It requires new relationships to be developed between AI/AN communities and private sector interests.

In FY 2006 the agency continued its efforts to more fully implement the three health initiatives with a major focus on demonstrating how these initiatives are working synergistically to reduce health disparities among AI/AN people. Community mobilization is a recurrent theme that connects all three initiatives; communication, information technology, performance and evidence-based efforts are all integral to our success.

The Chronic Disease Management Initiative developed a strategic plan to fully implement the Chronic Care Model in up to eight federal pilot sites. These pilot sites will demonstrate the changing ways we deliver care to improve patient outcomes across a variety of chronic diseases. This collaborative approach will also support other innovative efforts within the Indian health system to address behavioral health and HP/DP best practices. A partnership with several Federal agencies and the Institute for Healthcare Improvement is underway. Virtual collaboratives and other strategies will be developed to spread innovative practices throughout Indian Country. The HP/DP

Initiative continues to expand the infrastructure and capacity in all 12 IHS Areas and local programs. A grant announcement and successful selection of 13 grantees will address risk factors associated with chronic disease and behavioral health. The Behavioral Health Initiative has focused on four areas including suicide prevention, methamphetamine use reduction, child abuse prevention and continued implementation of the software packages in the Resource and Patient Management System (RPMS) that allow IHS/Tribal/Urban programs to track trends and develop community-specific interventions. The goal of the agency is to expand and communicate these approaches to other communities.

All Purpose Table
Indian Health Service

(Dollars in Thousands)

Jan 10, 2007

Program	FY 2006 Enacted	FY 2007 President's Budget	FY 2007 Continuing Resolution	FY 2008 President's Budget
SERVICES				
Hospitals & Health Clinics [1]	1,339,488	1,429,721	1,339,488	1,493,534
Dental Health	117,731	126,957	117,731	135,755
Mental Health	58,455	61,695	58,455	64,538
Alcohol & Substance Abuse	143,198	150,634	143,198	161,988
Contract Health Services	517,297	554,259	520,548	569,515
Total, Clinical Services	2,176,169	2,323,266	2,179,420	2,425,330
Public Health Nursing	48,959	53,043	48,959	56,825
Health Education	13,584	14,490	13,584	15,229
Community Health Reps.	52,946	55,790	52,946	55,795
Immunization AK	1,621	1,708	1,621	1,760
Total, Preventive Health	117,110	125,031	117,110	129,609
Urban Health	32,744	0	32,744	0
Indian Health Professions	31,039	31,697	31,039	31,866
Tribal Management	2,394	2,488	2,394	2,529
Direct Operations	62,194	63,804	62,194	64,632
Self-Governance	5,668	5,847	5,668	5,928
Contract Support Costs	264,730	270,316	264,730	271,636
Total, Other Services	398,769	374,152	398,769	376,591
TOTAL, SERVICES	2,692,048	2,822,449	2,695,299	2,931,530
FACILITIES				
Maintenance & Improvement	51,633	52,668	52,254	51,936
Sanitation Facilities Construction	92,143	94,003	93,259	88,500
Health Care Facilities Construction	37,779	17,664	36,664	12,664
Facilities & Environmental Health Support	150,709	161,333	160,046	164,826
Equipment	20,947	21,619	21,350	21,270
TOTAL, FACILITIES	353,211	347,287	363,573	339,196
TOTAL, BUDGET AUTHORITY	3,045,259	3,169,736	3,058,872	3,270,726
COLLECTIONS				
Medicare	141,953	143,036	143,036	143,036
Medicaid	464,371	482,157	482,157	482,157
Subtotal, M / M	*606,324*	*625,193*	*625,193*	*625,193*
Private Insurance	75,101	75,101	75,101	75,101
Total, M / M / PI	*681,425*	*700,294*	*700,294*	*700,294*
Quarters	6,288	6,288	6,288	6,288
TOTAL, COLLECTIONS	687,713	706,582	706,582	706,582
Special Diabetes Program for Indians	150,000	150,000	150,000	150,000
TOTAL, SDPI	150,000	150,000	150,000	150,000
TOTAL, PROGRAM LEVEL	3,882,972	4,026,318	3,915,454	4,127,308

[1] FY 2006 - 2008 H&C amounts reflect transfer to Dept of IHS' share of Direct Funding of TAPs.

Indian Health Service

FY 2008 Budget Request -- Congressional Justification

Detail of Changes

(Dollars in Thousands)

Dec 21, 2006

Sub Sub Activity	FY 2007 CR	Restore FY 2007 Base	CURRENT SERVICES: Federal/ Tribal Pay Costs	CURRENT SERVICES: Increased Cost of Health Care	CURRENT SERVICES: Population Growth	CURRENT SERVICES: Staffing for New Fac.	Current Services Subtotal	FY 2008 President's Budget
SERVICES:								
Hospitals & Health Clinics [1]	1,339,488	78,648	27,909	15,508	21,176	10,805	75,398	1,493,534
Dental Health	117,731	9,686	2,372	1,311	1,880	2,775	8,338	135,755
Mental Health	58,455	2,711	1,134	706	914	618	3,372	64,538
Alcohol & Substance Abuse	143,198	6,447	2,925	5,159	2,231	2,028	12,343	161,988
Contract Health Services	520,548	20,268	0	20,491	8,208	0	28,699	569,515
Total, Clinical Svcs	2,179,420	117,760	34,340	43,175	34,409	16,226	128,150	2,425,330
Public Health Nursing	48,959	4,358	997	504	786	1,221	3,508	56,825
Health Education	13,584	798	274	188	215	170	847	15,229
Comm. Health Reps	52,946	54	1,136	832	827	0	2,795	55,795
Immunization AK	1,621	53	36	25	25	0	86	1,760
Total, Prev Hlth	117,110	5,263	2,443	1,549	1,853	1,391	7,236	129,609
Urban Health	32,744	(32,744)	0	0	0	0	0	0
Indian Health Professions	31,039	175	44	608	0	0	652	31,866
Tribal Management	2,394	44	0	91	0	0	91	2,529
Direct Operations	62,194	774	1,295	369	0	0	1,664	64,632
Self-Governance	5,668	76	20	164	0	0	184	5,928
Contract Support Costs	264,730	1,401	0	5,505	0	0	5,505	271,636
Total, Other Services	398,769	(30,274)	1,359	6,737	0	0	8,096	376,591
Total, Services	2,695,299	92,749	38,142	51,461	36,262	17,617	143,482	2,931,530
FACILITIES:								
Maintenance & Improvement	52,254	(318)	0	0	0	0	0	51,936
Sanitation Facilities Construction	93,259	(4,759)	0	0	0	0	0	88,500
Health Care Facs. Construction	36,664	(24,000)	0	0	0	0	0	12,664
Facil. & Envir. Health Supp.	160,046	523	2,771	0	0	1,486	4,257	164,826
Equipment	21,350	(80)	0	0	0	0	0	21,270
Total, Facilities	363,573	(28,634)	2,771	0	0	1,486	4,257	339,196
Total, IHS	3,058,872	64,115	40,913	51,461	36,262	19,103	147,739	3,270,726
COLLECTIONS:								
Medicare	143,036	0	0	0	0	0	0	143,036
Medicaid	482,157	0	0	0	0	0	0	482,157
Subtotal, M / M	*625,193*	*0*	*0*	*0*	*0*	*0*	*0*	*625,193*
Private Insurance	75,101	0	0	0	0	0	0	75,101
Subtotal, M / M / PI	*700,294*	*0*	*0*	*0*	*0*	*0*	*0*	*700,294*
Quarters	6,288	0	0	0	0	0	0	6,288
TOTAL, COLLECTIONS	706,582	0	0	0	0	0	0	706,582
Spec. Diabetes Prog for Indians	150,000	0	0	0	0	0	0 0	150,000
TOTAL, SDPI	150,000	0	0	0	0	0	0	150,000
GRAND TOTAL	3,915,454	64,115	40,913	51,461	36,262	19,103	147,739	4,127,308

[1] FY 2007 H&C amount reflects transfer to Dept. of IHS' share of Direct Funding of Taps.

INDIAN HEALTH SERVICE
FULL-TIME EQUIVALENTS

	FY 2006 Estimate	FY 2007 Estimate	FY 2008 Estimate
Direct:			
Hospitals & Health Clinics	6,494	6,503	6,590
Dental Health	730	738	757
Mental Health	269	269	272
Alcohol & Substance Abuse	164	163	175
Contract Health Services	1	1	1
Total, Clinical Services	7,658	7,674	7,795
Public Health Nursing	239	243	249
Health Education	24	25	26
Community Health Reps.	6	6	6
Immunization, AK	0	0	0
Total, Preventive Hlth	269	274	281
Urban Health	7	7	0
Indian Health Professions	29	29	29
Tribal Management	0	0	0
Direct Operations	366	364	367
Self-Governance	7	7	7
Contract Support Costs	0	0	0
Total, Other Services	409	407	403
Total, SERVICES	8,336	8,355	8,479
Maintenance & Improvement	0	0	0
Sanitation Facilities Construction	194	193	195
Health Care Facs. Construction	0	0	0
Facil. & Envir. Health Support	1,080	1,087	1,106
Equipment	0	0	0
Total, FACILITIES	1,274	1,280	1,301
Total, Direct FTE	9,610	9,635	9,780
Reimbursable:			
Buybacks	1,330	1,330	1,330
Medicare	814	814	814
Medicaid	2,892	2,892	2,892
Private Insurance	639	639	639
Quarters	46	46	46
Total, Reimbursable FTE	5,721	5,721	5,721
TOTAL FTE	**15,331**	**15,356**	**15,501**

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Sub Sub Activity	2006 Enacted Budget Authority	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level	2007 Continuing Resolution Budget Authority	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level
SERVICES:										
Hospitals & Health Clinics	1,339,488	75,101	606,324 [2]	0	2,020,913	1,339,488	75,101	625,193 [2]	0	2,039,782
Dental Health	117,731	0	0	0	117,731	117,731	0	0	0	117,731
Mental Health	58,455	0	0	0	58,455	58,455	0	0	0	58,455
Alcohol & Substance Abuse	143,198	0	0	0	143,198	143,198	0	0	0	143,198
Contract Health Services	517,297	0	0	0	517,297	520,548	0	0	0	520,548
Total, Clinical Services	2,176,169	75,101	606,324	0	2,857,594	2,179,420	75,101	625,193	0	2,879,714
Public Health Nursing	48,959	0	0	0	48,959	48,959	0	0	0	48,959
Health Education	13,584	0	0	0	13,584	13,584	0	0	0	13,584
Comm. Health Reps.	52,946	0	0	0	52,946	52,946	0	0	0	52,946
Immunization AK	1,621	0	0	0	1,621	1,621	0	0	0	1,621
Total, Preventive Health	117,110	0	0	0	117,110	117,110	0	0	0	117,110
Urban Health	32,744	0	0	0	32,744	32,744	0	0	0	32,744
Indian Health Professions	31,039	0	0	0	31,039	31,039	0	0	0	31,039
Tribal Management	2,394	0	0	0	2,394	2,394	0	0	0	2,394
Direct Operations	62,194	0	0	0	62,194	62,194	0	0	0	62,194
Self-Governance	5,668	0	0	0	5,668	5,668	0	0	0	5,668
Contract Support Costs	264,730	0	0	0	264,730	264,730	0	0	0	264,730
TOTAL, SERVICES	2,692,048	75,101	606,324	0	3,373,473	2,695,299	75,101	625,193	0	3,395,593
FACILITIES:										
Maintenance & Improvement	51,633	0	0	6,288	57,921	52,254	0	0	6,288	58,542
Sanitation Facilities Construction	92,143	0	0	0	92,143	93,259	0	0	0	93,259
Health Care Facs. Constr.	37,779	0	0	0	37,779	36,664	0	0	0	36,664
Facil. & Envir. Health Support	150,709	0	0	0	150,709	160,046	0	0	0	160,046
Equipment	20,947	0	0	0	20,947	21,350	0	0	0	21,350
TOTAL, FACILITIES	353,211	0	0	6,288	359,499	363,573	0	0	6,288	369,861
TOTAL, IHS	3,045,259	75,101	606,324	6,288	3,732,972	3,058,872	75,101	625,193	6,288	3,765,454
Special Diabetes Program for Indians [1]	150,000	0	0	0	150,000	150,000	0	0	0	150,000
GRAND TOTAL	3,195,259	75,101	606,324	6,288	3,882,972	3,208,872	75,101	625,193	6,288	3,915,454

[1] For FY 2004-2008, the Special Diabetes Program for Indians is reauthorized for a total of $150,000,000 each year.

[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)

	2008 President's Budget					Increase / Decrease of 2008 over 2007				
Sub Sub Activity	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	1,493,534	75,101	625,193 [2]	0	2,193,828	154,046	0	0	0	154,046
Dental Health	135,755	0	0	0	135,755	18,024	0	0	0	18,024
Mental Health	64,538	0	0	0	64,538	6,083	0	0	0	6,083
Alcohol & Substance Abuse	161,988	0	0	0	161,988	18,790	0	0	0	18,790
Contract Health Services	569,515	0	0	0	569,515	48,967	0	0	0	48,967
Total, Clinical Services	2,425,330	75,101	625,193	0	3,125,624	245,910	0	0	0	245,910
Public Health Nursing	56,825	0	0	0	56,825	7,866	0	0	0	7,866
Health Education	15,229	0	0	0	15,229	1,645	0	0	0	1,645
Comm. Health Reps.	55,795	0	0	0	55,795	2,849	0	0	0	2,849
Immunization AK	1,760	0	0	0	1,760	139	0	0	0	139
Total, Preventive Health	129,609	0	0	0	129,609	12,499	0	0	0	12,499
Urban Health	0	0	0	0	0	(32,744)	0	0	0	(32,744)
Indian Health Professions	31,866	0	0	0	31,866	827	0	0	0	827
Tribal Management	2,529	0	0	0	2,529	135	0	0	0	135
Direct Operations	64,632	0	0	0	64,632	2,438	0	0	0	2,438
Self-Governance	5,928	0	0	0	5,928	260	0	0	0	260
Contract Support Costs	271,636	0	0	0	271,636	6,906	0	0	0	6,906
Total, Other Services	376,591	0	0	0	376,591	(22,178)	0	0	0	(22,178)
TOTAL, SERVICES	2,931,530	75,101	625,193	0	3,631,824	236,231	0	0	0	236,231
FACILITIES:										
Maintenance & Improvement	51,936	0	0	6,288	58,224	(318)	0	0	0	(318)
Sanitation Facilities Construction	88,500	0	0	0	88,500	(4,759)	0	0	0	(4,759)
Health Care Facs. Constr.	12,664	0	0	0	12,664	(24,000)	0	0	0	(24,000)
Facil. & Envir. Health Support	164,826	0	0	0	164,826	4,780	0	0	0	4,780
Equipment	21,270	0	0	0	21,270	(80)	0	0	0	(80)
TOTAL, FACILITIES	339,196	0	0	6,288	345,484	(24,377)	0	0	0	(24,377)
TOTAL, IHS	3,270,726	75,101	625,193	6,288	3,977,308	211,854	0	0	0	211,854
Special Diabetes Program for Indians [1]	150,000	0	0	0	150,000	0	0	0	0	0
GRAND TOTAL	3,420,726	75,101	625,193	6,288	4,127,308	211,854	0	0	0	211,854

[1] For FY 2004-2008, the Special Diabetes Program for Indians is reauthorized for a total of $150,000,000 each year.

[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 FY2002.

INDIAN HEALTH SERVICE
STAFFING AND OPERATING COSTS FOR NEW FACILITIES
FY 2008 Requirements

(Dollars in Thousands)

Opening Date:	Muskogee ,OK Joint Venture August 2007		Pyramid Lake, NV Satellite YRTC September 2007		TOTAL
Sub Sub Activity	Pos. [2]	Amount	FTE	Amount	Amount
Hospitals & Health Clinics	125	$10,805	0	$0	$10,805
Dental Health	31	2,775	0	0	2,775
Mental Health	8	618	0	0	618
Alcohol and Substance Abuse	0	0	29	2,028	2,028
Total, Clinical Services	164	$14,198	29	$2,028	$16,226
Public Health Nursing	12	1,221	0	0	1,221
Health Education	2	170	0	0	170
Total, Preventive Health	14	1,391	0	0	1,391
Total, Services	178	$15,589	29	$2,028	$17,617
Facilities Support [1]	9	1,486	0	0	1,486
Sub-total, FEHS	9	1,486	0	0	1,486
Total, Facilities	9	$1,486	0	$0	$1,486
Grand Total	**187**	**$17,075**	**29**	**$2,028**	**$19,103**

[1] Includes Utilities.

[2] Tribal positions (i.e., non-add FTE).

FY 2006 Crosswalk
Budget Authority
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2006 Actual
	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	699,435	0	0	0	0	0	0	699,435	640,053	0	0	0	0	0	0	640,053	1,339,488
Dental Health	70,144	0	0	0	0	0	0	70,144	47,587	0	0	0	0	0	0	47,587	117,731
Mental Health	31,037	0	0	0	0	0	0	31,037	27,418	0	0	0	0	0	0	27,418	58,455
Alcohol & Substance Abuse	21,328	0	0	0	0	0	0	21,328	121,870	0	0	0	0	0	0	121,870	143,198
Contract Health Services	263,029	0	0	0	0	0	0	263,029	254,268	0	0	0	0	0	0	254,268	517,297
Subtotal (CS)	1,084,973	0	0	0	0	0	0	1,084,973	1,091,196	0	0	0	0	0	0	1,091,196	2,176,169
Public Health Nursing	0	0	28,023	0	0	0	0	28,023	0	20,936	0	0	0	0	0	20,936	48,959
Health Education	0	0	3,591	0	0	0	0	3,591	0	9,993	0	0	0	0	0	9,993	13,584
Community Health Repr.	0	0	947	0	0	0	0	947	0	51,999	0	0	0	0	0	51,999	52,946
Immunization AK	0	0	0	0	0	0	0	0	0	1,621	0	0	0	0	0	1,621	1,621
Subtotal (PH)	0	0	32,560	0	0	0	0	32,560	0	84,550	0	0	0	0	0	84,550	117,110
Urban Health Project	0	6,127	0	0	0	0	0	6,127	0	0	26,617	0	0	0	0	26,617	32,744
Indian Health Professions	0	0	0	31,039	0	0	0	31,039	0	0	0	0	0	0	0	0	31,039
Tribal Management	0	0	0	37	0	0	0	37	0	0	0	2,357	0	0	0	2,357	2,394
Direct Operations	0	0	0	0	46,903	0	0	46,903	0	0	0	15,291	0	0	0	15,291	62,194
Self-Governance	0	0	0	0	0	2,107	0	2,107	0	0	0	0	3,561	0	0	3,561	5,668
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	264,730	0	264,730	264,730
Subtotal (OS)	0	6,127	0	31,076	46,903	2,107	0	86,213	0	0	26,617	17,648	3,561	264,730	0	312,556	398,769
Total, Services	1,084,973	6,127	32,560	31,076	46,903	2,107	0	1,203,747	1,091,196	84,550	26,617	17,648	3,561	264,730	0	1,488,301	2,692,048
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	26,143	26,143	0	0	0	0	0	0	25,490	25,490	51,633
Sanitation Facilities Constr.	0	0	0	0	0	0	32,250	32,250	0	0	0	0	0	0	59,893	59,893	92,143
Health Care Facs. Constr.	0	0	0	0	0	0	15,118	15,118	0	0	0	0	0	0	22,661	22,661	37,779
Facs. & Env. Health Sup	0	0	0	0	0	0	109,914	109,914	0	0	0	0	0	0	40,795	40,795	150,709
Equipment	0	0	0	0	0	0	6,987	6,987	0	0	0	0	0	0	13,960	13,960	20,947
Total, Facilities	0	0	0	0	0	0	190,412	190,412	0	0	0	0	0	0	162,799	162,799	353,211
TOTAL, IHS	1,084,973	6,127	32,560	31,076	46,903	2,107	190,412	1,394,159	1,091,196	84,550	26,617	17,648	3,561	264,730	162,799	1,651,100	3,045,259

FY 2007 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2007 CR
	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	699,435	0	0	0	0	0	0	699,435	640,053	0	0	0	0	0	0	640,053	1,339,488
Dental Health	70,144	0	0	0	0	0	0	70,144	47,587	0	0	0	0	0	0	47,587	117,731
Mental Health	31,037	0	0	0	0	0	0	31,037	27,418	0	0	0	0	0	0	27,418	58,455
Alcohol & Substance Abuse	21,328	0	0	0	0	0	0	21,328	121,870	0	0	0	0	0	0	121,870	143,198
Contract Health Services	264,654	0	0	0	0	0	0	264,654	255,894	0	0	0	0	0	0	255,894	520,548
Subtotal (CS)	1,086,598	0	0	0	0	0	0	1,086,598	1,092,822	0	0	0	0	0	0	1,092,822	2,179,420
Public Health Nursing	0	0	28,023	0	0	0	0	28,023	0	20,936	0	0	0	0	0	20,936	48,959
Health Education	0	0	3,591	0	0	0	0	3,591	0	9,993	0	0	0	0	0	9,993	13,584
Community Health Repr.	0	0	947	0	0	0	0	947	0	51,999	0	0	0	0	0	51,999	52,946
Immunization AK	0	0	0	0	0	0	0	0	0	1,621	0	0	0	0	0	1,621	1,621
Subtotal (PH)	0	0	32,560	0	0	0	0	32,560	0	84,550	0	0	0	0	0	84,550	117,110
Urban Health Project	0	6,127	0	0	0	0	0	6,127	0	0	26,617	0	0	0	0	26,617	32,744
Indian Health Professions	0	0	0	31,039	0	0	0	31,039	0	0	0	0	0	0	0	0	31,039
Tribal Management	0	0	0	37	0	0	0	37	0	0	0	2,357	0	0	0	2,357	2,394
Direct Operations	0	0	0	0	46,903	0	0	46,903	0	0	0	15,291	0	0	0	15,291	62,194
Self-Governance	0	0	0	0	0	2,107	0	2,107	0	0	0	0	3,561	0	0	3,561	5,668
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	264,730	0	264,730	264,730
Subtotal (OS)	0	6,127	0	31,076	46,903	2,107	0	86,213	0	0	26,617	17,648	3,561	264,730	0	312,556	398,769
Total, Services	1,086,598	6,127	32,560	31,076	46,903	2,107	0	1,205,372	1,092,822	84,550	26,617	17,648	3,561	264,730	0	1,489,927	2,695,299
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	26,764	26,764	0	0	0	0	0	0	25,490	25,490	52,254
Sanitation Facilities Constr.	0	0	0	0	0	0	32,641	32,641	0	0	0	0	0	0	60,618	60,618	93,259
Health Care Facs. Constr.	0	0	0	0	0	0	19,000	19,000	0	0	0	0	0	0	17,664	17,664	36,664
Facs. & Env. Health Sup	0	0	0	0	0	0	116,915	116,915	0	0	0	0	0	0	43,131	43,131	160,046
Equipment	0	0	0	0	0	0	7,390	7,390	0	0	0	0	0	0	13,960	13,960	21,350
Total, Facilities	0	0	0	0	0	0	202,711	202,710	0	0	0	0	0	0	160,863	160,863	363,573
TOTAL, IHS	1,086,598	6,127	32,560	31,076	46,903	2,107	202,711	1,408,082	1,092,822	84,550	26,617	17,648	3,561	264,730	160,863	1,650,791	3,058,872

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

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2008 President's Budget
	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	773,362	0	0	0	0	0	0	773,362	720,172	0	0	0	0	0	0	720,172	1,493,534
Dental Health	79,227	0	0	0	0	0	0	79,227	56,528	0	0	0	0	0	0	56,528	135,755
Mental Health	33,882	0	0	0	0	0	0	33,882	30,656	0	0	0	0	0	0	30,656	64,538
Alcohol & Substance Abuse	25,676	0	0	0	0	0	0	25,676	136,312	0	0	0	0	0	0	136,312	161,988
Contract Health Services	289,340	0	0	0	0	0	0	289,340	280,175	0	0	0	0	0	0	280,175	569,515
Subtotal (CS)	1,201,486	0	0	0	0	0	0	1,201,486	1,223,844	0	0	0	0	0	0	1,223,844	2,425,330
Public Health Nursing	0	0	31,778	0	0	0	0	31,778	0	25,047	0	0	0	0	0	25,047	56,825
Health Education	0	0	3,976	0	0	0	0	3,976	0	11,253	0	0	0	0	0	11,253	15,229
Community Health Repr.	0	0	985	0	0	0	0	985	0	54,810	0	0	0	0	0	54,810	55,795
Immunization AK	0	0	0	0	0	0	0	0	0	1,760	0	0	0	0	0	1,760	1,760
Subtotal (PH)	0	0	36,739	0	0	0	0	36,739	0	92,870	0	0	0	0	0	92,870	129,609
Urban Health Project	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Indian Health Professions	0	0	0	31,866	0	0	0	31,866	0	0	0	0	0	0	0	0	31,866
Tribal Management	0	0	0	40	0	0	0	40	0	0	0	2,489	0	0	0	2,489	2,529
Direct Operations	0	0	0	0	48,705	0	0	48,705	0	0	0	15,927	0	0	0	15,927	64,632
Self-Governance	0	0	0	0	0	2,216	0	2,216	0	0	0	0	3,712	0	0	3,712	5,928
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	271,636	0	271,636	271,636
Subtotal (OS)	0	0	0	31,906	48,705	2,216	0	82,827	0	0	0	18,416	3,712	271,636	0	293,764	376,591
Total, Services	1,201,486	0	36,739	31,906	48,705	2,216	0	1,321,052	1,223,844	92,870	0	18,416	3,712	271,636	0	1,610,478	2,931,530
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	26,602	26,602	0	0	0	0	0	0	25,334	25,334	51,936
Sanitation Facilities Constr.	0	0	0	0	0	0	30,975	30,975	0	0	0	0	0	0	57,525	57,525	88,500
Health Care Facs. Constr.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12,664	12,664	12,664
Facs. & Env. Health Sup	0	0	0	0	0	0	119,209	119,209	0	0	0	0	0	0	45,617	45,617	164,826
Equipment	0	0	0	0	0	0	7,363	7,363	0	0	0	0	0	0	13,907	13,907	21,270
Total, Facilities	0	0	0	0	0	0	184,150	184,149	0	0	0	0	0	0	155,047	155,047	339,196
TOTAL, IHS	1,201,486	0	36,739	31,906	48,705	2,216	184,150	1,505,202	1,223,844	92,870	0	18,416	3,712	271,636	155,047	1,765,524	3,270,726

THIS PAGE LEFT BLANK INTENTIONALLY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2008 Performance Budget Submission

TABLE OF CONTENTS

THIS PAGE LEFT BLANK INTENTIONALLY

INDIAN HEALTH SERVICE

Federal Funds

General and Special Funds:

INDIAN HEALTH SERVICES

For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination Act, the Indian Health Care Improvement Act, and titles II and III of the Public Health Service Act with respect to the Indian Health Service, ~~$2,695,299,000,~~ *$2,931,530,000*, together with payments received during the fiscal year pursuant to 42 U.S.C. 238(b) for services furnished by the Indian Health Service: *Provided*, That funds made available to tribes and tribal organizations through contracts, grant agreements, or any other agreements or compacts authorized by the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), shall be deemed to be obligated at the time of the grant or contract award and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: *Provided further*, That up to $18,000,000 shall remain available until expended, for the Indian Catastrophic Health Emergency Fund: *Provided further*, That ~~$520,548,000~~ *$551,515,000* for contract medical care shall remain available for obligation until September 30, ~~2007~~ *2009*: *Provided further*, That of the funds provided, up to $27,000,000, to remain available until expended, shall be used to carry out the loan repayment program under section 108 of the Indian Health Care Improvement Act: *Provided further*, That funds provided in this Act may be used for one-year contracts and grants which are to be performed in two fiscal years, so long as the total obligation is recorded in the year for which the funds are appropriated: *Provided further*, That the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act shall remain available until expended for the purpose of achieving compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act (exclusive of planning, design, or construction of new facilities): *Provided further*, That funding contained herein, and in any earlier appropriations Acts for scholarship programs under the Indian Health Care Improvement Act (25 U.S.C. 1613) shall remain available until expended: *Provided*

further, That amounts received by tribes and tribal organizations under title IV of the Indian Health Care Improvement Act shall be reported and accounted for and available to the receiving tribes and tribal organizations until expended: *Provided further*, That, notwithstanding any other provision of law, of the amounts provided herein, not to exceed ~~$264,730,000~~ *$271,636,000* shall be for payments to tribes and tribal organizations for contract or grant support costs associated with contracts, grants, self-governance compacts or annual funding agreements between the Indian Health Service and a tribe or tribal organization pursuant to the Indian Self-Determination Act of 1975, as amended, prior to or during fiscal year ~~2007~~ *2008*, 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 and 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.

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-De-termination 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, ~~$363,573,000,~~ *$339,196,000*, to remain available until expended: *Provided*, That notwithstanding any other provision of law, funds appropriated for the planning, design, construction or renovation of health facilities for the benefit of an Indian tribe or tribes may be used to purchase land for sites to

construct, improve, or enlarge health or related facilities: *Provided further*, That not to exceed $500,000 shall be used by the Indian Health Service to purchase TRANSAM equipment from the Department of Defense for distribution to the Indian Health Service and tribal facilities: *Provided further*, That none of the funds appropriated to the Indian Health Service may be used for sanitation facilities construction for new homes funded with grants by the housing programs of the United States Department of Housing and Urban Development: *Provided further*, That not to exceed $1,000,000 from this account and the ''Indian Health Services'' account shall be used by the Indian Health Service to obtain ambulances for the Indian Health Service and tribal facilities in conjunction with an existing interagency agreement between the Indian Health Service and the General Services Administration: *Provided further*, That 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.

ADMINISTRATIVE PROVISIONS, INDIAN HEALTH SERVICE

Appropriations in this Act to the Indian Health Service shall be available for services as authorized by 5 U.S.C. 3109 but at rates not to exceed the per diem rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. 5376; hire of passenger motor vehicles and aircraft; purchase of medical equipment; purchase of reprints; purchase, renovation and erection of modular buildings and renovation of existing facilities; payments for telephone service in private residences in the field, when authorized under regulations approved by the Secretary; and for uniforms or allowances therefor as authorized by 5 U.S.C. 5901–5902; and for expenses of attendance at meetings which are concerned with the functions or activities for which the appropriation is made or which will contribute to improved conduct, supervision, or management of those functions or activities.

In accordance with the provisions of the Indian Health Care Improvement Act, non-Indian patients may be extended health care at all tribally administered or Indian Health Service facilities, subject to charges, and the proceeds along with funds recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2651–2653) shall be credited to the

account of the facility providing the service and shall be available without fiscal year limitation. Notwithstanding any other law or regulation, funds transferred from the Department of Housing and Urban Development to the Indian Health Service shall be administered under Public Law 86–121 (the Indian Sanitation Facilities Act) and Public Law 93–638, as amended.

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

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

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

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

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

The appropriation structure for the Indian Health Service may not be altered without advance notification to the House and Senate Committees on Appropriations.

NOTE: A regular 2007 appropriation for these accounts had not been enacted at the time the budget was prepared; therefore, these accounts are operating under a continuing resolution (P.L. 109-289, Division B, as amended). The amounts included for 2007 in this budget reflect the levels provided by the continuing resolution.

GENERAL PROVISIONS

Sec. ~~409~~ *408*. Notwithstanding any other provision of law, amounts appropriated to or earmarked in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, 108-447, and 109-54 *and 109-289, division B,* for payments ~~to tribes and tribal organizations~~ for contract support costs associated with self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded by such Acts, are the total amounts available for fiscal years 1994 through ~~2006~~ *2007* for such purposes, except that the Bureau of Indian Affairs *and federally recognized tribes*~~,~~ ~~tribes and tribal organizations~~ may use their tribal *priority* allocations for unmet ~~indirect~~ *contract support* costs of ongoing contracts, grants, self-governance compacts or annual funding agreements. [2]

Explanation of Language Changes

Language Provision	Explanation
General Provisions:	
[2] Sec. ~~409~~ *408*. Notwithstanding any other provision of law, amounts appropriated to or earmarked in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, 108-447, and 109-54 *and 109-289, division B,* for payments ~~to tribes and tribal organizations~~ for contract support costs associated with self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded by such Acts, are the total amounts available for fiscal years 1994 through ~~2006~~ *2007* for such purposes, except that the Bureau of Indian Affairs *and federally recognized tribes*~~, tribes and tribal organizations~~ may use their tribal *priority* allocations for unmet ~~indirect~~ *contract support* costs of ongoing contracts, grants, self-governance compacts or annual funding agreements.	Continue provision to limit payments for contract support costs in past years (FY 1994 through FY 2007) to the funds available in law and accompanying report language in those years for the Bureau of Indian Affairs and the Indian Health Service.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
SERVICES

Amounts Available for Obligations

	2006 Actual	2007 CR	2008 Budget
Appropriation:			
Appropriation (Services)	$2,732,000,000	$2,695,000,000	$2,932,000,000
Enacted Rescission	(40,000,000)	0	0
Subtotal, Adjusted Appropriation	$2,692,000,000	$2,695,000,000	$2,932,000,000
Special Diabetes Program for Indians	150,000,000	150,000,000	150,000,000
Subtotal, adjusted budget authority	$2,842,000,000	$2,845,000,000	$3,082,000,000
Offsetting Collections:			
Federal sources	444,000,000	444,000,000	444,000,000
Non-federal sources	444,000,000	444,000,000	444,000,000
Subtotal	$888,000,000	$888,000,000	$888,000,000
Unobligated Balance, Start of Year	244,000,000	183,000,000	162,000,000
Unobligated Balance End of Year	183,000,000	162,000,000	141,000,000
Unobligated Balance Lapsing	0	0	0
Total Obligations	$3,791,000,000	$3,754,000,000	$3,991,000,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FACILITIES

Amounts Available for Obligations

	2006 Actual	2007 CR	2008 Budget
Appropriation	358,000,000	347,000,000	364,000,000
Enacted Rescission	(5,000,000)	0	0
Subtotal, Adjusted Appropriation	353,000,000	347,000,000	364,000,000
Offsetting Collections:			
Federal sources	7,000,000	7,000,000	7,000,000
Subtotal	$7,000,000	$7,000,000	$7,000,000
Unobligated balance, start of year	285,000,000	251,000,000	257,000,000
Unobligated balance end of year	251,000,000	257,000,000	263,000,000
Total Obligations	$394,000,000	$348,000,000	$365,000,000

INDIAN HEALTH SERVICE
SERVICES
Summary of Changes

FY 2007 CR	$2,695,299,000
Total estimated budget authority	2,695,299,000
Less Obligations	(2,695,299,000)
FY 2008 President's Budget	2,931,530,000
Less Obligations	(2,931,530,000)
Net Change	236,231,000
Less Obligations	(236,231,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$4,232,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	17,432,000
3	Tribal Pay Cost	--	n/a	--	43,224,000
4	Within Grade Increase	--	n/a	--	5,290,000
5	Two Days Pay	--	n/a	--	5,961,000
6	Increased Cost of Travel	--	30,748,000	--	1,136,000
7	Increased Cost of Transportation & Things	--	8,788,000	--	217,000
8	Increased Cost of Printing	--	850,000	--	18,000
9	Increased Cost of Rents, Communications, & Utilties	--	26,680,000	--	637,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	356,807,000	--	15,003,000
11	Increased Cost of Supplies	--	87,564,000	--	3,429,000
12	Increased Cost of Medical or other Equipment	--	11,352,000	--	448,000
13	Increased Cost of Land & Structure	--	91,000	--	0
14	Increased Cost of Grants	--	1,556,859,000	--	37,024,000
15	Increased Cost of Insurance / Indemnities	--	402,000	--	10,000
16	Increased Cost of Interest / Dividends	--	125,000	--	3,000
17	Increased Cost of Service & Supply Fund	--	n/a	--	723,000
18	Population Growth	--	n/a	--	39,171,000
	Subtotal, Built-In	--	2,080,266,000	--	173,958,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	n/a	--	15,589,000
	Pyramid Lake, NV YRTC	--	n/a	--	2,028,000
	Subtotal, Staffing	--	0	--	17,617,000
C. Restoration of FY 2007 Base:		--	0	--	125,493,000
	TOTAL INCREASES	--	2,080,266,000	--	317,068,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(48,093,000)
B. Program Decreases:					
	Urban Indian Health Program	--	0	--	(32,744,000)
	TOTAL DECREASES	--	0	--	(80,837,000)
NET CHANGE		--	**$2,080,266,000**	--	**$236,231,000**

INDIAN HEALTH SERVICE
Clinical Services
Summary of Changes

FY 2007 CR	$2,179,420,000
Total estimated budget authority	2,176,220,000
Less Obligations	(2,176,220,000)
FY 2008 President's Budget	2,425,330,000
Less Obligations	(2,425,330,000)
Net Change	245,910,000
Less Obligations	(245,910,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$3,853,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	15,831,000
3	Tribal Pay Cost	--	n/a	--	38,609,000
4	Within Grade Increase	--	n/a	--	4,721,000
5	Two Days Pay	--	n/a	--	5,413,000
6	Increased Cost of Travel	--	28,547,000	--	1,084,000
7	Increased Cost of Transportation & Things	--	7,205,000	--	193,000
8	Increased Cost of Printing	--	742,000	--	16,000
9	Increased Cost of Rents, Communications, & Utilties	--	19,976,000	--	621,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	377,604,000	--	14,767,000
11	Increased Cost of Supplies	--	85,923,000	--	3,363,000
12	Increased Cost of Medical or other Equipment	--	14,110,000	--	415,000
13	Increased Cost of Land & Structure	--	36,000	--	0
14	Increased Cost of Grants	--	1,098,593,000	--	28,317,000
15	Increased Cost of Insurance / Indemnities	--	644,000	--	9,000
16	Increased Cost of Interest / Dividends	--	95,000	--	3,000
17	Increased Cost of Service & Supply Fund	--	0	--	723,000
18	Population Growth	--	0	--	37,175,000
	Subtotal, Built-In	--	1,633,475,000	--	155,113,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	164	--	14,198,000
	Pyramid Lake, NV YRTC	--	29	--	2,029,000
	Subtotal, Staffing	--	193	--	16,227,000
C. Restoration of FY 2007 Base:		--	0	--	117,761,000
	TOTAL INCREASES	--	1,633,475,193	--	289,101,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(43,191,000)
	TOTAL DECREASES	--	0	--	(43,191,000)
NET CHANGE		--	**$1,633,475,193**	--	**$245,910,000**

INDIAN HEALTH SERVICE
Hospitals & Health Clinics
Summary of Changes

FY 2007 CR	$1,339,488,000
Total estimated budget authority	1,339,488,000
Less Obligations	(1,339,488,000)
FY 2008 President's Budget	1,493,534,000
Less Obligations	(1,493,534,000)
Net Change	154,046,000
Less Obligations	(154,046,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$3,337,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	13,703,000
3	Tribal Pay Cost	--	n/a	--	29,545,000
4	Within Grade Increase	--	n/a	--	3,906,000
5	Two Days Pay	--	n/a	--	4,685,000
6	Increased Cost of Travel	--	8,255,000	--	723,000
7	Increased Cost of Transportation & Things	--	6,845,000	--	205,000
8	Increased Cost of Printing	--	727,000	--	170,000
9	Increased Cost of Rents, Communications, & Utilties	--	25,602,000	--	16,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	104,972,000	--	615,000
11	Increased Cost of Supplies	--	70,955,000	--	3,943,000
12	Increased Cost of Medical or other Equipment	--	8,868,000	--	2,729,000
13	Increased Cost of Land & Structure	--	91,000	--	374,000
14	Increased Cost of Grants	--	658,169,000	--	0
15	Increased Cost of Insurance / Indemnities	--	327,000	--	9,622,000
16	Increased Cost of Interest / Dividends	--	87,000	--	8,000
17	Increased Cost of Service & Supply Fund	--	n/a	--	2,000
18	Population Growth	--	n/a	--	22,876,000
	Subtotal, Built-In	--	884,898,000	--	96,459,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	0	125	10,805,000
C. Restoration of FY 2007 Base:		--	0	0	78,648,000
	TOTAL INCREASES	--	884,898,000	125	185,912,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	(31,866,000)
	TOTAL DECREASES	--	0	0	(31,866,000)
NET CHANGE		--	**$884,898,000**	**125**	**$154,046,000**

INDIAN HEALTH SERVICE
Dental Health
Summary of Changes

FY 2007 CR	$117,731,000
Total estimated budget authority	117,731,000
Less Obligations	(117,731,000)
FY 2008 President's Budget	135,755,000
Less Obligations	(135,755,000)
Net Change	18,024,000
Less Obligations	(18,024,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$329,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	1,329,000
3	Tribal Pay Cost	--	n/a	--	2,153,000
4	Within Grade Increase	--	n/a	--	508,000
5	Two Days Pay	--	n/a	--	455,000
6	Increased Cost of Travel	--	895,000	--	23,000
7	Increased Cost of Transportation & Things	--	415,000	--	10,000
8	Increased Cost of Printing	--	7,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	51,000	--	1,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	8,187,000	--	351,000
11	Increased Cost of Supplies	--	4,327,000	--	192,000
12	Increased Cost of Medical or other Equipment	--	865,000	--	35,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	48,016,000	--	876,000
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	--	2,033,000
	Subtotal, Built-In	--	62,763,000	--	8,295,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	0	31	2,775,000
C. Restoration of FY 2007 Base:		--	0	0	9,686,000
	TOTAL INCREASES	--	62,763,000	31	20,756,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	(2,732,000)
	TOTAL DECREASES	--	0	0	(2,732,000)
NET CHANGE		--	**$62,763,000**	**31**	**$18,024,000**

INDIAN HEALTH SERVICE
Mental Health
Summary of Changes

FY 2007 CR	$58,455,000
Total estimated budget authority	58,455,000
Less Obligations	(58,455,000)
FY 2008 President's Budget	64,538,000
Less Obligations	(64,538,000)
Net Change	6,083,000
Less Obligations	(6,083,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$127,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	543,000
3	Tribal Pay Cost	--	n/a	--	1,238,000
4	Within Grade Increase	--	n/a	--	207,000
5	Two Days Pay	--	n/a	--	186,000
6	Increased Cost of Travel	--	280,000	--	7,000
7	Increased Cost of Transportation & Things	--	356,000	--	9,000
8	Increased Cost of Printing	--	4,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	23,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	5,796,000	--	246,000
11	Increased Cost of Supplies	--	982,000	--	36,000
12	Increased Cost of Medical or other Equipment	--	154,000	--	4,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	27,981,000	--	499,000
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	--	986,000
	Subtotal, Built-In	--	35,576,000	--	4,088,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	0	8	618,000
C. Restoration of FY 2007 Base:		--	0	0	2,711,000
	TOTAL INCREASES	--	35,576,000	8	7,417,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	(1,334,000)
	TOTAL DECREASES	--	0	0	(1,334,000)
NET CHANGE		--	**$35,576,000**	**8**	**$6,083,000**

INDIAN HEALTH SERVICE
Alcohol & Substance Abuse
Summary of Changes

FY 2007 CR	$143,198,000
Total estimated budget authority	143,198,000
Less Obligations	(143,198,000)
FY 2008 President's Budget	161,988,000
Less Obligations	(161,988,000)
Net Change	18,790,000
Less Obligations	(18,790,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$57,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	243,000
3	Tribal Pay Cost	--	n/a	--	5,673,000
4	Within Grade Increase	--	n/a	--	92,000
5	Two Days Pay	--	n/a	--	82,000
6	Increased Cost of Travel	--	266,000	--	6,000
7	Increased Cost of Transportation & Things	--	149,000	--	3,000
8	Increased Cost of Printing	--	1,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	216,000	--	5,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	5,709,000	--	228,000
11	Increased Cost of Supplies	--	642,000	--	26,000
12	Increased Cost of Medical or other Equipment	--	74,000	--	2,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	125,820,000	--	5,303,000
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	--	2,414,000
	Subtotal, Built-In	--	132,877,000	0	14,134,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Pyramid Lake, NV YRTC	--	0	29	2,029,000
C. Restoration of FY 2007 Base:		--	0	0	6,447,000
	TOTAL INCREASES	--	132,877,000	29	22,610,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	(3,820,000)
	TOTAL DECREASES	--	0	0	(3,820,000)
NET CHANGE		--	**$132,877,000**	**29**	**$18,790,000**

INDIAN HEALTH SERVICE
Contract Health Services
Summary of Changes

FY 2007 CR	$520,548,000
Total estimated budget authority	517,297,000
Less Obligations	(517,297,000)
FY 2008 President's Budget	569,515,000
Less Obligations	(569,515,000)
Net Change	48,967,000
Less Obligations	(48,967,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$3,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	13,000
3	Tribal Pay Cost	--	n/a	--	8,000
4	Within Grade Increase	--	n/a	--	5,000
5	Two Days Pay	--	n/a	--	843,000
6	Increased Cost of Travel	--	30,748,000	--	1,000
7	Increased Cost of Transportation & Things	--	8,788,000	--	0
8	Increased Cost of Printing	--	850,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	26,680,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	356,807,000	--	9,999,000
11	Increased Cost of Supplies	--	87,564,000	--	380,000
12	Increased Cost of Medical or other Equipment	--	11,352,000	--	0
13	Increased Cost of Land & Structure	--	91,000	--	0
14	Increased Cost of Grants	--	1,556,859,000	--	12,017,000
15	Increased Cost of Insurance / Indemnities	--	402,000	--	1,000
16	Increased Cost of Interest / Dividends	--	125,000	--	1,000
17	Increased Cost of Service & Supply Fund	--	n/a	--	0
18	Population Growth	--	n/a	--	8,866,000
	Subtotal, Built-In	--	2,080,266,000	--	32,137,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	0	--	0
	Pyramid Lake, NV YRTC	--	0	--	0
	Subtotal, Staffing	--	0	--	0
C. Restoration of FY 2007 Base:		--	0	--	20,268,000
	TOTAL INCREASES	--	2,080,266,000	--	52,405,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(3,438,000)
	TOTAL DECREASES	--	0	--	(3,438,000)
NET CHANGE		--	**$2,080,266,000**	--	**$48,967,000**

INDIAN HEALTH SERVICE
Preventive Health
Summary of Changes

FY 2007 CR	$117,110,000
Total estimated budget authority	117,110,000
Less Obligations	(117,110,000)
FY 2008 President's Budget	129,609,000
Less Obligations	(129,609,000)
Net Change	12,499,000
Less Obligations	(12,499,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$141,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	607,000
3	Tribal Pay Cost	--	n/a	--	3,875,000
4	Within Grade Increase	--	n/a	--	197,000
5	Two Days Pay	--	n/a	--	207,000
6	Increased Cost of Travel	--	427,000	--	7,000
7	Increased Cost of Transportation & Things	--	850,000	--	21,000
8	Increased Cost of Printing	--	9,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	71,000	--	3,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	3,075,000	--	136,000
11	Increased Cost of Supplies	--	1,741,000	--	52,000
12	Increased Cost of Medical or other Equipment	--	426,000	--	10,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	85,302,000	--	1,532,000
15	Increased Cost of Insurance / Indemnities	--	10,000	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	1,997,000
	Subtotal, Built-In	--	91,911,000	0	8,785,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	0	14	1,391,000
C. Restoration of FY 2007 Base:		--	0	0	5,263,000
	TOTAL INCREASES	--	91,911,000	14	15,439,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	(2,940,000)
	TOTAL DECREASES	--	0	0	(2,940,000)
NET CHANGE		--	**$91,911,000**	**14**	**$12,499,000**

INDIAN HEALTH SERVICE
Public Health Nursing
Summary of Changes

FY 2007 CR	$48,959,000
Total estimated budget authority	48,595,000
Less Obligations	(48,595,000)
FY 2008 President's Budget	56,825,000
Less Obligations	(56,825,000)
Net Change	7,866,000
Less Obligations	(7,866,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$124,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	530,000
3	Tribal Pay Cost	--	n/a	--	976,000
4	Within Grade Increase	--	n/a	--	197,000
5	Two Days Pay	--	n/a	--	181,000
6	Increased Cost of Travel	--	261,000	--	5,000
7	Increased Cost of Transportation & Things	--	816,000	--	20,000
8	Increased Cost of Printing	--	3,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	49,000	--	3,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	1,998,000	--	100,000
11	Increased Cost of Supplies	--	1,522,000	--	28,000
12	Increased Cost of Medical or other Equipment	--	251,000	--	6,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	21,782,000	--	413,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	2,000	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	846,000
	Subtotal, Built-In	--	26,684,000	0	3,429,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	0	12	1,221,000
C. Restoration of FY 2007 Base:		--	0	0	4,358,000
	TOTAL INCREASES	--	26,684,000	12	9,008,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	(1,142,000)
	TOTAL DECREASES	--	0	0	(1,142,000)
NET CHANGE		--	**$26,684,000**	**12**	**$7,866,000**

INDIAN HEALTH SERVICE
Health Education
Summary of Changes

FY 2007 CR	$13,584,000
Total estimated budget authority	13,584,000
Less Obligations	(13,584,000)
FY 2008 President's Budget	15,229,000
Less Obligations	(15,229,000)
Net Change	1,645,000
Less Obligations	(1,645,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$16,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	73,000
3	Tribal Pay Cost	--	n/a	--	426,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	25,000
6	Increased Cost of Travel	--	100,000	--	2,000
7	Increased Cost of Transportation & Things	--	31,000	--	1,000
8	Increased Cost of Printing	--	6,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	5,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	458,000	--	11,000
11	Increased Cost of Supplies	--	199,000	--	23,000
12	Increased Cost of Medical or other Equipment	--	173,000	--	4,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	9,909,000	--	171,000
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	--	232,000
	Subtotal, Built-In	--	10,881,000	0	984,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	0	2	170,000
C. Restoration of FY 2007 Base		--	0	0	798,000
	TOTAL INCREASES	--	10,881,000	2	1,952,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	(307,000)
				0	
	TOTAL DECREASES	--	0	--	(307,000)
NET CHANGE		--	**$10,881,000**	--	**$1,645,000**

INDIAN HEALTH SERVICE
Community Health Representatives
Summary of Changes

FY 2007 CR	$52,946,000
Total estimated budget authority	52,946,000
Less Obligations	(52,946,000)
FY 2008 President's Budget	55,795,000
Less Obligations	(55,795,000)
Net Change	2,849,000
Less Obligations	(2,849,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$1,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	4,000
3	Tribal Pay Cost	--	n/a	--	2,398,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	1,000
6	Increased Cost of Travel	--	66,000	--	0
7	Increased Cost of Transportation & Things	--	3,000	--	0
8	Increased Cost of Printing	--	3,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	17,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	619,000	--	25,000
11	Increased Cost of Supplies	--	20,000	--	1,000
12	Increased Cost of Medical or other Equipment	--	2,000	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	51,990,000	--	919,000
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	--	892,000
	Subtotal, Built-In	--	52,720,000	0	4,241,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	0	0
C. Restoration of FY 2007 Base:		--	0	0	54,000
	TOTAL INCREASES	--	52,720,000	0	4,295,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,446,000)
	TOTAL DECREASES	--	0	--	(1,446,000)
NET CHANGE		--	**$52,720,000**	--	**$2,849,000**

INDIAN HEALTH SERVICE
Immunization AK
Summary of Changes

FY 2007 CR	$1,621,000
Total estimated budget authority	1,621,000
Less Obligations	(1,621,000)
FY 2008 President's Budget	1,760,000
Less Obligations	(1,760,000)
Net Change	139,000
Less Obligations	(139,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$0
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	75,000
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, & Utilties	--	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	--	1,621,000	--	29,000
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	--	27,000
	Subtotal, Built-In	--	1,621,000	0	131,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	0	0	0
	Pyramid Lake, NV YRTC	--	0	0	0
	Subtotal, Staffing	--	0	0	0
C. Restoration of FY 2007 Base:		--	0	0	53,000
	TOTAL INCREASES	--	1,621,000	--	184,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	(45,000)
	TOTAL DECREASES	--	0	0	(45,000)
NET CHANGE		--	**$1,621,000**	--	**$139,000**

INDIAN HEALTH SERVICE
Other
Summary of Changes

FY 2007 CR	$398,769,000
Total estimated budget authority	398,769,000
Less Obligations	(398,769,000)
FY 2008 President's Budget	376,591,000
Less Obligations	(376,591,000)
Net Change	(22,178,000)
Less Obligations	22,178,000

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$238,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	994,000
3	Tribal Pay Cost	--	n/a	--	740,000
4	Within Grade Increase	--	n/a	--	372,000
5	Two Days Pay	--	n/a	--	341,000
6	Increased Cost of Travel	--	1,862,000	--	45,000
7	Increased Cost of Transportation & Things	--	262,000	--	3,000
8	Increased Cost of Printing	--	92,000	--	2,000
9	Increased Cost of Rents, Communications, & Utilties	--	491,000	--	13,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	7,024,000	--	100,000
11	Increased Cost of Supplies	--	974,000	--	13,000
12	Increased Cost of Medical or other Equipment	--	430,000	--	23,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	341,866,000	--	7,175,000
15	Increased Cost of Insurance / Indemnities	--	22,000	--	1,000
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	--	353,023,000	--	10,060,000
B. Contract Support Costs Increase		--	0	0	10,058,000
C. Restoration of FY 2007 Base		--	0	--	2,470,000
	TOTAL INCREASES	--	353,023,000	--	12,530,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,964,000)
B. Program Decrease:					
	Urban Indian Health Program	--	0	--	(32,744,000)
	TOTAL DECREASES	--	0	--	(34,708,000)
NET CHANGE		--	**$353,023,000**	--	**($22,178,000)**

INDIAN HEALTH SERVICE
Urban Indian Health
Summary of Changes

FY 2007 CR	$32,744,000
Total estimated budget authority	32,744,000
Less Obligations	0
FY 2008 President's Budget	0
Less Obligations	0
Net Change	(32,744,000)
Less Obligations	0

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$0
2	FY 2008 Pay Raise at 3% (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	--	90,000	--	0
7	Increased Cost of Transportation & Things	--	16,000	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	17,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	2,640,000	--	0
11	Increased Cost of Supplies	--	6,000	--	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	--	29,246,000	--	0
15	Increased Cost of Insurance / Indemnities	--	3,000	--	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	--	32,020,000	--	0
	TOTAL INCREASES	--	32,020,000	--	0
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Program Decreases:					
	Urban Indian Health Program	--	0	--	(32,744,000)
	TOTAL DECREASES	--	0	--	(32,744,000)
NET CHANGE		--	**$32,020,000**	--	**($32,744,000)**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2007 CR	$31,039,000
Total estimated budget authority	31,036,000
Less Obligations	(31,036,000)
FY 2008 President's Budget	31,866,000
Less Obligations	(31,866,000)
Net Change	827,000
Less Obligations	(827,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$10,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	43,000
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	15,000
6	Increased Cost of Travel	--	92,000	--	2,000
7	Increased Cost of Transportation & Things	--	2,000	--	0
8	Increased Cost of Printing	--	36,000	--	1,000
9	Increased Cost of Rents, Communications, & Utilties	--	137,000	--	1,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	125,000	--	6,000
11	Increased Cost of Supplies	--	40,000	--	0
12	Increased Cost of Medical or other Equipment	--	8,000	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	28,643,000	--	705,000
15	Increased Cost of Insurance / Indemnities	--	5,000	--	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	--	29,088,000	--	783,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Restoration of FY 2007 Base:		--	0	--	175,000
	TOTAL INCREASES	--	29,088,000	--	958,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(131,000)
	TOTAL DECREASES	--	0	--	(131,000)
NET CHANGE		--	**$29,088,000**	--	**$827,000**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2007 CR	$2,394,000
Total estimated budget authority	2,394,000
Less Obligations	(2,394,000)
FY 2008 President's Budget	2,529,000
Less Obligations	(2,529,000)
Net Change	135,000
Less Obligations	(135,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$0
2	FY 2008 Pay Raise at 3% (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	--	7,000	--	0
7	Increased Cost of Transportation & Things	--	1,000	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	2,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	24,000	--	1,000
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	--	2,360,000	--	102,000
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	--	2,394,000	--	103,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Restoration of FY 2007 Base:		--	0	--	44,000
	TOTAL INCREASES	--	2,394,000	--	147,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(12,000)
	TOTAL DECREASES	--	0	--	(12,000)
NET CHANGE		--	**$2,394,000**	--	**$135,000**

INDIAN HEALTH SERVICE
Direct Operations
Summary of Changes

FY 2007 CR	$62,194,000
Total estimated budget authority	62,194,000
Less Obligations	(62,194,000)
FY 2008 President's Budget	64,632,000
Less Obligations	(64,632,000)
Net Change	2,438,000
Less Obligations	(2,438,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$224,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	931,000
3	Tribal Pay Cost	--	n/a	--	740,000
4	Within Grade Increase	--	n/a	--	372,000
5	Two Days Pay	--	n/a	--	319,000
6	Increased Cost of Travel	--	1,560,000	--	40,000
7	Increased Cost of Transportation & Things	--	241,000	--	3,000
8	Increased Cost of Printing	--	56,000	--	1,000
9	Increased Cost of Rents, Communications, & Utilties	--	335,000	--	12,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	2,895,000	--	72,000
11	Increased Cost of Supplies	--	585,000	--	12,000
12	Increased Cost of Medical or other Equipment	--	322,000	--	20,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	14,340,000	--	263,000
15	Increased Cost of Insurance / Indemnities	--	0	--	1,000
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	--	20,334,000	--	3,010,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Restoration of FY 2007 Base:		--	0	--	774,000
	TOTAL INCREASES	--	20,334,000	--	3,784,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,346,000)
	TOTAL DECREASES	--	0	--	(1,346,000)
NET CHANGE		--	**$20,334,000**	--	**$2,438,000**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2007 CR	$5,668,000
Total estimated budget authority	5,668,000
Less Obligations	(5,668,000)
FY 2008 President's Budget	5,928,000
Less Obligations	(5,928,000)
Net Change	260,000
Less Obligations	(260,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$4,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	20,000
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	7,000
6	Increased Cost of Travel	--	113,000	--	3,000
7	Increased Cost of Transportation & Things	--	2,000	--	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	--	1,340,000	--	21,000
11	Increased Cost of Supplies	--	343,000	--	1,000
12	Increased Cost of Medical or other Equipment	--	98,000	--	3,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	2,547,000	--	158,000
15	Increased Cost of Insurance / Indemnities	--	14,000	--	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	--	4,457,000	--	217,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Restoration of FY 2007 Base:		--	0	--	76,000
	TOTAL INCREASES	--	4,457,000	--	293,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(33,000)
	TOTAL DECREASES	--	0	--	(33,000)
NET CHANGE		--	**$4,457,000**	--	**$260,000**

INDIAN HEALTH SERVICE
Contract Support Costs
Summary of Changes

FY 2007 CR	$264,730,000
Total estimated budget authority	264,730,000
Less Obligations	(264,730,000)
FY 2008 President's Budget	271,636,000
Less Obligations	(271,636,000)
Net Change	6,906,000
Less Obligations	(6,906,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	$0
2	FY 2008 Pay Raise at 3% (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	--	0	--	5,947,000
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	--	264,730,000	--	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	--	264,730,000	--	5,947,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Restoration of FY 2007 Base:		--	0	--	1,401,000
	TOTAL INCREASES	--	264,730,000	--	7,348,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(442,000)
	TOTAL DECREASES	--	0	--	(442,000)
NET CHANGE		--	**$264,730,000**	--	**$6,906,000**

INDIAN HEALTH SERVICE
FACILITIES
Summary of Changes

FY 2007 CR	$363,573,000
Total estimated budget authority	363,573,000
Less Obligations	(363,573,000)
FY 2008 President's Budget	339,196,000
Less Obligations	(339,196,000)
Net Change	(24,377,000)
Less Obligations	24,377,000

	FY 2007 CR Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	463,000
2 FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	1,877,000
3 Tribal Pay Cost	--	n/a	--	1,820,000
4 Within Grade Increase	--	n/a	--	712,000
5 Two Days Pay	--	n/a	--	641,000
6 Increased Cost of Travel	--	2,820,000	--	77,000
7 Increased Cost of Transportation & Things	--	3,431,000	--	80,000
8 Increased Cost of Printing	--	57,000	--	3,000
9 Increased Cost of Rents, Communications, & Utilties	--	15,874,000	--	347,000
10 Increased Cost of Health Care Provided under Contracts & Grants	--	100,772,000	--	2,049,000
11 Increased Cost of Supplies	--	6,820,000	--	179,000
12 Increased Cost of Medical or other Equipment	--	10,102,000	--	317,000
13 Increased Cost of Land & Structure	--	29,110,000	--	144,000
14 Increased Cost of Grants	--	105,269,000	--	2,833,000
15 Increased Cost of Insurance / Indemnities	--	15,000	--	0
16 Increased Cost of Interest / Dividends	--	11,000	--	23,000
17 Increased Cost of Service & Supply Fund	--	0	--	0
18 Population Growth	--	0	--	2,577,000
Subtotal, Built-In	--	274,281,000	--	14,142,000
B. Phasing-In of Staff & Operating Cost of New Facilities:				
Muskogee, OK Joint Venture	--	0	--	1,486,000
C. Restoration of FY 2007 Base:	--	0	--	0
TOTAL INCREASES	--	274,281,000	--	15,628,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(11,371,000)
B. Base Funding Reduction	--	0	--	(28,634,000)
TOTAL DECREASES	--	0	--	(40,005,000)
NET CHANGE	**--**	**$274,281,000**	**--**	**($24,377,000)**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2007 CR	$52,254,000
Total estimated budget authority	52,254,000
Less Obligations	(52,254,000)
FY 2008 President's Budget	51,936,000
Less Obligations	(51,936,000)
Net Change	(318,000)
Less Obligations	318,000

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	0
2	FY 2008 Pay Raise at 3% (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	--	40,000	--	3,000
7	Increased Cost of Transportation & Things	--	42,000	--	1,000
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	87,000	--	3,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	12,711,000	--	284,000
11	Increased Cost of Supplies	--	3,415,000	--	94,000
12	Increased Cost of Medical or other Equipment	--	962,000	--	10,000
13	Increased Cost of Land & Structure	--	7,873,000	--	143,000
14	Increased Cost of Grants	--	27,119,000	--	710,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	5,000	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	52,254,000	--	1,248,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Restoration of FY 2007 Base:		--	0	--	0
	TOTAL INCREASES	--	52,254,000	--	1,248,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,248,000)
B. Base Funding Reduction		--	0	--	(318,000)
	TOTAL DECREASES	--	0	--	(1,566,000)
NET CHANGE		**--**	**$52,254,000**	**--**	**($318,000)**

INDIAN HEALTH SERVICE
Sanitation Facilities Construction
Summary of Changes

FY 2007 CR	$93,259,000
Total estimated budget authority	93,259,000
Less Obligations	(93,259,000)
FY 2008 President's Budget	88,500,000
Less Obligations	(88,500,000)
Net Change	(4,759,000)
Less Obligations	4,759,000

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	0
2	FY 2008 Pay Raise at 3% (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	--	122,000	--	4,000
7	Increased Cost of Transportation & Things	--	770,000	--	21,000
8	Increased Cost of Printing	--	19,000	--	1,000
9	Increased Cost of Rents, Communications, & Utilties	--	29,000	--	3,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	67,800,000	--	1,520,000
11	Increased Cost of Supplies	--	569,000	--	20,000
12	Increased Cost of Medical or other Equipment	--	48,000	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	15,599,000	--	487,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	4,000	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	84,960,000	--	2,056,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Restoration of FY 2007 Base:		--	0	--	0
	TOTAL INCREASES	--	84,960,000	--	2,056,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(2,056,000)
B. Base Funding Reduction		--	0	--	(4,759,000)
	TOTAL DECREASES	--	0	--	(6,815,000)
NET CHANGE		**--**	**$84,960,000**	**--**	**($4,759,000)**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2007 CR	$36,664,000
Total estimated budget authority	36,664,000
Less Obligations	(36,664,000)
FY 2008 President's Budget	12,664,000
Less Obligations	(12,664,000)
Net Change	(24,000,000)
Less Obligations	(24,000,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	0
2	FY 2008 Pay Raise at 3% (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	--	10,000	--	0
8	Increased Cost of Printing	--	1,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	47,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	11,235,000	--	0
11	Increased Cost of Supplies	--	6,000	--	0
12	Increased Cost of Medical or other Equipment	--	1,389,000	--	0
13	Increased Cost of Land & Structure	--	21,181,000	--	0
14	Increased Cost of Grants	--	2,794,000	--	0
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	1,000	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	36,664,000	--	0
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. Restoration of FY 2007 Base:		--	0	--	0
	TOTAL INCREASES	--	36,664,000	--	0
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Base Funding Reduction		--	0	--	(24,000,000)
	TOTAL DECREASES	--	0	--	(24,000,000)
NET CHANGE		**--**	**$36,664,000**	**--**	**($24,000,000)**

INDIAN HEALTH SERVICE
Facilities & Environmental Health Support
Summary of Changes

FY 2007 CR	$160,046,000
Total estimated budget authority	160,046,000
Less Obligations	(160,046,000)
FY 2008 President's Budget	164,826,000
Less Obligations	(164,826,000)
Net Change	4,780,000
Less Obligations	(4,780,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	463,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	1,877,000
3	Tribal Pay Cost	--	n/a	--	1,820,000
4	Within Grade Increase	--	n/a	--	712,000
5	Two Days Pay	--	n/a	--	641,000
6	Increased Cost of Travel	--	2,658,000	--	70,000
7	Increased Cost of Transportation & Things	--	2,542,000	--	58,000
8	Increased Cost of Printing	--	37,000	--	2,000
9	Increased Cost of Rents, Communications, & Utilties	--	15,583,000	--	336,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	8,243,000	--	227,000
11	Increased Cost of Supplies	--	2,776,000	--	64,000
12	Increased Cost of Medical or other Equipment	--	2,035,000	--	35,000
13	Increased Cost of Land & Structure	--	54,000	--	1,000
14	Increased Cost of Grants	--	45,110,000	--	1,053,000
15	Increased Cost of Insurance / Indemnities	--	15,000	--	0
16	Increased Cost of Interest / Dividends	--	0	--	23,000
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	2,577,000
	Subtotal, Built-In	--	79,053,000	--	9,959,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	0	--	1,486,000
C. Restoration of FY 2007 Base:		--	0	--	523,000
	TOTAL INCREASES	--	79,053,000	--	11,968,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(7,188,000)
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	(7,188,000)
NET CHANGE		**--**	**$79,053,000**	**--**	**$4,780,000**

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

FY 2007 CR	$86,348,000
Total estimated budget authority	86,348,000
Less Obligations	(86,348,000)
FY 2008 President's Budget	89,473,000
Less Obligations	(89,473,000)
Net Change	3,125,000
Less Obligations	(3,125,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	211,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	925,000
3	Tribal Pay Cost	--	n/a	--	896,000
4	Within Grade Increase	--	n/a	--	350,000
5	Two Days Pay	--	n/a	--	316,000
6	Increased Cost of Travel	--	815,000	--	18,000
7	Increased Cost of Transportation & Things	--	1,015,000	--	23,000
8	Increased Cost of Printing	--	13,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	14,567,000	--	315,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	4,265,000	--	175,000
11	Increased Cost of Supplies	--	1,946,000	--	40,000
12	Increased Cost of Medical or other Equipment	--	1,061,000	--	12,000
13	Increased Cost of Land & Structure	--	54,000	--	1,000
14	Increased Cost of Grants	--	22,068,000	--	519,000
15	Increased Cost of Insurance / Indemnities	--	10,000	--	0
16	Increased Cost of Interest / Dividends	--	3,000	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	1,392,000
	Subtotal, Built-In	--	45,817,000	--	5,193,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	0	--	1,486,000
C. Restoration of FY 2007 Base:		--	0	--	282,000
	TOTAL INCREASES	--	45,817,000	--	6,961,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(3,836,000)
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	(3,836,000)
NET CHANGE		**--**	**$45,817,000**	**--**	**$3,125,000**

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

FY 2007 CR	$59,893,000
Total estimated budget authority	59,893,000
Less Obligations	(59,893,000)
FY 2008 President's Budget	61,214,000
Less Obligations	(61,214,000)
Net Change	1,321,000
Less Obligations	(1,321,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	202,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	759,000
3	Tribal Pay Cost	--	n/a	--	736,000
4	Within Grade Increase	--	n/a	--	280,000
5	Two Days Pay	--	n/a	--	259,000
6	Increased Cost of Travel	--	1,160,000	--	30,000
7	Increased Cost of Transportation & Things	--	1,459,000	--	33,000
8	Increased Cost of Printing	--	21,000	--	1,000
9	Increased Cost of Rents, Communications, & Utilties	--	530,000	--	9,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	1,991,000	--	29,000
11	Increased Cost of Supplies	--	741,000	--	14,000
12	Increased Cost of Medical or other Equipment	--	884,000	--	21,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	21,541,000	--	502,000
15	Increased Cost of Insurance / Indemnities	--	5,000	--	0
16	Increased Cost of Interest / Dividends	--	2,000	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	954,000
	Subtotal, Built-In	--	28,334,000	--	3,829,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	0	--	0
C. Restoration of FY 2007 Base:		--	0	--	196,000
	TOTAL INCREASES	--	28,334,000	--	4,025,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(2,704,000)
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	(2,704,000)
NET CHANGE		**--**	**$28,334,000**	**--**	**$1,321,000**

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

FY 2007 CR	$13,805,000
Total estimated budget authority	13,805,000
Less Obligations	(13,805,000)
FY 2008 President's Budget	14,139,000
Less Obligations	(14,139,000)
Net Change	334,000
Less Obligations	(334,000)

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	50,000
2	FY 2008 Pay Raise at 3% (9 mos.)	--	n/a	--	193,000
3	Tribal Pay Cost	--	n/a	--	188,000
4	Within Grade Increase	--	n/a	--	82,000
5	Two Days Pay	--	n/a	--	66,000
6	Increased Cost of Travel	--	683,000	--	22,000
7	Increased Cost of Transportation & Things	--	68,000	--	2,000
8	Increased Cost of Printing	--	3,000	--	1,000
9	Increased Cost of Rents, Communications, & Utilties	--	486,000	--	12,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	1,987,000	--	23,000
11	Increased Cost of Supplies	--	89,000	--	10,000
12	Increased Cost of Medical or other Equipment	--	90,000	--	2,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	1,501,000	--	32,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	(5,000)	--	23,000
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	231,000
	Subtotal, Built-In	--	4,902,000	--	937,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	0	--	0
C. Restoration of FY 2007 Base:		--	0	--	45,000
	TOTAL INCREASES	--	4,902,000	--	982,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(648,000)
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	(648,000)
NET CHANGE		**--**	**$4,902,000**	**--**	**$334,000**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2007 CR	$21,350,000
Total estimated budget authority	21,350,000
Less Obligations	(21,350,000)
FY 2008 President's Budget	21,270,000
Less Obligations	(21,270,000)
Net Change	(80,000)
Less Obligations	80,000

		FY 2007 CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2007 Pay Raise at 2.2 & 2.7% (3 mos.)	--	n/a	--	0
2	FY 2008 Pay Raise at 3% (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	--	67,000	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	128,000	--	5,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	783,000	--	18,000
11	Increased Cost of Supplies	--	54,000	--	1,000
12	Increased Cost of Medical or other Equipment	--	5,668,000	--	272,000
13	Increased Cost of Land & Structure	--	2,000	--	0
14	Increased Cost of Grants	--	14,647,000	--	583,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	1,000	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	21,350,000	--	879,000
B. Phasing-In of Staff & Operating Cost of New Facilities:					
	Muskogee, OK Joint Venture	--	0	--	0
C. Restoration of FY 2007 Base:		--	0	--	0
	TOTAL INCREASES	--	21,350,000	--	879,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(879,000)
B. Base Funding Reduction		--	0	--	(80,000)
	TOTAL DECREASES	--	0	--	(959,000)
NET CHANGE		**--**	**$21,350,000**	**--**	**($80,000)**

INDIAN HEALTH SERVICE

Budget Authority by Activity

(Dollars in Thousands)

	2006 Actual		2007 CR		2008 Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES:						
Hospitals & Health Clinics	6,494	$1,339,488	6,503	$1,339,488	6,590	$1,493,534
Dental Services	730	117,731	738	117,731	757	135,755
Mental Health	269	58,455	269	58,455	272	64,538
Alcohol & Substance Abuse	164	143,198	163	143,198	175	161,988
Contract Health Services	1	517,297	1	520,548	1	569,515
Total Clinical Services	7,658	2,176,169	7,674	2,179,420	7,795	2,425,330
Public Health Nursing	239	48,959	243	48,959	249	56,825
Health Education	24	13,584	25	13,584	26	15,229
Comm. Health Reps.	6	52,946	6	52,946	6	55,795
Immunization AK	0	1,621	0	1,621	0	1,760
Total Preventive Health	269	117,110	274	117,110	281	129,609
Urban Health	7	32,744	7	32,744	0	0
Indian Health Professions	29	31,039	29	31,039	29	31,866
Tribal Management	0	2,394	0	2,394	0	2,529
Direct Operations	366	62,194	364	62,194	367	64,632
Self-Governance	7	5,668	7	5,668	7	5,928
Contract Support Costs	0	264,730	0	264,730	0	271,636
Total Services	8,336	2,692,048	8,355	2,695,299	8,479	2,931,530
FACILITIES:						
Maintenance & Improvement	0	51,633	0	52,254	0	51,936
Sanitation Facilities Constr.	194	92,143	193	93,259	195	88,500
Health Care Facs. Constr.	0	37,779	0	36,664	0	12,664
Facil. & Envir. Health Supp.	1,080	150,709	1,087	160,046	1,106	164,826
Equipment	0	20,947	0	21,350	0	21,270
Total Facilities	1,274	$353,211	1,280	$363,573	1,301	339,196
Total IHS	9,610	$3,045,259	9,635	$3,058,872	9,780	3,270,726

DEPARTMENT OF HEALTH AND HUMAN SERVICES

INDIAN HEALTH SERVICE

Budget Authority by Object

(Dollars in Thousands)

	FY 2007 CR	FY 2008 Budget	FY 2008 +/- FY 2007
Full-time equivalent employment	15,356	15,501	145
Full-time equivalent of overtime and holiday hours	304	304	0
Average SES salary	$168,803	$173,867	5,064
Average GS grade	8.2	8.2	0
Average GS salary	$51,879	$53,435	1,556
Personnel Compensation:			
Full-Time Permanent (11.0)	$385,191	$405,735	$20,544
Other than Full-Time Permanent (11.3)	25,855	27,065	1,210
Other Personnel Comp. (11.5)	33,329	34,502	1,173
Military Personnel Comp (11.7)	93,467	98,850	5,383
Special Personal Services Payments (11.8)	139	139	0
Subtotal, Personnel Compensation	537,981	566,291	28,310
Civilian Personnel Benefits (12.1)	120,291	126,744	6,453
Military Personnel Benefits (12.2)	41,274	43,408	2,134
Benefits to Former Personnel (13.0)	6,418	6,419	1
Subtotal, Pay Costs	**705,964**	**742,862**	**36,898**
Travel (21.0)	33,659	36,339	2,680
Transportation of Things (22.0)	11,754	12,538	784
Rental Payments to GSA (23.1)	5,710	6,294	584
Rental Payments to Others (23.2)	1,775	1,903	128
Communications, Utilities & Misc. Charges (23.3)	28,928	29,956	1,028
Printing and Reproduction (24.0)	903	977	74
Other Contractual Services:			
Advisory and Assistance Services (25.1)	13,133	12,865	(268)
Other Services (25.2)	159,984	156,308	(3,676)
Purchases from Govt. Accts. (25.3)	48,149	54,127	5,978
Operation and Maintenance of Facilities (25.4)	10,119	11,078	959
Research and Development Contracts (25.5)	0	0	0
Medical Care (25.6)	243,676	270,613	26,937
Operation and Maintenance of Equipment (25.7)	7,345	7,889	544
Subsistence and Support of Persons (25.8)	2,431	521	(1,910)
Subtotal, Other Contractual Current	**484,837**	**513,401**	**28,564**
Supplies and Materials (26.0)	95,466	105,846	10,380
Equipment (31.0)	25,069	25,697	628
Land & Structures (32.0)	29,146	15,239	(13,907)
Investments & Loans (33.0)	0	0	0
Grants, Subsidies, & Constributions (41.0)	1,634,875	1,778,811	143,936
Insurance Claims & Indemnities (42.0)	678	723	45
Interest & Dividends (43.0)	108	140	32
Subtotal Non-Pay Costs	**2,352,908**	**2,527,864**	**174,956**
Total Budget Authority by Object Class	**$3,058,872**	**$3,270,726**	**$211,854**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
Salaries and Expenses
(Budget Authority - Dollars in Thousands)

Object Class	FY 2007 CR	FY 2008 Budget	Increase or Decrease
Personnel Compensation:			
Full-Time Permanent (11.0)	385,191	405,735	20,544
Other than Full-Time Permanent (11.3)	25,855	27,065	1,210
Other Personnel Comp. (11.5)	33,329	34,502	1,173
Military Personnel Comp. (11.7)	93,467	98,850	5,383
Special Personnel Services Payments (11.8)	139	139	0
Subtotal, Personnel Compensation	537,981	566,291	28,310
Civilian Personnel Benefits (12.1)	120,291	126,744	6,453
Millitary Personnel Benefits (12.2)	41,274	43,408	2,134
Benefits to Former Personnel (13.0)	6,418	6,419	1
Subtotal, Pay Costs	705,964	742,862	36,898
Travel (21.0)	14,243	18,169	3,926
Transportation of Things (22.0)	11,754	12,538	784
Rental Payments to Others (23.2)	1,775	1,903	128
Communications, Utilities & Misc. Charges (23.3)	28,928	29,956	1,028
Printing and Reproduction (24.0)	903	977	74
Other Contractual Services:			
Advisory and Assistance Services (25.1)	13,133	12,865	(268)
Other Services (25.2)	159,984	156,308	(3,676)
Purchases from Govt. Accts. (25.3)	48,149	54,127	5,978
Operation and Maintenance of Facilities (25.4)	10,119	11,078	959
Operation and Maintenance of Equipment (25.7)	7,345	7,889	544
Subsistance and Support of Persons (25.8)	2,431	521	(1,910)
Subtotal, Other Contractual	241,161	242,788	1,627
Supplies and Materials (26.0)	95,466	105,846	10,380
Subtotal, Non-Pay Costs	394,230	412,177	17,947
Total Salaries & Expenses	1,100,194	1,155,039	54,845

SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2008 CONGRESSIONAL JUSTIFICATION
House Report No. 109-465

Item
Dental program -- The budget continues funding in the dental program for Clinical and Preventive Support Centers. This is a critical national effort and the Committee expects the Service to continue to manage and fund these programs through IHS headquarters. These funds should not be subject to tribal share distributions. (page 169)

Action taken or to be taken
Eight support centers are currently funded through our national dental program, providing services to nine of our 12 geographic areas. Activities include the provision of culturally appropriate health education materials and presentations, on-site program reviews, local and regional continuing education opportunities for our providers and staff, information about our Government Performance and Results Act (GPRA) measures and suggestions on how to meet annual goals, the promotion of water fluoridation and other preventive measures, and other services requested and perceived to be of value by IHS dental and tribal dental personnel. Virtually none of these services were provided prior to the funding of our dental support center project. These services have resulted in higher quality services delivered to our Native American patients, a higher proportion of annual GPRA goals achieved, the fluoridation of numerous tribal water utilities, and an expressed appreciation for our centers by our dental personnel. It is the opinion of the IHS/HHS legal counsel that these funds are not subject to Tribal shares.

Item
Contract Support Cost Policy -- The Service should complete its revision of its contract support cost policy as soon as possible. The Committee will consider providing funding for new and expanded contracts in future fiscal years based upon the revised policy. (page 170)

Action taken or to be taken
On September 7, 2006, the Director of IHS, announced to Tribal Leaders that he would implement a temporary change to the existing IHS Contract Support Cost Policy (CSC), Circular No. 2004-03, for the FY 2007 through FY 2010 funding periods. The change affects the allocation methodology for CSC associated with new or expanded awards under P.L. 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), as amended. The CSC associated with new or expanded awards will be allocated at the average level of CSC funding paid to all existing, ongoing P.L. 93-638 awards. The policy change, which is consistent with the Committee's instruction, was formally adopted in November 2006.

To ensure responsiveness to the needs of Tribes in administering their health programs, and continued support of the IHS' commitment to the Federal Government's policy of Indian Self-Determination, the policy change will be monitored and fully evaluated by

the IHS/Tribal CSC Workgroup during the FY 2010 funding period to determine if the change should be made permanent.

Item

Urban Health Program -- Funding for the urban health program has been restored and the proposal to eliminate this program is rejected. Funding for IHS urban clinics is levered with nearly $2 for every $1 contributed by the Service. The Program Assessment Rating Tool score for the program was one point shy of "moderately effective", which is a score that many of the government programs in this bill can only hope to achieve in the future. The Committee encourages the Service to work with HHS to help these clinics get additional funding through the Community Health Centers program and to work with the individual clinics on continued improvements in health services delivery. (page 170)

Action taken or to be taken

Working with IHS, the CHC Program staff developed and conducted a competitive Section 330 grants training course, and addressed Federally-Qualified Health Care requirements, for all urban Indian programs on June 1, 2006 in Washington, DC. Communication, coordination, and collaboration will be continued in FY 2007. The focus will include program accreditation and training assistance to improve third party billing and board of directors' roles and responsibilities.

GPRA reporting was implemented, for the first time ever, in all urban Indian programs. They reported on 17 of 34 IHS GPRA measures in FY 2006 to establish baseline measures for future clinical assessments to determine quality of health care. Of the 34 IHS GPRA measures, 17 measures are appropriate for all of the 34 urban Indian programs. All urban Indian programs met the FY 2006 GPRA Report requirement. The draft data is currently being reviewed and analyzed for validation purposes and to determine baseline measures.

An assessment of the urban Indian programs' health information technology systems was conducted. Twenty-one programs indicated they want to acquire and implement the IHS' Resource and Patient Management System (RPMS). The IHS' Office of Information Technology developed a draft work plan and budget cost estimate for this activity in the last quarter of FY 2006. The draft work plan and budget will be finalized in FY 2007 so that work may be carried out over the next 20 months to implement this objective. The eight urban Indian programs in the California Area IHS are currently reporting on RPMS. The five remaining urban Indian programs are using off-the-shelf products in place of RPMS and are responsible for providing a bridge between their programs and RPMS.

Other FY 2006 areas of focus on improving health services included: (1) Partnered with Centers for Medicare and Medicaid Services (CMS) to develop and design an urban specific Medicare Modernization Act Part D training program. CMS conducted the training program and provided one-on-one consultation for all urban programs, March 2-3, 2006. (2) Partnered with the IHS' Office of Public Health to assure urban programs have complete information to develop emergency preparedness plans and work with local and State officials on pandemic flu planning and preparation. (3) Provided leadership,

guidance, and support to the Indigenous Games, June 25-July 9, 2006, in Denver, CO. (4) Partnered with the Office of the Secretary, Minority AIDS Office, and received funds to award HIV Rapid Testing grants, HIV/AIDS Prevention and Education grants and Case Management grants to urban Indian programs. (5) Urban Indian programs completed the FY 2006 Diabetes Audit; results will be available in FY 2007. (6) Implemented urban Indian program strategic planning activities in September 2006. The final urban Indian program strategic plan for 2006-2011 containing the urban Indian program vision, goals, objectives, activities with timeframes, and evaluation is due February 2007.

Item

Facilities Construction -- The Service needs to do a better job of requesting and justifying construction funding for its hospital and clinic facility needs. At the level of funding requested in 2007, it would take 48 years to complete the facilities on the current priority list. There are many facilities that should to be added to the list now and, in 48 years, all of the IHS facilities will need to be replaced or require major renovation. Even when the facilities construction program was much more generously funded, it took between 11 and 15 years from the time a proposal was received from a tribe until construction was completed. At the funding level requested for 2007, some facilities on the current priority list would wait more than 60 years from proposal submission until completion of construction and tribal facilities not on the list would wait considerably longer than that. Sixty years is beyond the reasonable life expectation for a hospital or clinic. Currently, about one third of the IHS-operated hospitals and health centers are more than 40 years old. (page 172)

Action taken or to be taken

The IHS maintains a five-year plan of health care facilities priority construction costs. The FY 2008 request continues construction of the highest priority inpatient facility construction project identified in the five-year plan.

The IHS is close to completing the revision of the current health care facilities priority system. This revision of the priority system was developed with Tribal consultation. It identifies a diverse need in health care facilities construction, from small clinics to inpatient facilities.

SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2008 CONGRESSIONAL JUSTIFICATION
Senate Report No. 109-275

Item
Joslin diabetes program – The budget request proposed to eliminate the direction associated with these funds. In agreement with the budget request, the Committee supports continued funding for the Alaska Federal Health Care Access Network, InPsych programs at the University of Montana and the University of North Dakota, as well as the InMed program and Recruitment of American Indians into Nursing [RAIN] program at the University of North Dakota, at no less than the current year enacted levels. The Committee remains supportive of the Service's work with the Joslin diabetes program and encourages the continuation of this collaborative effort in the coming fiscal year. (page 105)

Action taken or to be taken
The IHS supports continuation or expansion of the collaboration between IHS and the Joslin Vision Network (JVN). Considerable evidence exists to document the benefit this collaboration has brought to Indian country. By the end of FY 2006, 47 sites have been deployed in 15 States and 16,500 telemedicine studies have been performed resulting in a reduction in vision loss and blindness due to diabetes. An additional 18 sites and 8,000 telemedicine studies are scheduled to come into the network in FY 2007. Progress has occurred in the development of a portable JVN system for increasing access to small and remotely located populations, and in development of a data interface between the JVN and the IHS electronic health record. Disruption of the relationship with JVN would be harmful to patient care and ongoing efforts to improve compliance with diabetic retinopathy standards of care in Indian country using this innovative technology.

Item
Urban health centers – The Committee has included the funding level for urban health centers in the bill itself in order to underscore the importance of this program and the Committee's intention to insure that funding is continued in the Service's budget. The Committee is dismayed by reports from tribes that the Department of Health and Human Services has instructed the Service to proceed with plans to close down the 34 urban centers, despite the fact that the House Committee on Appropriations is already on record as disagreeing with the proposal for elimination. The Committee stresses that no funds were provided in fiscal year 2006 to effect the closure of these facilities and it expects the Department to refrain from any further action until House and Senate Committees on Appropriations have concluded negotiations on the 2007 budget. (page 105)

Action taken or to be taken
No urban Indian health programs were closed in FY 2006. Working with IHS, the CHC Program staff developed and conducted a competitive Section 330 grants training course, and addressed Federally-Qualified Health Care requirements, for all urban Indian programs on June 1, 2006 in Washington, DC. In FY 2007, the IHS will continue communication, coordination, and collaboration with CHC Program staff and focus on

program accreditation and training assistance to improve third party billing and board of directors' roles and responsibilities.

The 2003 OMB PART Assessment recommendation to develop baselines and targets was addressed. GPRA reporting was implemented, for the first time ever, in all urban Indian programs. Urban Indian programs reported on 17 of 34 IHS GPRA measures in FY 2006 to establish baseline measures for assessing clinical performance and quality of health care. Of the 34 IHS GPRA measures, 17 measures are appropriate for all of the 34 urban Indian programs. All urban Indian programs met the FY 2006 GPRA Report requirement. The draft data is currently being reviewed and analyzed for validation purposes and to determine baseline measures.

Other FY 2006 areas of focus on improving health services included: (1) Partnered with Centers for Medicare and Medicaid Services (CMS) to develop and design an urban specific Medicare Modernization Act Part D training program. (2) Partnered with the IHS' Office of Public Health to assure urban Indian programs have complete information to develop emergency preparedness plans and work with local and State officials on pandemic flu planning and preparation. (3) Provided leadership, guidance, and support to the Indigenous Games, June 25-July 9, 2006, in Denver, CO. (4) Partnered with the Office of the Secretary, Minority AIDS Office, and received funds to award HIV Rapid Testing grants, HIV/AIDS Prevention and Education grants and Case Management grants to urban Indian programs. (5) Urban Indian programs completed the FY 2006 Diabetes Audit; results will be available in FY 2007. (6) Implemented urban Indian program strategic planning activities in September 2006. The final urban Indian program strategic plan for 2006-2011 containing the urban Indian program vision, goals, objectives, activities with timeframes, and evaluation is due February 2007.

Item

Land acquisitions – The Committee is aware of the Service's proposal to use third party collections to acquire land in order to expand parking facilities at the W.W. Hastings Hospital in Tahlequah, Oklahoma, and authorizes the Service to proceed with the purchase. Similarly, the Committee approves of the Service's intention to use up to $2,700,000 in previously identified unobligated balances for the purchase of land for construction of the northern and southern California youth regional treatment centers. The Committee expects the Service to move forward with these two acquisitions as it was directed to do in the joint explanatory statement of the committee of conference accompanying House Report 108-792. (page 106)

Action taken or to be taken

IHS received an approval letter on December 14, 2006, from the U.S. House of Representatives Subcommittee on Interior, Environment, and Related Agencies Committee on Appropriation for the W.W. Hastings Hospital land acquisition. IHS is proceeding with the purchase action through HHS.

IHS is currently preceding with the site selection processes for the northern and southern California youth regional treatment centers. IHS will advance the purchase as expeditiously as possible once the sites are selected.

Item

Funding facility construction projects – The Committee is extremely concerned about the growing backlog of facility construction projects throughout Indian country and the failure by both the Indian Health Service and the Department of Health and Human Services to request adequate funding to meet this need. The Committee notes that multiple facility projects have been waiting for funding for several years. In fiscal year 2008, the Committee expects the Service, in conjunction with the Department, to resume a more aggressive approach to funding facilities construction and request funds for the projects now at the top of the priority list and ready to proceed, including both the Barrow and Nome, Alaska, hospitals. (page 106)

Action taken or to be taken

The IHS maintains a five-year plan of health care facilities priority construction costs. This five-year plan is updated yearly and provided to the Administration and Congress through the planning and budgeting process. It includes the highest relative need and priority projects ready for funding, which include Barrow and Nome.

The IHS is close to completing the revision of the current health care facilities priority system. This revision of the priority system was developed with Tribal consultation. It identifies a diverse need in health care facilities construction, from small clinics to inpatient facilities.

INDIAN HEALTH SERVICE

Authorizing Legislation

(Dollars in Thousands)

Jan 10, 2007

	FY 2007		FY 2008	
	Amount Authorized	CR	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.	$2,695,299	$2,695,299	$2,931,530	$2,931,530
2. Facilities Appropriation: Indian Sanitation Facilities Act P.L. 86-121, P.L. 101-512, Section 704 of the IHCIA P.L. 103-413, P.L. 102-573 P.L. 98-473, Quarters Return Funds	369,861	369,861	345,484	345,484
3. Public and Private Collections: Economy Act 31 U.S.C. 686 Section 301, P.L. 94-437, Title V of IHCIA.	700,294	700,294	700,294	700,294
4. Special Diabetes Program for Indians: 111 STAT. 574 (P.L. 105-33) 114.2763A-525, (P.L. 106-554, Sec. 432)	$150,000	$150,000	$150,000	$150,000
Unfunded authorizations:	0	0	0	0
Total appropriations:	$3,915,454	$3,915,454	$4,127,308	$4,127,308
Total appropriations against Definite authorizations:	$3,915,454	$3,915,454	$4,127,308	$4,127,308

INDIAN HEALTH SERVICE
Appropriation History Table
Services

Dec 27, 2006

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
1998	$1,835,465,000	$1,829,088,000	$1,958,235,000	$1,841,074,000
1999	$1,843,873,000	$1,932,953,000	$1,888,602,000	$1,950,322,000
Rescission	-	-	-	($1,942,000)
2000	$2,094,922,000	$2,085,407,000	$2,094,922,000	$2,078,967,000
Rescission	-	-	-	($4,794,000)
2001	$2,271,055,000	$2,106,178,000	$2,184,421,000	$2,240,658,000
Supplemental				$30,000,000
Rescission	-	-	-	($4,995,000)
2002	$2,387,014,000	$2,390,014,000	$2,388,614,000	$2,389,614,000
Rescission	-	-	-	($1,009,000)
2003	$2,513,668,000	$2,508,756,000	$2,466,280,000	$2,492,115,000
Rescission	-	-	-	($16,199,000)
2004	$2,502,393,000	$2,556,082,000	$2,546,524,000	$2,561,932,000
Rescission	-	-	-	($16,550,000)
Rescission	-	-	-	($15,018,000)
2005	$2,612,824,000	$2,627,918,000	$2,633,624,000	$2,632,667,000
Rescission				($15,638,000)
Rescission				($20,936,000)
2006	$2,732,298,000	$2,732,298,000	$2,732,323,000	$2,732,298,000
Rescission				($13,006,000)
Rescission				($27,192,000)
2007	$2,822,449,000	$2,830,085,000	$2,835,493,000	
2008	$2,931,530,000			

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

Dec 27, 2006

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
1998	$286,535,000	$257,310,000	$168,401,000	$257,538,000
1999	$274,476,000	$313,175,000	$263,516,000	$289,465,000
Supplemental	-	-	-	$2,500,000
2000	$317,465,000	$312,478,000	$189,252,000	$318,580,000
Rescission	-	-	-	($2,025,000)
2001	$349,374,000	$336,423,000	$349,650,000	$363,904,000
Rescission	-	-	-	($801,000)
2002	$319,795,000	$369,795,000	$362,854,000	$369,487,000
2003	$370,475,000	$362,571,000	$391,865,000	$376,190,000
Rescission	-	-	-	($2,445,000)
2004	$387,269,000	$392,560,000	$391,188,000	$396,232,000
Rescission	-	-	-	($2,560,000)
Rescission	-	-	-	($2,322,000)
2005	$354,448,000	$405,453,000	$364,148,000	$394,453,000
Rescission				($2,343,000)
Rescission				($3,137,000)
2006	$315,668,000	$370,774,000	$335,643,000	$358,485,000
Rescission				($1,706,000)
Rescission				($3,569,000)
2007	$347,287,000	$363,573,000	$357,287,000	
2008	$339,196,000			

THIS PAGE LEFT BLANK INTENTIONALLY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2008 Performance Budget Submission

TABLE OF CONTENTS

THIS PAGE LEFT BLANK INTENTIONALLY

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$2,176,169,000	$2,179,420,000	$2,425,330,000	+$245,910,000
FTE	7,658	7,674	7,795	+121

SUMMARY OF THE BUDGET REQUEST

The FY 2008 budget request of $2,425,330,000 and 7,795 FTE is an increase of $245,910,000 and 121 FTE over the FY 2007 Continuing Resolution level of $2,179,420,000 and 7,674 FTE.

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

THIS PAGE LEFT BLANK INTENTIONALLY

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$1,339,488,000	$1,339,488,000	$1,493,534,000	+$154,046,000
FTE	6,494	6,503	6,590	+87
Inpatient Admissions				
IHS Direct	38,500	37,000	39,000	+2,000
Tribal Direct	20,500	20,000	21,000	+1,000
Total	**59,000**	**57,000**	**60,000**	**+3,000**
Outpatient Visits				
IHS Direct	4,470,200	4,291,400	4,400,000	+108,600
Tribal Direct	5,326,600	5,113,500	5,250,000	+136,500
Total	**9,796,800**	**9,404,900**	**9,650,000**	**+245,100**

STATEMENT OF THE BUDGET REQUEST

The budget request of $1,493,534,000 for Hospitals and Health Clinics (H&HC) funds predominantly the provision of direct, personal health care services to federally recognized American Indians and Alaska Natives (AI/AN) through IHS and Tribal hospitals and health clinics.

PROGRAM DESCRIPTION

These funds are provided to 12 Area (regional) Offices which in turn provide resource distribution, program monitoring and evaluation activities, and technical support to 163 Federal and Tribal service units (local level) for over 600 health care facilities providing care to 1.9 million AI/ANs primarily in services areas that are rural, isolated and underserved. The Hospitals and Health Clinics budget supports essential personal health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, etc. In addition, the program includes public health initiatives targeting health conditions disproportionately affecting AI/ANs such as specialized programs for diabetes, maternal and child health, youth services, communicable diseases including HIV/AIDS, tuberculosis, and hepatitis, and a continuing emphasis on women's and elders' health and disease surveillance. **These health programs support the HHS Strategic Plan objectives to reduce disparities in ethnic and racial health outcomes and to increase access to quality health care services for minority populations, including AI/AN.** Collecting, analyzing, and

interpreting health information leading to the identification of these and other health conditions as well as possible interventions is done through a network of Tribally-operated Epidemiology Centers in collaboration with a national IHS coordinating center. Information technology that supports both personal health services and public health initiatives is primarily funded through the Hospitals and Health Clinics budget. Almost *one-half* of the H&HC budget is transferred to Tribal governments or Tribal organizations under P.L. 93-638 contracts or compacts which provide these individual and community health services. This is reflected in the workload table which shows that approximately 55 percent of the outpatient workload and 35 percent of the inpatient workload is performed by Tribally managed hospitals and clinics.

FUNDING HISTORY -- Funding for the Hospitals and Health Clinics program during the past 5 years has been as follows:

Fiscal Year	Amount	FTE
2003	$1,211,988,000	6,368
2004	$1,249,781,000	6,408
2005	$1,289,418,000	6,492
2006	$1,339,488,000	6,494
2007 CR	$1,339,488,000	6,503

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $1,493,534,000 and 6,590 FTE is an increase of $154,046,000 and 87 FTE over the FY 2007 Continuing Resolution level of $1,339,488,000 and 6,503 FTE. The increase will provide:

Adjustment of CR 2007 level to current services level: +$78,648,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Costs: +$27,909,000 – The provision of these funds will support the increased pay costs of the agency. The IHS is a workforce intensive agency and the Hospitals and Health Clinics budget funds the salaries and benefits of much of the clinical staff necessary to provide health services, including physicians, nurses, imaging technicians, pharmacists, lab techs, etc., and the administrative staff necessary to manage the health program which works to eliminate disparities in health status between the AI/AN population and the rest of the U.S.

Inflation: +$15,508,000 – Additional funding is for the increased cost of providing health care using the FY 2007 Economic Assumptions. Although not as tangible as pay raises, inflation is nevertheless a real cost to the IHS and Tribal health programs.

The increasing cost of pharmaceuticals is a particular concern. IHS and Tribal programs already find it difficult to provide the latest and most effective medications (e.g., thiazolidinediones for diabetes mellitus or pegylated interferon alpha for hepatitis C) even though almost all pharmaceuticals are purchased through Federal discount programs. Medications are rationed in some cases as service unit managers put restrictions in place to ensure availability of funds through the end of the fiscal year.

Population Growth: +$21,176,000 – These additional funds will support the increased services need resulting from the growing AI/AN population. A 1.6% growth rate is projected, based on State birth and death data.

Staffing / Operating Cost Requirements for New Facilities: +$10,805,000 – The funds will provide staffing and operating costs for the facility at Muskogee, OK, which is scheduled to open August FY 2007. Funding for the staffing and operating costs for this new facility allows IHS to expand provision of health care in those areas where existing capacity is most overextended. The following table displays the requested increase.

Facility	Amount	Federal FTE	Tribal Positions
Muskogee, OK Joint Venture	$10,805,000	0	125
Grand Total:	**$10,805,000**	**0**	**125**

PERFORMANCE ANALYSIS

The IHS budget request for Hospitals and Health Clinics supports the Secretary's 500-Day Plan to close the health care gap, particularly among racial and ethnic minority populations, as well as the HHS Strategic goals and objectives. Following are brief descriptions of several activities funded through H&HC that impact performance:

Diabetes -- The agency continues to make significant progress in addressing chronic diseases. A primary focus has been in the treatment and prevention of diabetes and its complications. Diabetes continues to be a growing problem in AI/AN communities with rates increasing rapidly in the majority of IHS Areas. The incidence of the disease is increasing rapidly in younger individuals.

Supplemental funding, key Tribal involvement, collaboration with other Federal agencies and community emphasis all contributed to the IHS meeting or exceeding four of six continuing diabetes GPRA elements. Ongoing interventions include more effective pharmaceuticals, more aggressive screening for the secondary effects of diabetes, earlier intervention when complications are identified, and greater patient compliance with care regimens. The level and quality of services provided to over 100,000 diabetics throughout the IHS are audited annually to improve standardized care and patient outcomes. A wide range of IHS performance measures including foot care, eye care, end organ status, and adequacy of blood sugar control, have been incorporated into the National Committee for Quality Assurance/American Diabetes Association national performance diabetes care benchmarks. In addition, over two thirds of tribal communities now report having programs in place for community-wide prevention of

diabetes and 83 percent of tribal communities offer primary prevention programs for children and youth.

During 2008, GPRA measure #5 is to maintain the proportion of patients with diagnosed diabetes assessed for nephropathy at FY 2007 screening rate. In FY 2006 IHS met this measure which was to increase the proportion of patients with diagnosed diabetes assessed for nephropathy to 50 percent. This goal was exceeded with 55 percent of patients assessed. 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 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 measure is intended to increase screening of diabetic patients for nephropathy in order to prevent or delay kidney failure. This measure has been changed to require quantitative testing in addition to or instead of the previous qualitative screening method. Screening rates for this revised measure are expected to be lower, so the FY 2007 target is to establish a new baseline.

Accreditation -- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care, and the Centers for Medicare and Medicaid Services (CMS) regularly conduct in-depth quality reviews of IHS and Tribal hospitals. The average accreditation grid scores are consistently at or above the average score for all U.S. hospitals. The most frequently cited area for improvement is physical plant safety and efficiency. The average age of IHS facilities is greater than 30 years.

During FY 2008, GPRA measure #20 is to maintain 100 percent accreditation of all IHS-operated hospitals and outpatient clinics (excluding tribally operated facilities). IHS met this measure in FY 2006 as six IHS hospitals were evaluated by either the JCAHO or CMS; all remain fully accredited. The six hospitals surveyed in FY 2006: Eagle Butte and Rosebud surveyed by CMS; Claremore, Clinton, San Carlos and Sells surveyed by JCAHO. IHS also achieved its goal of 100 percent accreditation of ambulatory facilities. However, one Tribe retroceded its clinic to the IHS, and that facility is currently pursuing accreditation. The IHS expects to attain accreditation for this facility. Accreditation is essential for maximizing third-party collections, and contributes both directly and indirectly to improve clinical quality. The local IHS multidisciplinary team approach to accreditation and ongoing quality management, with guidance and support from Area staff, has been the mainstay of success. This is one of the most demanding measures to meet, given the growing clinical quality of care assessments that are required as well as issues related to health facilities maintenance and renovation that are critical to accreditation.

In conjunction with the GPRA measures described above, 18 other performance measures are directly related to the H&HC budget. These measures include pap smear and mammography screening, domestic violence screening, improving automated extraction

of clinical performance measures and data quality, immunization rates, community-based cardiovascular disease and obesity prevention, and reducing tobacco usage. Assessing performance data from the most current reported data demonstrates effective H&HC outcomes. GPRA data reported for FY 2006 showed that 16 GPRA measures met or exceeded their targets whereas 4 did not. The 4 that did not meet target were each only 1% under the goal; e.g. the target for pap smears was 60 percent but only 59 percent was achieved.

Emergency Preparedness – The IHS' emergency management 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, and public health infrastructure. IHS is:

(1) building capacity in public health infrastructure through linkages among its hospitals and clinics with local, county, Tribal and State agencies throughout the country;
(2) working to assure that the needs of Tribal communities are addressed by States which have received additional targeted funding for emergency preparedness and response;
(3) working with and expanding the capacity of 82 local Tribal emergency medical systems (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 Commissioned Officers for national and international emergencies as was done for the tsunami in southeast Asia and for hurricanes Katrina and Rita that hit Louisiana and Mississippi;
(5) preparing its hospitals and clinics to diagnose and treat victims of a bioterrorism or other mass casualty situation such as pandemic influenza;
(6) coordinating support for IHS and Tribal emergency preparedness programs with other governmental and non-governmental emergency preparedness programs; and
(7) participating in numerous local, regional, and national exercises to test response capabilities and enhance linkages with public safety elements at all levels.

In FY 2006, IHS developed a comprehensive emergency management program that focuses on strengthening an all-hazards response capability both in the Agency and in the AI/AN communities. This program provided key efforts in the enhancement of the Department's Emergency Preparedness Program in response to the President's *Hurricane Katrina Lessons Learned* report and in the development of pandemic influenza plans at Federal, State, local, and Tribal government levels. One of the FY 2006 Director's Performance Contract program objectives that was met was to deploy a satellite communications system. All of these efforts are in support of **HHS Departmental-wide objectives 7.a) to build the capacity of the health care system to respond to public health threats in a more timely and effective manner, and 7.c) to prepare for a potential H5N1 flu pandemic.**

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

In FY 2005, the IHS and Tribes spent approximately $275 million on pharmaceuticals. Between FY 1999 and FY 2006, IHS and Tribal pharmaceutical costs increased an average of 14.74 percent per year. The interventions to control costs include greater use of bulk purchasing methods through the Department of Veterans Affairs pharmaceutical prime vendor (about 90 percent of all purchases) and the 340B program (almost 10% of purchases), increased use of a limited but more efficacious formulary, and education of providers about specific pharmacoeconomic strategies. This effort was enhanced by the provision of resources to expand IHS pharmacy residency activities. The residency programs now operate in 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 -- The IHS program continues to focus on increasing access to preventive and curative services for the underserved in Indian communities through a strategy targeting health programs reflecting community health status to provide the most effective services to the most people. However, these prevention strategies are often difficult to maintain since the impact of the programs is often distant in time and community attention to these efforts may wane in the face of more immediate concerns such as treatment for trauma associated with family violence.

In FY 2006, the agency continued the implementation of a major initiative on Health Promotion and Disease Prevention (HP/DP); it is one of the Director's 3 health priorities. This initiative was launched in FY 2003 in order to reduce health disparities. Although the IHS is the model health system in integrating individual and community health, increased emphasis is being focused on both clinical and community-based health promotion and disease prevention efforts. The main focus is on our collective ability to develop and implement programs that will prevent disease, not focusing exclusively on treatment of disease. Some of these strategies include:

- Focusing on traditional practices and values which have a very strong role in promoting wellness.
- Promotion and implementation of effective model programs such as for breast feeding, and language and cultural training in early childhood and elementary settings.
- Continuation of the Healthy Fellowship program, teaching community members the skills needed for building healthy communities and serving as catalysts for change at the community level.
- Identification and dissemination of best practices in clinical and community-based HP/DP interventions, such as the "Just Move It" campaign.

- Engaging youth and strengthening families to address the burden of disease. The agency is working closely with the national youth organizations, such as Boys and Girls Clubs and United National Indian Tribal Youth, Inc. (UNITY), to promote healthy lifestyles for AI/AN children and youth.
- Engaging professional health experts, Federal leaders, Tribal leaders, and community leaders through the Health Promotion Task Force and Policy Advisory Committee to guide this initiative to eliminate health disparities.

In FY 2005, $2M of new funding was used to fund the Healthy Communities Fellowship program and to develop a new HP/DP grant program to support HP/DP programs at the community level; these programs have been continued in FY 2006 and 2007. The focus of the grants is on supporting healthy lifestyles and choices such as eating healthier, being physically active, and avoiding tobacco, alcohol, and other harmful substances to decrease cardiovascular disease, cancer, diabetes, obesity, and unintentional injuries. **This initiative supports the HHS Department-wide objective 19.a) to reduce unhealthy behaviors and other factors that contribute to the development of chronic diseases.**

Chronic Disease Initiative – The IHS has established a long and successful history of addressing acute, infectious diseases. Today, however, increasing chronic disease burdens continue to challenge the Indian health system. The IHS recognizes that the future of AI/AN communities depends on how effectively we address the increasing incidence of chronic diseases like diabetes, cardiovascular disease, asthma, obesity, depression, and some cancers.

In 2006, the IHS launched the Chronic Disease Initiative to effectively and efficiently address chronic disease care by creating improvements in the health care system that are reliable, patient-centered, and evidence-based. The ultimate goal will be to spread this approach to the management of chronic disease throughout the entire Indian Health System.

The Chronic Disease Initiative directs a campaign of continual and measurable improvements in our health care system to:
1. Provide knowledge, skills, and support to the Indian health system as sites explore, test, and implement fundamental system changes.
2. Facilitate the improvement work of groups of organizations within the Indian health system as they improve the quality of chronic disease care.
3. Accelerate the spread and utilization of effective practices based on the chronic care model throughout the Indian health system.

At the end of FY 2006, the Chronic Care Initiative Executive Committee began an innovative effort to bring together five Federal and one Tribal program to test foundational changes in the delivery of care for chronic disease. These health care programs will leverage healthcare delivery changes and information systems to improve patient self-management skills and patient activation, and to create patient care teams that are designed for efficiency and effectiveness. Outcome evaluation of these proposed

changes will be based upon existing performance measures. In addition, new measurements will be developed as appropriate. Experiences at local sites will be shared between these health care facilities in a collaborative fashion to increase their chances of success.

Some proposed measures and long-term goals for this collaborative process are:

- Greater than 85 percent of patients are engaged in their care and are confident in their ability to self-manage their health and any illness or condition.
- Greater than 85 percent of patients receive the evidence-based care appropriate to their health or condition.
- Greater than 85 percent of all patients will have documented plans of care utilized by members of the care team.

In FY 2007, up to five tribal and one urban program are being added to the collaborative effort. The successes that will be developed in the initial innovation will then begin to be spread to a minimum of an additional 25 sites over the next few years as a new larger group of facilities join a new collaborative effort that will be launched. This new effort will begin in FY 2008 and will utilize peer-to-peer learning based on the natural leaders who have emerged in the early phases of the initiative. These leaders will provide local sites with the knowledge and support to pursue an ever-widening campaign for ongoing health care system improvement.

Epidemiology and Disease Control – Congress first funded the innovative IHS Tribal Epidemiology Center (TEC) program in FY 1996. Initially, four TECs were selected following competition and recommendations of an objective review panel and funded up to $155,000 each through cooperative agreements. Ten years later, after the most recent competitive 5-year cooperative agreement award process, the IHS TEC program has been expanded to include eleven TECs. In FY 2008, IHS will continue to fund the national coordinating center in Albuquerque and 11 Tribal epidemiology centers through cooperative agreements with AI/AN Tribes and Tribal organizations, such as Indian health boards, at an average of approximately $400,000. Augmenting this financial support with highly-trained and experienced federal health professionals assigned to requesting TECs could result in the equivalent of an additional $80,000 to each participating TEC.

Operating from within Tribal organizations, TECs are uniquely positioned to provide support to local disease surveillance and control programs, and also in assessing the effectiveness of public health programs. In addition, TECs continue working towards improving data needed for GPRA reporting and monitoring of the Healthy People 2010 objectives. All TECs strive to monitor health status of Tribes in their region, producing reports annually or biannually for constituent Tribes. The Division of Epidemiology and Disease Prevention continues to work towards standardizing TEC reporting to be able to 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. Epidemiology centers also assist Tribes in looking at the cost of health care for Indian people in order to improve the use of resources.

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

In FY 2008, this program will continue to enhance the ability of the Indian health system to collect, manage, and utilize data more effectively to better understand and develop the link between public health problems and behavior, socioeconomic conditions, and geography. 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.

Information Technology (IT) - IT is essential to effective health care delivery and efficient resource management in the Indian Health Service. As demonstrated in the strategic performance measures sections for each of the three major IT strategic investments, IHS IT directly supports the President's Management Agenda as well as HHS and IHS strategic goals and objectives. **These efforts support the Secretary's 500-Day Plan to transform the health care system through IT.** Health care is information intensive and increasingly dependent on technology to assure that appropriate information is available whenever and wherever it is needed. IHS IT infrastructure includes people, hardware, software, communications and security that support every aspect of the IHS mission. IHS IT is based on an architecture that incorporates Federal Health Architecture guidelines and industry standards for the collection, processing and transmission of information. IHS IT is managed through three major programs as a strategic investment by senior management, fully integrated with the agency's programs, and critical to improving service delivery.

The Resource and Patient Management System (RPMS) is the IHS enterprise health information system. RPMS consists of more than 60 integrated software applications for patient care and practice management; this health information system is used at approximately 400 IHS, Tribal and urban (I/T/U) locations. IHS also maintains an

enterprise level data repository, the National Patient Reporting Information System (NPIRS), that provides a broad range of retrospective clinical and administrative information to managers at all levels of the Indian health system to allow them to better manage individual patients, local facilities, regional and national programs and to allow IHS management to provide legislatively required reports to the Administration and Congress. The IHS telecommunications infrastructure connects IHS, Tribal, and urban facilities as part of the larger HHS telecommunications network. The IHS participates in HHS enterprise-wide initiatives to improve IT infrastructure and works with the Department of Veterans Affairs and other federal partners to develop software and share technology resources. These collaborations are reflected in the IHS IT architecture and five-year plan.

Noteworthy accomplishments for IHS IT include a PART score of "Effective" for RPMS, the successful migration of NPIRS to a state-of-the-art enterprise-level data warehouse system, and adoption of Consolidated Health Informatics e-Gov standards in the IHS IT architecture. Through improvements in IT systems and infrastructure, IHS continues to more effectively measure GPRA performance measures and meet HHS reporting requirements. IT-related GPRA performance measures are included in the IHS FY 2008 Annual Performance Plan. These measures address the development of improved automated data capabilities that support clinical care and performance measurement. More detailed information is available in the Detail of Performance Analysis Section.

The IHS continues to improve its IT infrastructure to support Presidential, Secretarial and IHS goals and priorities, as documented in the Strategic Performance and Measures sections for the three IHS IT major investments. Compliance with E-Gov initiatives will dramatically improve the exchange of health care information. The Secretary's priority to accelerate the adoption of information technology in health care will reduce medical errors and improve health care quality. The IHS **Electronic Health Record (EHR)** project supports the Secretary's priority by providing computer-based physician order entry, encounter documentation, access to medical literature and other essential capabilities. The EHR project supports the **HHS Department –wide objective 8 to expand electronic government.** The RPMS Integrated Behavioral Health initiative is intended to improve treatment effectiveness by enhancing and integrating data capture, treatment guidelines and reporting for mental health, alcohol and substance abuse, and social services. These initiatives, as well as increasingly affordable health care technologies such as telemedicine, require continuous improvement of IHS IT infrastructure.

The **IHS** will contribute **$1,151,875** of its FY 2008 budget to support Department enterprise information technology initiatives as well as the President's Management Agenda (PMA) Expanding 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 the PMA 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. The HHS Department initiatives also position the Department to have a consolidated approach, ready to join in PMA initiatives.

Of the amount specified above, **$305,087** is allocated to support the President's Management Agenda Expanding E-Government initiatives for FY 2008. This amount supports the PMA E-Government initiatives of as follows:

PMA e-Gov Initiative	FY 2007 Allocation	FY 2008 Allocation
Business Gateway	$24,038	$14,507
E-Authentication	$0	$0
E-Rulemaking	$0	$0
E-Travel	$0	$50,244
Grants.Gov	$15,900	$16,377
Integrated Acquisition	$44,420	$45,776
Geospatial LOB	$0	$0
Federal Health Architecture LoB	$137,927	$134,244
Human Resources LoB	$32,015	$32,015
Grants Management LoB	$839	$1,656
Financial Management LoB	$2,779	$4,764
Budget Formulation & Execution LoB	$2,501	$2,835
IT Infrastructure LoB	$2,668	$2,668
TOTAL	**$263,087**	**$305,087**

LoB = Lines of Business

Prospective benefits from these initiatives are:

Business Gateway: Provides cross-agency access to government information including: forms; compliance assistance resources; and, tools, in a single access point. The site offers businesses various capabilities including: "issues based" search and organized agency links to answer business questions; links to help resources regarding which regulations businesses need to comply with and how to comply; online single access to government forms; and, streamlined submission processes that reduce the regulatory paperwork burdens. HHS' participation in this initiative provides HHS with an effective communication means to provide its regulations, policies, and forms applicable to the business community in a business-facing, single access point.

E-Travel: The E-Travel Program provides a standard set of travel management services government-wide. These services leverage administrative, financial and information technology best practices. By the end of FY 2006, all but one HHS OPDIV has consolidated services to GovTrip and legacy systems retired. By May 2008, all HHS travel will be conducted through this single system and the last remaining legacy functions will be retired.

Grants.gov: Allows HHS to publish grant funding opportunities and application packages online while allowing the grant community (State, local and Tribal governments, education and research organizations, non-profit organization, public housing agencies and individuals) to search for opportunities, download application forms, complete applications locally, and electronically submit applications using common forms, processes and systems. In FY 2006, HHS received over 56,000 electronic applications from the grants community via Grants.gov.

Integrated Acquisition Environment: Eliminated the need for agencies to build and maintain their own agency-specific databases, and enables all agencies to record vendor and contract information and to post procurement opportunities. It allows HHS vendor performance data to be shared across the Federal government.

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-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. The IHS Electronic Health Record (EHR) project supports the Secretary's priority by providing computer-based physician order entry, encounter documentation, access to medical literature and other essential capabilities. The RPMS Integrated Behavioral Health initiative is intended to improve treatment effectiveness by enhancing and integrating data capture, treatment guidelines and reporting for mental health, alcohol and substance abuse, and social services.

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. IHS will deploy the Unified Financial Management System (UFMS), which will positively impact the management of acquisitions, financial management, and budget execution.

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-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: A recent effort, 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.

Program Assessment Rating Tool (PART)

The H&HC sub activity was included in the Federally Administered Activities program that was evaluated using the PART. The current PART recommendations are to develop a long-term performance goal to decrease obesity rates in the AI/AN population and to develop an annual target for decreasing obesity in AI/AN children. In FY 2006, the IHS GPRA measure #31 changed its focus to childhood weight control. As a first step in addressing childhood obesity, IHS will establish the baseline proportion of children ages 2-5 years who are overweight, with a body mass index (BMI) at or above the 95th percentile. In FY 2007 and FY 2008, the GPRA goal is to maintain the proportion of children, ages 2-5 years, with a BMI of 95 percent or higher at the 2006 level. In FY 2007, the IHS is establishing a baseline rate for the proportion of 2-month-olds who are exclusively breastfeeding as at the current time this is the only intervention shown to have an impact on weight in early childhood.

Obesity is a significant factor and a compounding problem for many chronic diseases facing AI/AN people. According to data from over 400,000 patients that receive services through the IHS, 70 percent are overweight and 44 percent of our user population over age 2 is obese. To address this issue, an internal obesity initiative planning group has been formed and is setting goals and priorities for the agency in order to eliminate health disparities associated with obesity. Six goals were developed to provide a culturally appropriate framework to move AI/AN people towards healthier weights. They are:

1) enhance and create actionable data – BMI data, collected in the Resource and Patient Management System (RPMS), can be used at the local, Area or national level;
2) transform policy into action;
3) partner with Tribes to build and maximize community capacity – “Restoring Balance: Community Directed Health Promotion for AI/AN Communities” is being

updated; community mobilization strategies have been incorporated into the "2006 Healthy Beverage Action Kit" available on the IHS website.

4) create a new organizational workforce model to improve access to quality nutrition and physical activity services – the IHS cardiovascular disease program is developing telehealth services including nutritional counseling by a registered dietician.
5) enhance integrated quality care systems – an example is the chronic disease initiative; and
6) leverage and strengthen partnerships to mobilize and maximize resources.

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$117,731,000	$117,731,000	$135,755,000	$18,024,000
FTE	730	738	757	+19
Patient Visits	1,005,600	965,400	1,020,000	+54,600
Services Provided	3,078,300	2,955,200	3,100,000	+144,800

STATEMENT OF THE BUDGET REQUEST

The FY 2008 budget request of $135,755,000 for the Dental Program funds the provision of dental care to the American Indian and Alaska Native (AI/AN) population.

PROGRAM DESCRIPTION

The purpose of the Dental Program is to raise the oral health status of the AI/AN population to the highest possible level through the provision of high quality preventive and treatment services at both the community and clinic levels. The Program has been traditionally oriented toward preventive and basic care. More complex, rehabilitative care, although a legitimate need, is often deferred so that the basic services may be provided to more persons. Within the Schedule of Services, which is a service priority hierarchy used by the Dental Program, over 90 percent of services provided are basic and emergency care. Estimates of demand for treatment remain high; however, a continuing emphasis on community oral health promotion/disease prevention is essential to long-term improvement in the oral health of AI/AN people.

The Dental Program is addressing the Secretary's 500-Day Plan to transform the health care system by supporting community-based and clinic-based programs to close the health care gap among the AI/AN population.

Services which alleviate pain or prevent disease are given a higher priority than those intended to contain or correct damage caused by disease. Thus, priority is given to services such as treating dental emergencies, procedures aimed towards preventing the onset of disease and services deemed necessary for routine diagnosis and treatment to control the early stages of disease. Procedures such as complex dental restorations, crown and bridge prosthetic devices, surgical extraction of teeth, and specialty care in the

fields of orthodontics and periodontal surgery are not offered to most AI/AN people seeking treatment at IHS facilities.

Beginning in FY 2000, the IHS developed a process to build public health infrastructure through Tribal and IHS partnerships. Four Tribal health boards were funded to implement Dental Clinical and Preventive Support Centers, whose purpose is to provide technical support, training, and assistance in clinical and preventive aspects of dental programs providing care to AI/AN people. The four health boards initially funded were: Alaska Native Tribal Health Consortium, All Indian Pueblo Council, Intertribal Council of Arizona, and Northwest Portland Area Indian Health Board. In FY 2001, three additional awards were made: Confederated Salish and Kootenai Tribes of the Flathead Nation in cooperation with the Billings Area IHS, Oklahoma City Area Inter-Tribal Health Board, and the Aberdeen Area IHS. Funding awards for the Dental Clinical and Preventive Support Centers were repeated during FY 2005 and FY 2006, with a total of ten IHS geographic areas served by nine support centers. Each of the support centers approaches the objectives in a unique manner, but all strive towards providing the technical support, training and assistance needed for the improvement of access to care and quality of care provided to AI/AN people. The nine support centers continue to develop and implement the unique and innovative dental public health programs that have helped to address the dental public health needs of the communities served.

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

Fiscal Year	Amount	FTE
2003	$99,633,000	738
2004	$104,513,000	760
2005	$109,023,000	765
2006	$117,731,000	730
2007 CR	$117,731,000	738

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $135,755,000 and 757 FTE is an increase of $18,024,000 and 19 FTE over the FY 2007 Continuing Resolution level of $117,731,000 and 738 FTE. The increase will provide:

Adjustment of CR 2007 level to current services level: +$9,686,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Cost: +$2,372,000 - This will fund federal and Tribal pay cost increases which will assist the IHS in maintaining access to services for the IHS patient population. Pay

increases are critical for retaining and recruiting dental professionals to work in rural and other difficult to staff areas.

Inflation: +$1,311,000 - This additional funding will address the increased costs of providing dental services.

Population Growth: +$1,880,000 - These resources will support the dental program's ability to provide dental services to the increasing AI/AN population.

Staffing / Operating Cost Requirements for New Facilities: +$2,775,000 – These resources will fund staff at one Joint Venture project which will be open one full year in FY 2008. The following table displays the requested increase.

Facility	Amount	Federal FTE	Tribal Positions
Muskogee, OK Joint Venture	$2,775,000	0	31
Grand Total:	**$2,775,000**	**0**	**31**

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

The Healthy People 2010 goal for dental sealants is stated in terms of prevalence of sealants in children and adolescents: at least 50 percent of children age 8 and adolescents age 14 will have sealants on molar teeth by 2010. Data from the most recent IHS national oral health survey completed in 2000 indicate that 62 percent of AI/AN children and adolescents ages 6 – 14 had sealants on molar teeth. This means that by the year 2000, when the HP2010 objectives were formulated, the IHS had already surpassed the national goal set for 2010 for dental sealants. In FY 2008, the IHS Dental Program will maintain at the FY2007 target rate of 246,645 dental sealants. Identifying and treating this high risk group of children and adolescents with this proven dental preventive service directly addresses ***HHS Strategic Plan Goal 3, Objective 3.5: Expand access to health care services for targeted populations with special health care needs,*** as well as ***Secretary Leavitt's 500 Day Plan goal to transform health care systems by supporting community-based approaches to close the health care gap, particularly among racial and ethnic minority populations, including AI/AN people***.

In terms of the number of sealants applied annually, the IHS has the largest dental sealant program in the world. Each year, approximately a quarter of a million sealants are applied to the teeth of roughly 90,000 patients. While production is assessed every year,

the program is not able to assess the prevalence of sealants annually. Hence, the annual performance goal is expressed in terms of production rather than prevalence.

Another key dental performance measure of the IHS is centered on access to care. Access is defined as the timely use of personal health services to achieve the best possible health outcomes. Implicit with this definition is acceptance of the importance and interrelationship of the use of health services and desirable health outcomes. Therefore, managing access to care represents a significant challenge facing dental programs. The IHS Dental Program has developed strategies to maintain access to dental care by integrating dental programs with other health care disciplines and resources, efficient and effective use of program resources and developing conservative strategies of treatment. Increasing vacancy rates of dental providers have proved to be a significant challenge to the IHS Dental Program. The dental program continues to face challenges in the recruitment and retention of dentists due to the lack of parity with the private sector relative to pay and a 33 percent decline in the number of dentists being trained in U.S. dental schools over the past 15 years. In FY 2008, the Dental Program will plan to maintain the FY 2007 target rate of 24 percent of patients who receive dental services. Working in partnership with professional organizations, dental schools, and Tribes, efforts are being made to remedy this workforce crisis through an aggressive recruitment program. This includes use of loan repayment, scholarships, the internet and media. Doing so will address ***HHS Strategic Plan Goal 3, Objective 3.6: Increase access to health services for the AI/AN population.***

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$58,455,000	$58,455,000	$64,538,000	+$6,083,000
FTE	269	269	272	3
Outpatient Visits	276,200	265,000	278,000	+13,000

STATEMENT OF THE BUDGET REQUEST

The budget request of $64,538,000 for the Mental Health and Social Services (MH/SS) program supports mental health and social service treatment, rehabilitation, and prevention services.

PROGRAM DESCRIPTION

The purpose of the MH/SS program is to raise the behavioral health status of the American Indian and Alaska Native (AI/AN) population to the highest possible level through the provision of preventive and treatment services at both the community and clinic levels. Approximately 65 percent of these funds go directly to Tribally contracted and compacted programs in accordance with Tribal self-governance provisions of P.L. 93-638.

The IHS MH/SS program is a community-oriented clinical and preventive mental health service program that provides inpatient hospitalization, outpatient mental health and related services, crisis triage, case management, prevention programming and outreach services. The IHS MH/SS Program provides general executive direction, management and administrative support, and recruitment of MH/SS Program staff to 12 Area Offices (regional) that, in turn, provide resource distribution, program monitoring and evaluation activities, and technical support to 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/ANs and their communities.

The most common MH/SS Program model is an acute, crisis-oriented outpatient service staffed by one or more mental health professionals. On-call emergency mental health services are provided outside of usual clinic or hospital hours. Medical and clinical social work are usually provided by one or more social workers who assist with discharge

planning and provide family intervention for child abuse, suicide, domestic violence, parenting skills, and marital counseling.

Director's Behavioral Health Initiative – In FY 2005, the Director, IHS, launched the Behavioral Health Initiative which focuses on four behavioral health strategic goals: 1) mobilize Tribes and Tribal programs to promote behavioral health in systematic, evidence based approaches, which embrace traditions and culture as critical foundations for that health; 2) support and promote programmatic collaborations within communities, as well as with State and Federal programs and agencies; 3) promote leadership development from the community to national level, with training and mentorship; and 4) provide advocacy for behavioral health programming in Indian communities among Federal, State, Tribal, local, and private organizations. **This initiative also supports the HHS goal to reduce the major threats to the health and well-being of Americans including reducing behavioral health and other factors that contribute to chronic disease.**

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

FUNDING HISTORY -- Funding for the Mental Health program during the past 5 years has been as follows:

FISCAL YEAR	AMOUNT	FTE
2003	$50,297,000	255
2004	$53,294,000	253
2005	$55,060,000	252
2006	$58,455,000	269
2007 CR	$58,455,000	269

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $64,538,000 and 272 FTE is an increase of $6,083,000 and 3 FTE over the FY 2007 Continuing Resolution level of $58,455,000 and 269 FTE. The increase will provide:

Adjustment of CR 2007 level to current services level: +$2,711,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted

budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Cost: +$1,134,000 – This will fund federal and Tribal pay cost increases which will assist the IHS in maintaining access to services for the IHS patient population. Provision of these funds is necessary to maintain the current IHS and Tribal health system which works to eliminate disparities in health status between the AI/AN population and the rest of the U.S.

Inflation: +$706,000 – This additional funding will address the increased costs of providing MH/SS services.

Population Growth: +$914,000 – These resources will support the mental health program's ability to provide mental health and social services to the increasing AI/AN population.

Staffing and Operating Cost Requirements for New Facilities: +$618,000 – These resources will fund staff at one Joint Venture project which will be open one full year in FY 2008. The following table displays the requested increase.

Facility	Amount	Federal FTE	Tribal Positions
Muskogee, OK Joint Venture	$618,000	0	8
Grand Total:	**$618,000**	**0**	**8**

PERFORMANCE ANALYSIS

In evaluating performance, workload, and programs, the Government Performance and Results Act (GPRA) measures and initiatives were used. The suicide surveillance performance measure supports the **HHS Strategic Plan, Goal 1: Reducing the major threats to the health and well-being of Americans; HHS 20 Department-wide objectives, specifically portions of 19c: Reducing the incidence and consequences of injuries, violence, substance abuse, mental health problems, unintended pregnancies and sexually transmitted diseases. Program objectives and activities also support the IHS Strategic Plan, Goals 1 and 2: Build and Sustain Healthy Communities and Provide Accessible, Quality Health Care. Disparities and emergent clinical and community situations continue throughout the system, including significant tragedies that captured the nation's attention.**

The following represents specific workload activity based upon actual FY 2006 MH/SS Program data set. They reflect the most current year for which information is available from the MH/SS Program reporting system and should be considered estimates because, in accordance with P.L. 93-638, Tribes are not required to submit this information to the IHS data reporting system. The number of MH/SS client services provided and documented were 276,228 and the following categories represented approximately 60 percent of the total services provided:

- Individual Treatment – 33 percent
- Case Management – 10 percent
- Medication/Medication Management – 8 percent
- Assessments and Evaluations – 7 percent
- Family and Group Treatment – 2 percent

The suicide death rate for the AI/AN population increased in the 1990s and is currently 72 percent greater than the national average. This measure is part of an expanding systemic effort at reducing the prevalence of suicide in the AI/AN population. In FY 2005 the target for this measure was to integrate the Behavioral Health suicide reporting tool into RPMS. Suicide surveillance data can currently be entered electronically into RPMS. An electronic version of the suicide reporting form in the RPMS Electronic Health Record was released for beta testing in late FY 2005. Baseline data was collected in FY 2006. During FY 2007, we will maintain baseline data on suicide using the RPMS suicide reporting tool, and strive to increase use by 5 percent in FY 2008.

During FY 2005, IHS improved the behavioral health data system by assuring at least 55 percent of the I/T/U programs will report minimum agreed-to behavioral health-related data to the national data warehouse. During FY 2006, IHS established a baseline rate of annual screening for depression in adults ages 18 and over collected from the behavioral health and other RPMS software packages. This goal will change in FY 2007 to improve behavioral health data by increasing use of RPMS behavioral health software applications; the specific target is to maintain rate of depression screening rate at FY 2006 level.

The purpose of this measure is to collect data in order to track and evaluate improvements in the behavioral health status of AI/AN. Better behavioral health data collection and analysis will improve planning, implementation and evaluation of mental health, alcohol and substance abuse, and social services efforts across I/T/U programs.

The IHS National Suicide Prevention Network (NSPN) is described in the IHS Director's Performance Agreement under One HHS Program and Management Objectives #19: Emphasize Healthy Living and Prevention of Disease, Illness, and Disability. During FY 2006, the NSPN trained at least 12 people (one from each IHS Area) on community-based suicide prevention strategies and delivered on-site assistance (in collaboration with SAMHSA's Center for Mental Health Services) to at least 7 Tribal communities experiencing suicide clusters, or in need of suicide prevention activities, in support of the National Action Alliance for Suicide Prevention. The training of the 12 people from each of the IHS Areas occurred July 24-25, 2006, at Rapid City, SD. The training included Question, Persuade, and Refer (QPR) basic suicide prevention skills training, community mentoring programs, and other train-the-trainer workshops. Some of the communities that are receiving assistance to date include: Red Lake Tribe, MN; Standing Rock Tribe, ND and SD; Crow Creek, SD; Ft. Belknap, MT; Ft. Peck, MT; Omaha, Winnebago, and

Santee Tribes of NE; To'hono Odham & Pasqua Yaqui Tribes, AZ; Supai Tribe, AZ; and the Alaska Native Tribal Health Corporation.

During FY 2008, the NSPN will: 1) Continue to train at least 12 persons (one from each Area in train-the-trainers in topics such as youth suicide prevention and intervention, basic suicide prevention skills training, and mobilizing communities to respond to suicide crises); 2) Update and maintain the IHS Community Suicide Prevention Website; 3) Provide cooperative agreements and grants to at least 10 Tribes and/or Tribal organizations, Urban AI/AN programs and/or Tribal Colleges and Universities to develop and implement their own model demonstration suicide prevention or intervention programs; and 4) Provide at least 10 program awards to IHS federal programs (located on Tribal lands) to develop and implement their own model demonstration suicide prevention or intervention programs.

This measure is also part of the expanding systematic effort aimed at reducing the prevalence of suicide among AI/AN. The purpose of the NSPN program is to provide suicide cluster response and technical assistance, and related services, to support AI/AN community suicide prevention efforts. This effort is targeting two major service areas: (1) the development of a community suicide prevention website or "tool kit" accessible through www.ihs.gov; and (2) the training of at least 12 people (representing one person for each IHS Area) to deliver on-site community and program assistance for communities which are experiencing suicide clusters or are otherwise in need of suicide prevention assistance. The website is under development. Those who have been trained to provide community assistance have expressed satisfaction with the training and our monitoring reflects that their knowledge is being translated to the community.

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$143,198,000	$143,198,000	$161,988,000	+$18,790,000
FTE	164	163	175	+12
Outpatients Visits	64,000	60,800	65,000	+4,200
Inpatients Days	3,000	2,900	3,100	+200

STATEMENT OF THE BUDGET REQUEST

The budget request of $161,988,000 for Alcohol and Substance Abuse supports alcohol and other drug dependency treatments, rehabilitation, and prevention services.

PROGRAM DESCRIPTION

The purpose of the Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral health status of American Indian/Alaska Native (AI/AN) to the highest possible level through the provision of preventive and treatment services at both the community and clinic levels. About 85 percent of these funds go directly to tribally contracted and compacted programs in accordance with Tribal self-governance provisions of P.L. 93-638. These programs provide alcohol and substance abuse treatment and prevention services within rural and urban communities, with a focus on holistic and culturally-based approaches. The ASAP exists as part of an integrated Behavioral Health Team (BHT) that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in AI/AN communities.

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

Presently there are 11 operating Youth Regional Treatment Centers (YRTC). All programs are accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF) and three are State certified. Many of the approximately 300 Tribal alcohol programs are State-licensed and/or certified. Alaska currently has two YRTC programs, and they are in the process of seeking funds to build an additional facility. The two YRTCs that are congressionally authorized for the California Area IHS are moving

from planning to implementation with Program Justification Documents approved by IHS Headquarters. In addition, there are more than a dozen AI/AN alcohol/substance abuse adult residential treatment facilities, including two serving pregnant women and/or women with children.

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

* Federally operated

It is noted that three Areas have no YRTCs and none are planned due to funding constraints. Youth in these Areas are dependent upon programs operated by the States or private entities.

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

- The latest data available from *Trends in Indian Health 2001-2002, published in 2004,* indicate that alcoholism mortality rates in some Tribal communities have increased significantly since 1992 to nearly seven times the alcoholism death rate of the overall U.S. population. The AI/AN drug-related death rate is 18 percent higher than the rate for the overall U.S. population. Comprehensive care requirements favor staff trained in both mental health and alcohol/substance abuse disorders to effectively and safely meet the needs of people with diagnosed dual disorders. The gap in services available between AI/ANs and the rest of the U.S. population continues to widen.

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

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

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

Director's Behavioral Health Initiative – In FY 2005 the Director of IHS launched the Behavioral Health Initiative, which focuses on four behavioral health strategic goals: 1) mobilize Tribes and Tribal programs to promote behavioral health in systematic, evidence-based approaches, which embrace traditions and culture as critical foundations for that health; 2) support and promote programmatic collaborations within communities, as well as with state and federal programs and agencies; 3) promote leadership development from the community to the national level, with training and mentorship; and 4) provide advocacy for behavioral health programming in Indian communities among federal, state, Tribal, local, and private organizations.

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

1. Data Systems and Technology Infrastructure: Ongoing behavioral health data systems and software development are program priorities for IHS to ultimately make completely electronic health care documentation and comprehensive national data collection a reality. **This activity supports the Secretary's 500-Day Plan to transform the health care system by employing health information technology to the benefit of the patients, providers and payers as well as the HHS strategic goal to improve the quality of health care services.** Data collection, management and improvement efforts include expansion of the MH/SS system in I/T/U facilities including suicide, child abuse, and domestic violence in addition to other ongoing clinical information gathering and analysis. Two integrated behavioral health clinical documentation and data platforms have been deployed and there are currently over 340 clinics and Tribal programs reporting to the IHS National Database using one of them. In addition, the ASAP is supporting two software enhancement projects that further integrate and coordinate assessment, treatment planning, and case management utilizing the American Society of Addiction Medicine (ASAM) Patient Placement Criteria and the Center for Substance Abuse Treatment Alcohol Severity Index (ASI). These systems are still in development and testing at the 11 YRTCs and in the Billings Area.

2. Collaborative Activities and Joint Initiatives: In FY 2006, the IHS collaborated with the Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, Bureau of Indian Affairs, Department of Housing and Urban Development, Department of Transportation, Administration on Aging, and the Department of Justice. Multiple programs and collaborations are in place, which bring together convergent interests and resources to support ASA activities nationally. In addition, IHS is the lead agency for the Memorandum of Understanding between the Department of Health and Human Services and Health Canada, signed in FY 2003, to promote program partnerships and collaborative efforts between the two countries over the next 5 years.

Suicide, Fetal Alcohol Syndrome/Fetal Alcohol Effects, and cross border issues, including care across borders, were identified as primary areas for collaboration. **This activity supports the Secretary's 500-Day Plan to protect life, family and human dignity as well as to improve the human condition around the world.**

FUNDING HISTORY -- Funding for the Alcohol and Substance Abuse program during the past 5 years has been as follows:

FISCAL YEAR	AMOUNT	FTE
2003	$136,849,000	178
2004	$138,250,000	174
2005	$139,073,000	169
2006	$143,198,000	164
2007 CR	$143,198,000	163

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $161,988,000 and 175 FTE is an increase of $18,790,000 and 12 FTE over the FY 2007 Continuing Resolution level of $143,198,000 and 163 FTE. The increase will provide:

Adjustment of CR 2007 level to current services level: +$6,447,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Cost: +$2,925,000 – These resources will fund federal and Tribal pay cost increases which will assist the IHS in maintaining access to services for the IHS patient population. Provision of these funds is necessary to maintain the current IHS and Tribal health system which works to eliminate disparities in health status between the AI/AN population and the rest of the U.S.

Inflation: +$5,159,000 – This additional funding will address the increased costs of providing alcohol and substance abuse services.

Population Growth: +$2,231,000 - These resources will support IHS' ability to provide alcohol and other drug dependency treatments, rehabilitation, and preventive services to the increasing AI/AN population.

Staffing and Operating Costs for New Facilities: +$2,028,000 and 29 FTE – These resources will fund the staffing and operating cost at one Youth Regional Treatment Center which will be completed in September 2007. The following table displays the requested increase.

Facility	Amount	Federal FTE	Tribal Positions
Pyramid Lake, NV Youth Regional Treatment Center	$2,028,000	29	0
Grand Total:	**$2,028,000**	**29**	**0**

PERFORMANCE ANALYSIS

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

Alcohol dependence and related alcohol problems account for the majority of visits for ASAP services for FY 2006, the most recent full-year data set available. It is important to note these data are now being drawn from the new behavioral health data systems developed over the last three years and deployed within the last year. While having specific data is encouraging, they should be considered estimates for this year as the data systems are still being deployed and, in accordance with P.L. 93-638, Tribes are not required to submit this information to the IHS data reporting system. The data reveal little change in the overall demand or type of service, although increase in substances other than alcohol are noted and are believed to be due to increased methamphetamine use, which is troubling.

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

Methamphetamine data reveal a 30 percent increase in patients seen between FY 2004 and FY 2005 alone. Over the five-year period from FY 2000 through FY 2005, patient contacts increased three and a half times from 2,002 in FY 2000 to 7,003 in FY 2005. Although the FY 2006 data are not yet complete, a total number of 8,565 methamphetamine-related contacts have been documented. This number represents a 15 percent increase over the FY 2005 contacts. These data are alarming and, in response, IHS established collaborative programming with other agencies and departments to coordinate medical, social, educational, and legal efforts. Federal partners include the Departments of Interior, Education, and Justice.

During FY 2008, IHS will increase outreach, education, prevention, and treatment of methamphetamine-related issues. In FY 2008, each IHS Area will have at least four Tribal communities with a methamphetamine Plan including a community task force; four trainings on a methamphetamine "tool kit"; and an Area-wide training, summit/

conference on methamphetamine. This measure aims to expand current efforts aimed at reducing the prevalence of methamphetamine abuse related problems in the AI/AN population, and to support AI/AN community methamphetamine education, prevention and treatment efforts.

During FY 2005, the Youth Regional Treatment Centers that had been in operation for 18 months or more achieved 100 percent accreditation either through CARF, or a comparable accreditation process. This Goal remains the same for FY 2007. This measure has changed to focus on accreditation, as the components of the previous measure are met and surpassed with accredited facilities. Accreditation by JCAHO, CARF, or comparable State-accrediting bodies ensures that the centers meet acceptable standards of treatment. This measure evaluates the centers and ensures that these programs are appropriately accredited. Successful completion of residential treatment can help reduce drug and alcohol use and relapse in youths.

During FY 2006, IHS increased the prenatal screening rate for alcohol use by 17 percent in female patients age 15 to 44 over the FY 2005 rate. The goal is to maintain the 28 percent screening rate for FY 2007 and FY 2008. This measure is included in the "One HHS" 10 Department-wide Management Objectives to achieve a relative 10 percent increase by FY 2007. The agency has already met and exceeded that targeted increase. Moreover, the number of patients screened for alcohol use increased dramatically. The purpose of this measure is to improve screening for alcohol use in women of childbearing age. The baseline screening rate was established in FY 2004. Heavy drinking during pregnancy can cause significant birth defects including Fetal Alcohol Spectrum Disorder (FASD) and is the most preventable cause of mental retardation. Rates of FASD are higher among AI/AN women than the general population. Screening for alcohol use and dependency in women of childbearing age should result in appropriate interventions.

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

CONTRACT HEALTH SERVICES

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$517,297,000	$520,548,000	$569,515,000	+$48,967,00
FTE	1	1	1	0
Gen.Med & Surg. Hospitalization: ADPL	216	208	230	+22
Ambulatory Care: Outpatient Visits	511,000	485,000	505,000	+20,000
Patient & Escort Travel: 1-way	37,000	35,700	39,400	+3,700
Dental Services	60,000	58,200	64,300	+6,100

STATEMENT OF THE BUDGET REQUEST

The FY 2008 budget request of $569,515,000 for Contract Health Services (CHS) is to provide funds for medical care services outside the IHS direct care program. The CHS program supports the provision of medical care in IHS and Tribal facilities with the acquisition of health care and medical services that are otherwise not available at IHS and Tribal health care facilities.

PROGRAM DESCRIPTION

The CHS program is administered through the 12 IHS Area Offices that consist of 167 IHS and Tribal facilities. The facilities include two major IHS-operated medical centers and one Tribally operated medical center. In addition, the CHS program monitors, evaluates and provides technical support to IHS and Tribal facilities. Many of our Areas do not have Federal or Tribal facilities available in the locale or provide limited services. Such Areas therefore rely heavily on contract care to meet their most critical health care needs. The CHS program purchases medical care and urgent health care services including hospital care, physician services, outpatient services, laboratory, dental, and radiology, pharmacy, and transportation services. Purchasing rationed health care services beyond the medical priority one emergent care level from the private sector is absolutely essential to the health and well being of our American Indian and Alaska Native (AI/AN) population. Lack of access to care means increased suffering for our AI/AN population and higher future medical costs.

In summary, the CHS funds are used in situations where:

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

The CHS program supports public health initiatives targeting health conditions disproportionately affecting AI/AN people such as diabetes, maternal and child health, substance abuse, communicable diseases including HIV/AIDS, tuberculosis, hepatitis, youth services, and mammography and colorectal cancer screening.

The CHS budget also includes a Catastrophic Health Emergency Fund (CHEF) in the amount of $18,000,000. CHEF case costs range from $25,000 (CHEF threshold) to over $1M and are critical cases (vehicle accidents and injuries, fires, organ transplants, etc.) that are of the highest priority. In FY 2005, IHS was able to fund approximately 700 high cost cases in amounts ranging from $1,000 to $875,000. Of 1,400 high cost cases in FY 2005, IHS was able to fund approximately 700 cases in amounts ranging from $1,000 to $875,000.

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

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

Fiscal Year	Amount	FTE
2003	$475,022,000	1
2004	$479,070,000	1
2005	$498,068,000	1
2006	$517,297,000	1
2007 CR	$520,548,000	1

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $569,515,000 and 1 FTE is an increase of $48,967,000 over the FY 2007 Continuing Resolution level of $520,548,000 and 1 FTE. This budget request will provide funds for the following:

Adjustment of CR 2007 level to current services level: +$20,268,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Inflation: +$20,491,000 to support medical inflationary costs.

Population Growth: +$8,208,000 for 1.6 percent growth in the AI/AN population. The funds will be used to purchase inpatient and emergency cares services from the private sector that cannot be provided at IHS and Tribal facilities.

PERFORMANCE ANALYSIS

The Medicare Modernization Act (MMA) Medicare-like rates (MLR) provision no longer requires the IHS, Tribes, and Urban (I/T/U) health programs to pay open market and full billed charges for inpatient services to Medicare participating hospitals. The MLR will alleviate some inpatient costs where IHS and Tribes are unable to negotiate medical contracts. However, the CHS program must continue to negotiate rates not covered by the MMA MLR in order to be in compliance with the IHS payment policy for other health care services such as outpatient services outside of an inpatient facility and physician charges. The CHS program will continue to attain the best prices available from private providers and negotiate contracts for the best possible rates following the CHS regulations and the IHS medical priority system.

The CHS program purchases medical services for diabetes, cancer, heart disease, injuries, mental health, domestic/community/family abuse/violence, maternal and child health, elder care, refractions, ultrasound examinations, physical therapy, dental hygiene, orthopedic services, and transportation. The CHS program continues to support the IHS performance goals of reducing heart disease, substance abuse, injuries, glycemic control for diabetics, high blood pressure control, nephropathy, cancer screening for women through pap smears and mammography, immunization for 19 to 35 month-old children, and vaccination for influenza and pneumococcal for 65 years and older.

The AI/AN population experience disproportionate rates of diabetes mellitus, cardiovascular disease, obesity, suicide, and unintentional injuries. Health complications resulting from such disparities are significant and growing in Indian communities. The additional resources requested will continue to address some of these denied or deferred high priority cases and enable the CHS program to extend CHS services for diabetes, cancer, heart disease, injuries, mental health, domestic violence, maternal and child health, elder care, refractions, ultrasound examinations, physical therapy, dental hygiene, orthopedic services, and transportation.

Change in hospital replacements has resulted in an increased need for CHS. Over the past 10 years, the IHS has initiated the replacement of hospitals with more cost effective comprehensive health care centers, thereby requiring the IHS to purchase inpatient and specialized care from outside sources. This trend reflects the transition of the Indian health care delivery system from acute care to preventive and community-based patient care.

CHS efforts address the Departmental and Agency goals of health promotion and disease prevention and the HHS strategic goal to reduce the major threats to the health and well-being of Americans. It also increases access to health care services and addresses the Secretary's 500-Day Plan and the President's Management Agenda of wellness and prevention activities specifically supporting community-based approaches to decrease the health disparity gap in the AI/AN population. The CHS program takes a proactive approach in purchasing health care services and supports the IHS goals to increase primary, secondary, and tertiary care.

THIS PAGE LEFT BLANK INTENTIONALLY

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$117,110,000	$117,110,000	$129,609,000	+$12,499,000
FTE	269	274	281	+7

SUMMARY OF THE BUDGET REQUEST

The FY 2008 budget request of $129,609,000 and 281 FTE is an increase of $12,499,000 and 7 FTE over the FY 2007 Continuing Resolution level of $117,110,000 and 274 FTE.

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

THIS PAGE LEFT BLANK INTENTIONALLY

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$48,959,000	$48,959,000	$56,825,000	+$7,866,000
FTE	239	243	249	+6
Encounters	426,015	405,000	433,000	+$28,000

STATEMENT OF THE BUDGET REQUEST

The FY 2008 Public Health Nursing (PHN) budget request of $56,825,000 supports population-focused services to promote healthier communities through outreach activities including community screenings, home visits, well-child examinations, immunizations, prenatal care, postpartum care, and follow-up visits for skilled nursing services.

PROGRAM DESCRIPTION

PHN services provide population-based health care utilizing interventions that facilitate health promotion/disease prevention (HP/DP) services for individuals, families, communities, and systems to vulnerable populations that need unique outreach. Forty-nine percent of this budget request falls under P.L. 93-638 and supports Tribally compacted and contracted PHN programs. The American Indian and Alaska Native (AI/AN) population experiences disproportionate rates of diabetes mellitus, cardiovascular disease, obesity, suicide, and unintentional injuries. It is the goal of the IHS PHN program to continue and increase primary, secondary, and tertiary prevention efforts by targeting health interventions towards individuals, families, and groups before a disease process begins; and to increase patient and community-based interdisciplinary collaboration to effectively address the health disparities that face the AI/AN population.

The PHN program faces unique challenges in providing population-focused services to promote healthier communities. These services are provided to a diverse population whose health care needs range from HP/DP services, surveillance, and case finding to complex nursing care related to chronic disease (tertiary prevention) across the age span from birth to elderly, both in the home and other community settings. The PHN is a major link to accessing health care for many AI/AN who live in rural and isolated communities.

The threat of bioterrorism has also brought additional responsibilities for PHN programs across the country. As a community-based program, PHN is integral to the emergency preparedness arena, through disease treatment, health surveillance, and education; and through collaboration with service unit, county, and State emergency preparedness programs. Such activities support the **HHS Strategic Plan, Goal 1: Reduce the major threats to the health and well-being of Americans**.

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

Fiscal Year	Amount	FTE
2003	$39,616,000	261
2004	$42,580,000	252
2005	$45,015,000	240
2006	$48,959,000	239
2007 CR	$48,959,000	243

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $56,825,000 and 249 FTE is an increase of $7,866,000 and 6 FTE over the FY 2007 Continuing Resolution level of $48,959,000 and 243 FTE. The increase will provide:

Adjustment of CR 2007 level to current services level: +$4,358,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Cost: +$997,000 – These resources will fund federal and Tribal pay cost increases which will assist the IHS in maintaining access to services for the IHS patient population. Provision of these funds is necessary to maintain the current IHS and Tribal health system which works to eliminate disparities in health status between the AI/AN population and the rest of the U.S.

Inflation: +$504,000 – This additional funding will address the increased costs of providing public health nursing services.

Population Growth: +$786,000 - These resources will support the public health nursing program's ability to provide public health nursing services to the growing AI/AN population.

Staffing and Operating Cost Requirements for New Facilities: +$1,221,000 - These resources will fund staff at one Joint Venture project which will be open one full year in FY 2008. The following table displays the requested increase.

Facility	Amount	Federal FTE	Tribal Positions
Muskogee, OK Joint Venture	$1,221,000	0	12
Grand Total:	**$1,221,000**	**0**	**12**

PERFORMANCE ANALYSIS

The PHN program continued to support activities that focused on measurable outcomes relating to the following: obesity, cardiovascular disease prevention in women, maternal child health, tobacco cessation, and immunizations. These programs have measurable outcomes for intervention activities. These activities have been made possible through appropriation funding distributed in the form of program awards for IHS and Tribal PHN programs. The 25 competitive awards issued in FY 2006 will be continued in FY 2007 and emphasize Departmental and Agency goals of access to health care, HP/DP services, and advocacy in policy appropriate for the development and implementation of HP/DP activities. FY 2008 Public Health Nursing will meet the target baseline for FY 2007 with a 5 percent increase in encounters.

The public health scope of work is broad. It involves primary prevention of disease in individuals, families and communities through promotion of healthy lifestyle changes and education to prevent disease; secondary prevention of disease through early detection and screening and treatment; tertiary prevention preventing disease progression through on going care and treatment case management of chronic diseases. These services are performed in the community settings of schools, community sites, and home. The historical measure of number of home visits did not capture all of what public health nurses were accomplishing.

The FY 2006 measure addresses *developing a database to capture the time spent and nature of public health activities other than one-to-one patient care*. The database developed has the capability of capturing the time spent and specific activities at the local level and the PHN program met this performance goal. Preliminary data shows public health nursing contributions towards 12 agency performance measures: tobacco screening, domestic violence screening, depression screening, blood pressure measurements, weight measurements, adult influenza vaccine, adult pneumococcal vaccine, and childhood vaccinations. PHN activities also include home visits to the maternal and child health population which impacts childhood obesity through breastfeeding promotion, and developmental screening for early identification of developmental problems in childhood, and finally, parenting education. The PHN performance measure supports several elements of the IHS Strategic Plan goal of providing accessible quality health care; and more specifically, providing quality health information for decision making to patients, providers, and communities through improved information systems.

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

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$13,584,000	$13,584,000	$15,229,000	$1,645,000
FTE	24	25	26	+1
Clients Served	1,696,881	1,612,000	1,712,000	+100,000

Note: The Client Served increase is based on an IHS mandated Performance Contract to increase the number of clients that received patient education by 5% over the FY 2006 baseline and by 7% in 2007.

STATEMENT OF THE BUDGET REQUEST

The budget request of $15,229,000 for Health Education will assist IHS facilities, Indian Tribes and Tribal organizations develop comprehensive health education programs for American Indians and Alaska Natives (AI/AN). Tribes currently manage approximately 43 percent of the health education program funds.

PROGRAM DESCRIPTION

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

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

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

- Develop and strengthen a standardized, nationwide patient and health education program as evidenced by the integration of the IHS Patient Education Protocols into all IHS software packages including the PCC, PCC+ and the Electronic Health Record; with the continued provision of ongoing training to IHS and Tribal staff on the documentation and coding of patient and health education. **This effort supports the HHS strategic goal improve the quality of health care services.**

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

- Increase a concentrated focus on the area of the HP2010 Focus Area: Health Literacy:
  - 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 proportion of health communication activities that include research and evaluation on health literacy**.**
  - Increase the health information contained on www.ihs.gov ensuring that information disclosed is quality-assured and cultural appropriate for AI/AN.
  - Work to establish at least one Center for Excellence in Health Communication within IHS.
  - Improve the communication skills of health care providers working with AI/AN populations.

- Increase staff, consumer and patient use of quality health care information through the development of the concept of a centralized education and training center that is the focal point of education and training within the Indian Health Service.

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

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

Fiscal Year	Amount	FTE
2003	$10,991,000	25
2004	$11,793,000	25
2005	$12,429,000	25
2006	$13,584,000	24
2007 CR	$13,584,000	25

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $15,229,000 and 26 FTE is an increase of $1,645,000 and 1 FTE over the FY 2007 Continuing Resolution level of $13,584,000 and 25 FTE.

Adjustment of CR 2007 level to current services level: +$798,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Cost: +$274,000 – To fund federal and Tribal pay cost increases which will assist the IHS in maintaining access to services for the IHS patient population. Provision of these funds is necessary to maintain the current IHS and Tribal health system which works to eliminate disparities in health status between the AI/AN population and the rest of the U.S.

Inflation: +$188,000 – This additional funding will address the increased costs of providing health education services.

Population Growth: +$215,000 - These resources will support the Health Education program's ability to provide educational services to the growing AI/AN population.

Staffing and Operating Cost Requirements for New Facilities: +$170,000 – These resources will fund staff at one Joint Venture project which will be open one full year in FY 2008. The following table displays the requested increase.

Facilities	Amount	FTE Federal	Tribal
Muskogee, OK Joint Venture	$170,000	0	2

PERFORMANCE ANALYSIS

The IHS Health Education performance emphasizes healthy living and prevention of disease, illness, and disability to reduce unhealthy behaviors and other factors that contribute to the development of chronic diseases (diabetes, obesity, asthma, heart disease, stroke and cancer).

1. The IHS Health Education program is Co-Lead on the GPRA Indicator to establish the proportion of tobacco using patients that receive tobacco cessation intervention.

2. The Health Education program will support the **HHS Priority on Prevention** through increasing consumer and patient use of health care quality information by:
   - Increasing the number of AI/AN clients that received patient education services.

- Improving health literacy by enhancing services (Patient Wellness Handouts) via patient education kiosks in I/T/U hospital and clinic waiting rooms to improve consumer access to health care materials and personal health information.

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

These programs support the HHS Strategic goal to reduce the major threats to the health and well-being of Americans. The IHS Health Education program is responsible for "increasing the patient education provided to AI/AN by 5 percent." Current RPMS patient education statistics indicate that educational services within the IHS are increasing by an average of greater than 5 percent in FY 2006.

The IHS Health Education Programs was selected to serve as Co-Lead on the Tobacco GPRA Indicator. Beginning in 2007, this Tobacco Indicator began assessing the percent of tobacco-using patients that are referred to a tobacco cessation program. The IHS 2007 baseline for Tobacco Cessation Referrals was 12 percent.

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$52,946,000	$52,946,000	$55,795,000	+$2,849,000
FTE	6	6	6	0
Patient Contacts	1,654,000	1,587,800	1,587,800	0

STATEMENT OF THE BUDGET REQUEST

The budget request of $55,795,000 for the Community Health Representatives (CHR) program funds quality Health Promotion/Disease Prevention (HP/DP) services along with health care outreach services to American Indian and Alaska Native (AI/AN) people within their communities.

PROGRAM DESCRIPTION

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

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

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

Fiscal Year	Amount	FTE
2003	$50,444,000	5
2004	$50,996,000	4
2005	$51,365,000	6
2006	$52,946,000	6
2007 CR	$52,946,000	6

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $55,795,000 and 6 FTE is an increase of $2,849,000 over the FY 2007 Continuing Resolution level of $52,946,000 and 6 FTE. The increase will provide:

Adjustment of CR 2007 level to current services level: +$54,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Cost: +$1,136,000 – These resources will fund federal and Tribal pay cost increases which will assist the IHS in maintaining access to services for the IHS patient population. Provision of these funds is necessary to maintain the current IHS and Tribal health system which works to eliminate disparities in health status between the AI/AN population and the rest of the U.S.

Inflation: +$832,000 – This additional funding will help address the increased costs of providing community health representative services.

Population Growth: +$827,000 – These resources will help support the community health representative program to provide outreach services to the growing AI/AN population.

PERFORMANCE ANALYSIS

The CHR Program supports the achievement of GPRA measures including immunization rates for children and elders, blood pressure and glycemic control for diabetics, and injury prevention programs. To meet those measures requires a collaborative effort on the part of CHRs, Public Health Nurses, Health Educators, Maternal and Child Health workers, Diabetes specialists and Environmental Health specialists. IHS utilizes a multidisciplinary approach to maximize health resources to meet health care needs. The GPRA measures reflect cross-cutting strategies involving CHRs in the community and reveal only a limited snapshot of the critically important role CHRs serve in AI/AN communities. Across the scope of IHS' CHR programs, CHRs provide many links to effectively integrate efforts designed to positively impact chronically underserved AI/AN communities, **thus supporting the HHS goal to increase the percentage of the**

Nation's children and adults who have access to health care services and expand consumer choices. At an individual level CHRs positively impact health-promoting behaviors, provide interagency coordination at the agency level and build community competence among AI/AN communities, all of which support DHHS goals.

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

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

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. In FY 2007, CHRs will increase patient service hours by 5 percent over the FY 2006 baseline. In FY 2008 CHRs will increase patient services hours directed at chronic diseases by 2 percent over the FY 2007 level.

This performance goal should allow CHR Programs to continue to target emerging chronic diseases and behavioral health issues facing the AI/AN population through HP/DP activities focusing on blood pressure monitoring and referrals and cholesterol screening to address health conditions like diabetes and obesity along with injury prevention through community outreach. It also supports several of the IHS GPRA indicators. Reaching this goal is contingent on increasing utilization and accessibility of the CHR data software application by CHR Tribal programs.

As an important component of the community-based approach to addressing health disparities among AI/ANs, CHRs will also address the proportion of patients with diagnosed diabetes that have achieved blood pressure control (<130/80). CHR efforts contribute to the accomplishment of several GPRA measures. This measure, in particular, is a collaborative effort among providers aimed at reducing complications from diabetes.

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

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

The CHR Program is also working to meet the **Secretary's 500-Day Plan of adopting information technology** in health care by implementing a desktop or laptop-based software program which allows for the remote movement of patient data from the field to the Patient Care Component (PCC) Software at the service facility or Area. The CHR Program is reviewing data requirements (including collection and entry capability) and training needs to improve documentation practices in order to enhance its data quality and reporting capability. As a result of this ongoing process, CHR PCC Remote software application is in beta testing and should be rolled out nationally for the use of individual Tribal CHR programs, at their discretion, nationally in FY 2007. In addition, a national

group of CHRs has been formed who are being trained as instructors for proper coding, use of the new software application, data entry and export, and patient/administrative report generation. National CHR Program at IHS Headquarters will launch a web-based system entitled the "Indian Health CHR Information System" to enable each Tribally-contracted CHR Program to track its own aggregate data and compare against CHR Area and national statistics. Upon completion of assigning security access codes, this system should be available for use by the third quarter of Fiscal Year 2007.

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

HEPATITIS B AND HAEMOPHILUS IMMUNIZATION PROGRAMS (ALASKA)

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres.Budget	Increase or Decrease
BA	$1,621,000	$1,621,000	$1,760,000	+$139,000
FTE	0	0	0	0

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
Services Provided:				
# Hepatitis Program patient visits for clinical care	3,900	4,100	4,200	+100
# Chronic carriers surveyed	1,300	1,300	1,300	0
Patients Immunized/Viral Load:				
# Hepatitis A,B	8,400	8,400	8,400	0
Hepatitis C patients followed	1,700	1,900	2,000	+100
Studies evaluating need for Hepatitis A and Hepatitis B booster doses:				
Infants, Children	1,050	1,050	1,050	0
Adults	1,000	1,000	1,000	0
Nonalcoholic fatty liver registry patients	450	500	550	+50
Autoimmune Hepatitis Registry Patients	100	110	120	+10
Immunization Records Audited:				
# Trained in RPMS	150	160	170	+10
# Health Aide Training	100	100	120	+20
# Tribal Site Visits	6	6	7	+1
3-27 mon. old AK Native immuniz. rates reported	4,800	5,100	5,200	+100
19-35 mon. old imm audited	2,800	2,900	3,100	+200
11-17 year old imm. audited		5,000	7,000	+2000
65+ year old imm. Audited		6,000	7,000	+1000
Purchase of Vaccine/Lab Reagents:				
Hepatitis A	$45,000	$45,000	$45,000	$0
Hepatitis B	$45,000	$45,000	$45,000	$0

Notes: (1) Resources from IHS, NIH, CDC grants and other contracts support Services Provided. (2) The increase of Services Provided are due to expansion of clinical and other services provided. For example, IHS added a full day clinic (52/year) at Alaska Native Medical Center and two field clinics which increased patient loads and serves to increase diagnosis of liver disease in patients previously not screened/tested. We have also implemented new vaccines and initiated immunization tracking for adolescents and adults.

STATEMENT OF THE BUDGET REQUEST

The FY 2008 budget request of $1,760,000 would be applied to program activities of the Haemophilus Influenza type B Immunization and Hepatitis Programs for American Indian and Alaska Native (AI/AN) people.

PROGRAM DESCRIPTION

The Liver Disease and Hepatitis Program (Hepatitis B Program) and the Immunization (Haemophilus Influenza) Program are distinct programs of the Alaska Native Tribal Health Consortium. Based on demonstrated high rates of disease, these activities include clinical care of chronic liver disease patients, consultation on immunization and hepatitis issues, follow-up of hepatitis B carriers, training and technical assistance for Tribal health providers and Community Health Aides, consultation for the RPMS Immunization Package, patient and public education, immunization audits, vaccine-preventable disease surveillance, and coordination with the State of Alaska. The Liver Disease and Hepatitis Program implemented a program to diagnose, evaluate and counsel patients with non-alcoholic fatty liver disease. The Immunization Program is implementing routine rotavirus and human papillomavirus (HPV) vaccination and working with the CDC Arctic Investigation Program and Tribal agencies to promote and monitor the impact of HPV vaccine in Alaska Native females.

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/ANs.

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

Fiscal Year	Amount	FTE
2003	$1,546,000	0
2004	$1,561,000	0
2005	$1,572,000	0
2006	$1,621,000	0
2007 CR	$1,621,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $1,760,000 and 0 FTE is an increase of $139,000 over the FY 2007 Continuing Resolution level of $1,621,000 and 0 FTE. The increase will provide:

Adjustment of CR 2007 level to current services level: +$53,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Costs: +$36,000 – These resources will fund pay increases for Tribal employees, immunization coordinators, consultants, and program director.

Inflation: +$25,000 – These resources will address inflationary costs.

Population Growth: +$25,000 – These resources will fund and support additional immunization services for the growing AI/AN population.

PERFORMANCE ANALYSIS

The Program addresses GPRA measure 24: Combined immunization rates for AI/AN children patients aged 19-35 months; and 25: Influenza vaccination rates among adult patients aged 65 years and older; and 26: Pneumococcal vaccination rates among adult patients aged 65 years and older. In addition, the program supports the HHS Strategic Plan, Goal 1.3 to increase immunization rates among adults and children impacting disparities in rates of immunization and vaccine-preventable disease and providing the best practices in immunizations.

Immunization (Hib) Program: Key Accomplishments

(1) Alaska Area reports immunizations on the highest proportion of the 19-35 month old user population, among IHS Areas.
(2) Increased proportion of 19-35 month old children fully immunized to 88 percent (above U.S. rate of 80 percent).
(3) 95 percent decrease in vaccine-type pneumococcal cases among Alaska Natives <2 years old.
(4) 98 percent decrease in Hib disease with estimated 450 cases prevented by vaccine.
(5) Alaska Native elders have high rates of pneumococcal vaccination reported by GPRA (89 percent).
(6) Release of new version of Indian Health Service's Immunization tracking which we helped design and test.
(7) Implemented research project to evaluate the viral etiology of respiratory hospitalizations in high risk Alaska Native children.
(8) Implemented audits of immunization rates in Alaska Native elders, and designed electronic report for auditing adolescent immunization rates.

Routine immunizations represent a cost-effective public health measure that significantly improves the health of children. The FY 2006 target for childhood vaccination was met and exceeded for Alaska Area, with the percentage of children ages 19-35 months receiving recommended vaccines at 86 percent, up 1 percent from the FY 2004 baseline of 85 percent.

Vaccination of the elderly against pneumococcal disease is one of the few medical interventions found to improve health and save on medical costs. This measure is included in the "One HHS" 10 Department-wide Management Objectives to attain a 10 percent relative increase by FY 2007. The FY 2006 Alaska Area elder's pneumococcal vaccination rate of 89 percent exceeds the National GPRA objective of 72 percent for 2006 and is close to the National 2010 goal of 90 percent.

Vaccination of adolescents has taken on new importance with licensure and national recommendations for Tdap (tetanus and diphtheria with acellular pertussis) and human papillomavirus vaccines. The Haemophilus Immunization program will start monitoring adolescent vaccination rates in 2007.

Liver Disease and Hepatitis Program: Key Accomplishments

- The Liver Disease and Hepatitis Program follows 1,350 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, 60 percent of patients were screened for liver cancer at least once during the year.
- The Liver Disease and Hepatitis Program monitors over 1,600 Alaska Natives with hepatitis C infection for alpha-fetoprotein to detect liver cancer early and perform liver function tests to identify potential treatment candidates.
- The Liver Disease and Hepatitis Program actively screen for autoimmune hepatitis (AIH) and nonalcoholic fatty liver disease in the Alaska Native population. The program has determined the prevalence of AIH to be 42.9/100,000 and is conducting 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 non-alcoholic fatty liver disease.
- The Liver Disease and Hepatitis Program is continuing studies on the immunogenicity, safety and long-term efficacy of hepatitis A and B vaccines in infants, children and adults with 1,050 patients enrolled. The results of many of these studies are published and have made a significant contribution to the literature.
- The Liver Disease and Hepatitis 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. We found that hepatitis B virus genotype F is significantly associated with liver cancer, suggesting that health care providers need to pay particular attention to viral genotype.

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

Authorizing Legislation: Program authorized by Title V, P.L. 94-437, Indian health Care Improvement Act, as amended.

.

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$32,744,000	$32,744,000	$-0-	($32,744,000)
FTE	7	7	-0-	(7)
Services Provided	680,993	690,600	-0-	(690,600)

STATEMENT OF THE BUDGET REQUEST

The FY 2008 Budget does not request funds for Urban Health. This is a reduction of $32,744,000 below the FY 2007 Continuing Resolution (CR) level.

PROGRAM DESCRIPTION

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

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

- notifying their user population, the urban Indian community, and other community safety net providers, including hospitals; as well as, other federal, State, county and local agencies; and,
- assuring adherence to IHS Records Management Policy.

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

Fiscal Year	Amount	FTE
2003	$31,323,000	11
2004	$31,619,000	9
2005	$31,816,000	7
2006	$32,744,000	7
2007 CR	$32,744,000	7

RATIONALE FOR THE BUDGET REQUEST

IHS resources have always been targeted to providing health care to communities on or near reservations. For many of these communities, health care from outside the IHS does not exist. Unlike Indian people living in isolated rural areas, urban Indians live near hospitals and health care providers, and they have access to programs such as Medicaid, and other federal, State and local health care programs, on the same basis as all Americans. One important source of health care for all low income urban Americans is the Health Centers program, administered by the Health Resources Services Administration. Funding increases for the Health Centers program may allow it to serve 1.5 million more urban Americans in CY 2008 than it served in CY 2004. Health Centers currently operate in all of the 34 cities served by the Urban Indian Health Program and in hundreds of other cities where Indian people live.

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$31,039,000	$31,039,000	$31,866,000	+$827,000
FTE	29	29	29	0

STATEMENT OF THE BUDGET REQUEST

The FY 2008 budget request of $31,866,000 for Indian Health Professions supports scholarships, loan repayments, and recruitment and retention of health professionals. Based on FY 2006 awards information, 92.3 percent of the budget has been awarded to students. The remaining 7.7 percent of the scholarship budget goes to the Internal Revenue Service to pay the IHS portion of the Federal Insurance Contributions Act (FICA) taxes. In addition to the payment of the IHS FICA taxes, scholarship recipients also pay their portion of FICA (7.7 percent), as well as State and Federal taxes.

In support of Tribal consultation, the IHS Scholarship program receives a recommended priority list from the Tribal health programs that helps to determine the discipline priorities. The FY 2007 priorities consist of 27 health professions. Examples include physicians, nurses, podiatrists, pharmacists and dentists.

PROGRAM DESCRIPTION

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

The Indian Health Professions program supports self-determination and access to health care. This is done through efforts to enable AI/AN to enter health professions and to support effective recruitment and retention of health professional staff by providing

scholarships, loan repayment, temporary employment, and health professions recruitment activities.

The Indian Health Professions budget supports several performance areas that indirectly support the entire set of GPRA measures by developing the IHS workforce, i.e., providers and other professional staff. The Scholarship Program had 461 participants in FY 2006. The Scholarship Program is currently identifying continuation and new student awards for 2006 Fall/Spring semester. FY 2007 awards will not be finalized until October 2007. Awards made in FY 2006 were distributed among the program's three sections as follows:

Section 103[1]	78
Section 103P[2]	67
Section 104[3]	316

[1]Section 103 is comprised of students in preparatory programs, such as pre-nursing, pre-pharmacy, pre-physical therapy, etc.
[2]Section 103P is comprised of students in pre-medicine, pre-dentistry, and pre-podiatry programs.
[3]Section 104 is comprised of students in health professions education programs such as medical school, dental school, pharmacy school, nursing school, etc.

In FY 2006, there were 791 health professional participants in the IHS loan repayment program, broken down as follows:

New awards[1]	269
Contract extensions[2]	229
New awards in FY 2005[3]	293

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

The Loan Repayment Program is currently identifying extension and new health/allied health professional awards for FY 2007 and this process will not be completed until September 2007. Health professionals provided temporary service to IHS facilities through several mechanisms. These include: direct employment into temporary positions, directly contracting with various facilities, working with contract locum tenens companies, and volunteering their services for various periods of time.

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

- Establishing and maintaining a website that contains information regarding health professional needs at IHS, Tribal, and urban Indian health facilities;
- Utilizing special pay and bonus authorities as much as possible;
- Establishing internship arrangements between IHS facilities and health profession training programs;

- Advertising in professional journals;
- Attending health fairs at colleges;
- Attending high school career days;
- Adding funds to the IHS Loan Repayment Program;
- Establishing special salary rates under the Title 38 authority;
- Sending direct mailings to practicing and student health professionals;
- Establishing seven Dental Clinical and Support Centers, whose activities include addressing the issues of recruitment and retention;
- Establishing workgroups of professionals to address the issues of recruitment and retention;
- Surveying current employees to see what attracted them to Indian health and what has made them stay on or may incline them toward leaving;
- Working with the National Health Service Corps (NHSC) to make Indian health facilities eligible to employ NHSC scholarship recipients;
- Encouraging high school and college students to enter the health professions;
- IHS Scholarship Programs;
- Nursing Scholarship Program;
- Nursing Residency Program; and
- Advanced General Practice Residency Program for dentists.

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

Vacancy Rates for Selected Health Professions
1/2000 vs. 12/2006

Profession	Vacancy Rate 1/2000	Vacancy Rate 12/2006
Dentist	35%	32%
Nurse	11%	17%
Optometrist	14%	13%
Pharmacist	12%	12%
Physician	11%	12%

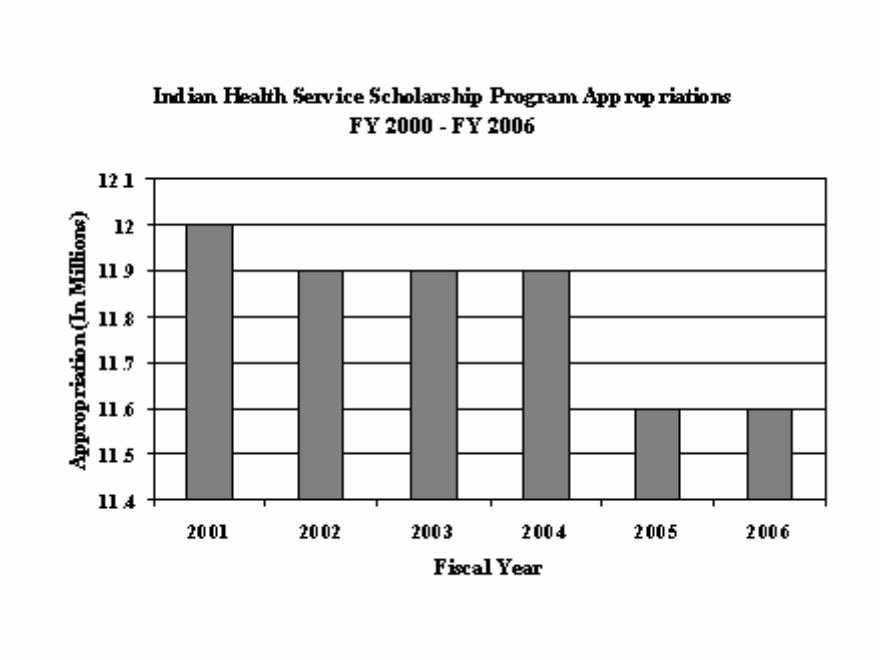
Overall, we are doing about as well now as we were 4 years ago, even though we have more positions to fill. There are clearly negative changes in nurse groups, however, and the dental vacancy rate remains high. The scholarship and loan repayment programs continue to be major factors in our efforts to address these staffing needs.

Behavioral Health is one of the IHS Director's Initiatives that is supported through the Scholarship, Loan Repayment, and Extern programs, as well as the resources for clinical psychologists.

However, Clinical psychologists take a minimum of 8 years in academics and advanced clinical training in order to receive their license. Through the Indians into Psychology

(INPSYCH) program and the Health Professions Scholarship program, 10 licensed clinical psychologists were placed in the Indian health programs in 2005. Two more clinical psychologists are currently ready for placement.

This figure illustrates the situation of the scholarship program. Appropriations have been relatively stable.



The Loan Repayment Program (LRP) made 269 new awards in FY 2006 and 293 new awards in FY 2005. However, there were also 337 matched applicants in FY 2005 and 252 in FY 2006 that were employed in an Indian health program and applied for loan repayment but could not be funded. IHS funded fewer health/allied health care providers in FY 2006 than in FY 2005 because the debt load for these individuals has increased considerably over the past several years. For example, the average debt load for physicians in FY 2005 went from $115,219 to $120,290 in FY 2006. This increase has both positive and negative effects on the LRP. Positively, people tend to stay longer in order to pay off more of their loans. Negatively, this increased length of service ties up more money for contract extensions, making less available for new contracts. Since we lose people each year and new positions are created as new facilities open, the overall impact is that we are able to fund a smaller proportion of matched applicants each year. We estimate that in FY 2007 there will be approximately 350 health/allied health professionals who are eligible for loan repayment that cannot be funded under the current appropriation. This becomes a contribution to increased turnover and vacancy rates as we are unable to fund qualified applicants who are already working at Indian health facilities.

The Extern Program is also an excellent recruitment tool for both civil service and commissioned corps personnel by providing clinical experience to students who are in a health/allied health professions career track. It also helps to meet the Secretary's initiative of hiring more Commissioned Officers into the IHS by providing the Junior

Commissioned Officer Student Training and Extern Program (Junior COSTEP) as a means of serving an externship. The numbers of student externs supported through the program and the personnel system they have chosen as their means of serving are as follows:

FY 2004: 165 Civil Service vs. 41 Commissioned Officer
FY 2005: 169 Civil Service vs. 32 Commissioned Officer
FY 2006: 216 Civil Service vs. 28 Commissioned Officer

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

Fiscal Year	Amount	FTE
2003	$31,114,000	31
2004	$30,774,000	32
2005	$30,392,000	32
2006	$31,039,000	29
2007 CR	$31,039,000	29

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $31,866,000 and 29 FTE is an increase of $827,000 over the FY Continuing Resolution level of $31,039,000 and 29 FTE. The increase will provide:

Adjustment of CR 2007 level to current services level: +$175,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Costs: +$44,000 – to fund the federal pay increases to the IHS scholarship, loan repayment, and recruitment program staff who administer the programs.

Inflation: +$608,000 – to address inflationary costs to cover the increases of educational expenses for students in the IHS Scholarship Program.

PERFORMANCE ANALYSIS

The resources requested for FY 2008 will enable the Indian health programs to continue their support of the IHS recruitment and retention efforts and development of health professionals in critical health professional shortage areas. Additionally, in order to assist in meeting the Director's goals of reducing uncontrolled depression in individuals and communities and the secondary results of this disease, such as addictions, domestic and community violence, and suicide, IHS will be able to fund more professionals in the behavioral health disciplines.

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

Proposed Distribution of Indian Health Professions Funds in FY 2008

Section	Title	Amount	Expected Outcome
103	Health Professions Preparatory Scholarship	$3,848,354	122 agreements, both new and continuing.
104	Health Professions Scholarship	$10,217,486	300 contracts, new and continuing.
105	Extern Programs	$1,314,244	150 temporary clinical assignments
108	Loan Repayment Program	$12,906,478	271 contracts in FY 2006.
112	Quentin N. Burdick American Indians into Nursing Program	$1,709,967	6 grants
114	INMED Program	$1,119,471	2 grants
217	American Indians into Psychology Program	$750,000	3 grants
TOTAL		**$31,866,000**	

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$2,394,000	$2,394,000	$2,529,000	+$135,000
FTE	0	0	0	0

STATEMENT OF THE BUDGET REQUEST

The budget request of $2,529,000 for the Tribal Management Grant (TMG) Program will fund competitive discretionary grants to Tribes and Tribal organizations to further develop and improve their management capacity and capability to contract programs, services, functions and activities provided by the Indian Health Service (IHS).

PROGRAM DESCRIPTION

The TMG Program is a national competitive grant program that awards grants annually to Federally-recognized Tribes and qualified Tribal Organizations. Tribes and Tribal Organizations utilize TMG funding to enhance their management capabilities through such projects as conducting health programs-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 IHS programs, services, functions, or activities. The IHS distributes the total appropriated amount via grants to Tribes and Tribal Organizations with an approximate 4 percent of the overall funds reserved to meet grant program operation expenses.

FUNDING HISTORY -- Funding for the TMG Program during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2003	$2,390,000	0
2004	$2,376,000	0
2005	$2,343,000	0
2006	$2,394,000	0
2007 CR	$2,394,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request for the TMG program of $2,529,000 is an increase of $135,000 over the FY 2007 Continuing Resolution level of $2,394,000. The increase will allow for inflation and full funding of an award versus partial funding as noted below:

Adjustment of CR 2007 level to current services level: +$44,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Inflation: +$91,000 to support increased costs.

The table below details the number of continuation and new grant awards funded and proposed to be awarded:

Fiscal Year	Amount	Continuation / New Awards
2003	$2,390,000	10 / 18
2004	$2,376,000	07 / 20
2005	$2,343,000	07 / 23
2006	$2,394,000	11 / 13
2007 CR	$2,394,000	13 / 11
2008 Pres. Budget	$2,529,000	09 /13 Estimated

PERFORMANCE ANALYSIS

The TMG program's outcomes are consistent with the **HHS Strategic Goal 5, "Improve the quality of health care services", the IHS' Strategic Goal 3 "Provide accessible, quality health care" and the Secretary's 500-Day Plan within "Transform the Healthcare System" in "Supporting community-based approaches to closing the healthcare gap, particularly among racial and ethnic minority populations, including American Indian and Alaska Natives."** The TMG program encourages Tribes and Tribal Organizations to be knowledgeable of the HHS and IHS goals and considers these factors in the selection of the proposed projects to be undertaken. Tribes and Tribal organizations continually work to improve the quality of health care provided to their communities by achieving and maintaining health care and facility accreditations. An example of related achievements includes the establishment and training of Tribal Health Boards which serve as health advisory committees to Tribal Councils. Through the Tribal health board initiatives and recommendations the Tribal leaders are better prepared to meet their community's health needs and maintain compliance through quality assurance, medical records, and information technology systems improvements to assure their licensing and quality of care. All of these activities improve the management

capacity of Tribes to take on additional programs, services, functions and activities provided by the IHS.

The overarching performance goal is to provide assistance to Tribes and Tribal Organizations to improve health program management overall and assistance to assume all or part of IHS Programs, Functions, Services and Activities that are non-residual. The IHS supports the participation of Tribes and Tribal Organizations in Self-Determination activities.

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$62,194,000	$62,194,000	$64,632,000	$2,438,000
FTE	366	364	367	3
Managers/analysts fully trained for 2008 UFMS implementation	0	350	350	
IHS employees in leadership positions trained to close knowledge gaps in entrepreneurship and financial management.	0	138	138	

STATEMENT OF THE BUDGET REQUEST

The budget request of $64,632,000 for Direct Operations supports the Indian Health Service (IHS) in carrying out its responsibility of providing leadership, oversight, executive direction and administrative support to 12 regional offices serving approximately 1.9 million American Indians and Alaska Natives (AI/AN) across the United States.

PROGRAM DESCRIPTION

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

The Headquarters operations are determined by statute and administrative requirements set forth by the Department of Health and Human Services, the Administration, the Congress, and field operations (12 Area Offices and 163 Service Units). Headquarters actively works with the Department to formulate and implement national health care priorities, goals, and objectives. The agency works with the Department to formulate a budget and necessary legislation. In addition, it responds to congressional inquiries, and interacts with other governmental entities to enhance and support health services for

Indian people. The IHS Headquarters also formulates policy and distributes resources; provides general program direction and oversight for IHS Areas and Service Units; provides technical expertise to all components of the Indian health system, 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 2006 Enacted	FY 2007 CR	FY 2008 Pres. Budget
Headquarters (56.5%)	$35,140,000	$35,140,000	$36,517,080
Title I Contracts (non-add)	*2,131,585*	*2,131,585*	*2,215,143*
Title V Compacts (non-add)	*5,488,464*	*5,488,464*	*5,703,612*
Area Offices (12) (43.5%)	27,054,000	27,054,000	28,114,920
Title I Contracts (non-add)	*800,873*	*800,873*	*832,267*
Title V Compacts (non-add)	*7,374,635*	*7,374,635*	*7,663,721*
BA	**$62,194,000**	**$62,194,000**	**$64,632,000**
FTE	366	364	367

FUNDING HISTORY – Funding for Direct Operations during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2003	$55,312,000	334
2004	$60,714,000	357
2005	$61,649,000	387
2006	$62,194,000	366
2007 CR	$62,194,000	364

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $64,632,000 and 367 FTE is an increase of $2,438,000 and 3 FTE over the FY 2007 Continuing Resolution level of $62,194,000 and 364 FTE.

The increase will provide:

Adjustment of CR 2007 level to current services level: +$774,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Costs: +$1,295,000 – for federal and Tribal pay increases. The provision of these funds is necessary to maintain the current I/T/U health system which works to eliminate disparities in health status between the AI/AN population and the rest of the U.S.

Inflation: +$369,000 – These additional resources will address the increases in costs for travel, training, supplies and equipment, and services required for federal and Tribal employees.

PERFORMANCE ANALYSIS

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 PMA, the HHS Top 20 Performance Objectives, and the Secretary's 500-Day Plan. The IHS will carry out and report on specific activities in 6 of the 10 government-wide objectives of the PMA. The Department tracks the performance of all HHS Operating Divisions by the use of a Management Scorecard which reflects the PMA objectives. For FY 2008, IHS activities will continue in the following PMA and HHS Performance Objective areas:

- Strategic Management of Human Capital—performance contracts and workforce planning;
- Competitive Sourcing—Tribal self-determination;
- Improved Financial Performance—support the implementation timeline for the HHS Unified Financial Management System and continued audit improvements and fiscal monitoring;
- Expanded Electronic Government—support and implement current and planned e-Gov activities (e.g., e-grants, e-learning, e-travel, automated position hiring and classification, I procurement, migration to HHS mail, implementation of HSPD-12 access to information systems); and,
- Budget and Performance Integration—GPRA and Program Assessment Rating Tool; and
- Federal Real Property Asset Management--effectively managing the construction, monitoring and appropriate disposal of health care facilities.

- HHS Consolidated Acquisition System-Department-wide contract management system that will integrate the Unified Financial Management System (UFMS).

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

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

Performance Plan FY 2008 -- The IHS FY 2008 Performance Plan complies with the requirements of the GPRA and the objectives contained in the President's Management Agenda (PMA), the Department's Performance Objectives, the priorities of the Secretary of Health and Human Services (HHS), and the *HealthyPeople 2010* goals of achieving equivalent and improved health status for all Americans over the next decade. The IHS and its stakeholders have always considered GPRA and performance measures, in general, as a natural extension of the public health model the Agency has used effectively for over a half century to make significant improvements in the health status of Indian people.

Headquarters, through this activity, will continue to develop and expand its crosscutting collaborations and partnership with other Federal agencies and outside organizations to achieve common goals and objectives addressing health disparities of AI/ANs. The magnitude of health disparities and resources needed require crosscutting networks to meet many performance measures and PMA objectives, such as (**a**) linking performance measurements to the budget and eventually to cost, (**b**) preparing the workforce to meet challenges in the delivery and administration of health care, and (**c**) developing and refining Information Technology Planning, Capital Planning, and Program Evaluation as the environment changes in response to Tribal contracting and compacting, changes in technology, and health care in the United States.

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$5,668,000	$5,668,000	$5,928,000	+$260,000
FTE	7	7	7	0

STATEMENT OF THE BUDGET REQUEST

With this budget request of $5,928,000 the IHS will support the provision of technical assistance to approximately 376 Tribes and Tribal organizations; fund up to 24 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 Headquarters and Areas for any new Tribes entering Self-Governance.

PROGRAM DESCRIPTION

In FY 1992, the Indian Health Service (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, in conjunction with Tribal representatives, has been engaged in a process to develop methodologies for identification of Tribal shares for all Tribes. Tribal shares are those funds historically held at the Headquarters and Area organizational levels of the IHS. **In FY 2008 approximately $1.142 billion will be transferred to support 105 compacts and 126 funding agreements.**

In **FY 2008** funding request for Self-Governance of $5.9 million would provide: the OTSG operating budget of $3.3 million and a reserve fund of $2.6 million for shortfall. These funds were appropriated to fund shortfalls in compact funding in cases where there cannot be a direct transfer of funds from IHS to the Tribes to fund self-governance compacts without jeopardizing the support provided by IHS to other Tribes. Therefore, the **reserve funds** are used (1) to ensure that funding of Tribal shares under Self-Governance compacting does not adversely impact non-Self-Governance Tribes. These funds are provided directly to the Self-Governance Tribes or to Area Offices and/or

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

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

Fiscal Year	Amount	FTE
2003	$5,553,000	8
2004	$5,644,000	8
2005	$5,586,000	6
2006	$5,668,000	7
2007 CR	$5,668,000	7

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $5,928,000 and 7 FTE is an increase of $260,000 over the FY 2007 Continuing Resolution level of $5,668,000. The increase will provide:

Adjustment of CR 2007 level to current services level: +$76,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Costs: +$20,000 – These resources will fund pay increases for Federal employees, specifically for the Office of Tribal Self-Governance located within IHS Headquarters. Pay increases are necessary for maintaining the base program funds that support Tribes entering into self-governance.

Inflation: +$164,000 – These resources will address inflationary costs associated with ongoing operations.

PERFORMANCE ANALYSIS

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

- various GPRA Tribal projects throughout the country;

- various pilot projects with Tribes on: eligibility issues, reports to Congress, assessments of the incidence of domestic and other violence related medical

conditions, and information technology which improve communications and collaboration;

- assistance to the Community Health Representatives program and training center in Aberdeen – IHS/Veterans Affairs Interagency Agreement;

- assistance to the IHS-wide Emergency Medical Services program and GSA ambulance agreement;

- a Best Practices project which compiled and documented the successful outcomes of the Self-Governance Tribes, which included the following as examples:

  - Collaboration between Tribal-State governments on pressing health policy issues;
  - Disease prevention and health education are top priorities – set by the community and Tribal Council and worked on collaboratively by the various dept.;
  - Ability to build their own health centers – which offers family medicine with services not seen before Self-Governance including ophthalmology, podiatry, and a pharmacy;
  - The use of traditional healers in their health clinics;
  - New programs,- drug and alcohol, preventive health, dental and expanded elder care;
  - Diabetes patients referred for complete three-month wellness program, preventive health care;
  - Tribe now has a full range of clinical services from medical nutrition therapy, cancer early detection program, diabetes prevention and intervention.

The Self-Governance budget supports efforts to address the following elements of the Secretary's 500-day plan – Transform Health Care System. These are:

- Expressing a clear vision of health information technology that conveys the benefits to patients, providers and payers through funding of the Tribal GPRA pilot projects. Specifically, the Alaska and Nashville Areas have worked in partnership with the IHS to develop and expand the Clinical Reporting System software, which is a reporting tool for GPRA as well as other indicators. This software made its first appearance in FY 2002 and has since been revised and/or updated to reflect changes to the national GPRA measures. It is available to all Tribes. The OTSG plans to evaluate the GPRA Pilot Projects throughout FY 2007.

- Supporting community-based approaches to closing the healthcare gap, particularly among racial and ethnic minority populations, including American Indians and Alaska Natives. The OTSG encourages accreditation at 100 percent for Tribally-Operated hospitals and clinics. Approximately 54 percent of Tribally Operated Health Programs (TOHP) representing 77 percent of users served by Tribal programs received services in programs that are accredited by the Joint Commission on Accreditation of Healthcare Organizations, Accreditation Association for Ambulatory Health Care, or other appropriate accrediting bodies. These evaluations are the

recognized benchmark of quality in the health care industry and are conducted by external peer review teams using rigorous health care quality effectiveness criteria.

- Supporting community-based approaches to closing the healthcare gap, particularly among racial and ethnic minority populations, including AI/ANs. The Self-Governance budget supports efforts to reduce disparities in ethnic and racial health outcomes through encouragement of Tribal participation and compliance with GPRA and GPRA Pilot Projects. Based on GPRA indicators reported by the IHS direct and Tribal programs, TOHPs reported outcomes on performance measures that are similar to those of IHS overall in 2004. Increasing the percentage of TOHPs providing GPRA data will provide IHS with a more complete picture of program performance.

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

CONTRACT SUPPORT COSTS

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$264,730,000	$264,730,000	$271,636,000	+$6,906,000
FTE	0	0	0	0

STATEMENT OF THE BUDGET REQUEST

The budget request of $271,636,000 for Contract Support Costs (CSC) will fund costs which are required to be provided to Tribal governments and Tribal organizations, to assist in establishing and maintaining support systems (e.g., administrative and accounting systems) needed to administer self-determination agreements and to ensure compliance with the contract and prudent management.

PROGRAM DESCRIPTION

The Indian Self-Determination and Education Assistance Act (ISDEAA) allows Tribes to assume operation of Federal programs and to receive not less than the amount of direct program funding that the Secretary would have otherwise provided for the direct operation of the program. Currently about $1.766 billion of the Agency's appropriation is under Tribal Health Administration primarily through Title I and V of the ISDEAA. The ISDEAA also provides that there be added to the program amount, contract support costs. The CSC are defined in the ISDEAA as the reasonable costs for activities either not normally provided by the Secretary in his/her direct operation of the program, or were provided by the Secretary in support of the program from resources other than those under contract.

Specific elements of CSC include are:

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

The IHS has had a CSC policy in existence since 1992 that governs the administration and allocation of CSC. The policy was developed through extensive consultation and participation of Tribes. The Director of IHS recently made a decision to revise the policy

again for 2008 to amend procedures related to the funding of CSC associated with new or expanded programs in order to assure continued funding equity in the current fiscal environment. The IHS CSC policy conforms to applicable OMB Circular A-87 and A-122 cost principles.

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

Fiscal Year	Amount	FTE
2003	$268,974,000	0
2004	$267,398,000	0
2005	$263,683,000	0
2006	$264,730,000	0
2007 CR	$264,730,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $271,636,000 and 0 FTE is an increase of $6,906,000 over the FY 2007 Continuing Resolution level of $264,730,000 and 0 FTE. The increase will provide:

Adjustment of CR 2007 level to current services level: +$1,401,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Inflation: +$5,505,000 – These resources will support non-medical inflationary costs associated with the annual increased cost of providing health care under ISDEAA contracts and compacts in FY 2008.

PERFORMANCE ANALYSIS

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

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

Throughout calendar year 2006, Tribally-operated health programs (TOHP) worked to address the follow-up recommendations from the findings of the performance assessment rating tool (PART). 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 their PART 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 PART 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 77 percent of AI/ANs served in 2006. By law, the government cannot require Tribal programs to submit performance data. 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. The HHS (IHS & CMS) and Tribes are collaborating to address the follow up recommendations included in the FY 2007 President's Budget.

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. This guidance requires that Tribes and the IHS reach agreement concerning the unavailability of 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 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 PFSA/PSFA would be declined.

[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.

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

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

	FY 2006 Enacted	FY 2007 Estimate	FY 2008 Estimate
Medicare:			
Federal	$100,882,000	$101,965,000	$101,965,000
Tribal [1]	6,986,000	6,986,000	6,986,000
Tribal [2]	34,085,000	34,085,000	34,085,000
Subtotal:	141,953,000	143,036,000	143,036,000
Medicaid:			
Federal	366,973,000	384,759,000	384,759,000
Tribal [1]	22,217,000	22,217,000	22,217,000
Tribal [2]	75,181,000	75,181,000	75,181,000
Subtotal:	464,371,000	482,157,000	482,157,000
Medicare/Medicaid Total:	606,324,000	625,193,000	625,193,000
Private Insurance	75,101,000	75,101,000	75,101,000
TOTAL:	**$681,425,000**	**$700,294,000**	**$700,294,000**
FTE	4,345	4,345	4,345

[1] Represents CMS Tribal collection estimates.

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

PROGRAM DESCRIPTION

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

Medicare/Medicaid

The FY 2008 Medicare and Medicaid (M&M) budget estimate continues the FY 2007 revised collection estimate of $700,294,000. The FY 2007 revised estimate assumes that the FY 2006 actual collections will be increased by $18,869,000 to fully incorporate the calendar year (CY) 2006 rate changes for M&M. The CY 2006 rate changes were approved following a review of the of 46 IHS hospital cost reports for FY 2004. A

priority is being placed on the development of the FY 2005 cost reports as future rate adjustments will be proposed following their completion and analysis.
In FY 2007 and FY 2008, the IHS will continue to focus on strengthening business office policies and management practices, including internal controls, patient benefits coordination, provider documentation training, certified procedural coding training and automated claims processing. Also, IHS will continue the development of modifications to its third party billing and accounts receivable software to improve effectiveness and to ensure system integration with its business processes and compliance with HIPAA, M&M regulations. The impact of Medicaid reforms for FY 2007 and FY 2008 revenue is not fully known at this time.

IHS will continue working 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 participate in M&M programs. IHS will also continue to work with the CMS and the Tribes on 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 accreditation and improve the delivery of health care for AI/AN people.

Private Third Party Collection

The FY 2008 Private Insurance budget estimate will continue for the FY 2007 collection level. During FY 2007 and in FY 2008, IHS will continue its efforts to enhance each health facility's capability to identify patients who have private insurance coverage and improve claims processing, documentation and coding to increase private insurance billing and collections. Funds collected will be used by the local Service Units to improve services, including the purchase of medical supplies and equipment, and to improve local service unit business management practices. In addition, the IHS will continue to utilize private contractors to pursue collections on outstanding claims from private payers.

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

(Dollars in Thousands)

Type of Obligation	FY 2006	FY 2007	FY 2008
Personnel Benefits & Compensation	$295,674	$303,005	$313,818
Travel & Transportation	3,867	4,001	3,835
Transportation of Things	2,016	2,111	2,023
Comm./Util./Rent	8,188	8,517	8,162
Printing & Reproduction	172	178	171
Other Contractual Services	112,275	118,333	113,372
Supplies	100,290	104,488	100,130

Equipment	5,462	5,753	5,512
Land & Structures	5,836	6,000	5,752
Grants	8,723	8,974	8,604
Insurance / Indemnities	284	293	281
Interest/Dividends	169	172	165
Subtotal	542,956	561,825	561,825
Tribal Collections	$138,469	$138,469	$138,469
Total Collections	**$681,425**	**$700,294**	**$700,294**

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$150,000,000	$150,000,000	$150,000,000	$0
FTE	0	0	0	0

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

STATEMENT OF THE BUDGET-

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

SDPI Appropriation

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

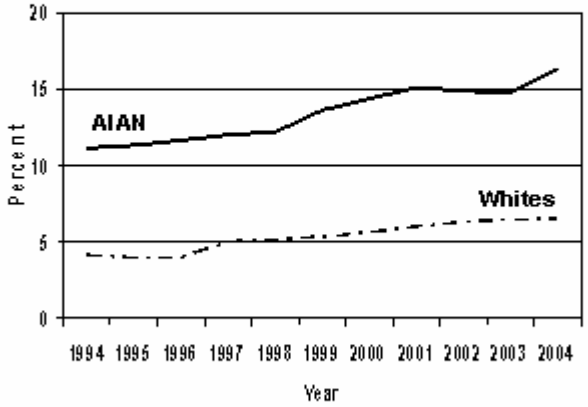
The *SDPI* reauthorization for $150 million for FY 2004-2008, directed the IHS to expand the program and implement a competitive grant program for eligible entities for the implementation of specific interventions proven to prevent diabetes and reduce cardiovascular risk, the most compelling complication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

PROGRAM DESCRIPTION

Problem of Diabetes in AI/ANs

AI/AN communities suffer a disproportionately high rate of type 2 diabetes. Between 1997 and 2004, the prevalence of diagnosed diabetes increased by 45 percent in all major regions (all ages) served by the Indian Health Service.

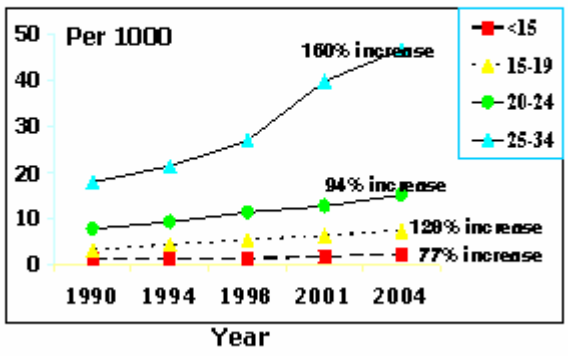
Age-adjusted* prevalence of diagnosed diabetes among American Indians and Alaska Natives (AIAN) and U.S. Whites aged 20 years or older, United States, 1994–2004



*Based on the 2000 U.S. standard population.
Source: Indian Health Service ambulatory patient-care data and the National Health Interview Survey.

The highest rate of increase has occurred among AI/AN young adults aged 25-34 years, with a 160 percent increase from 1990-2004. Alarmingly, type 2 diabetes rose 128 percent in AI/AN adolescents 15-19 years old (see new graph with black lines).

Prevalence of diagnosed diabetes among children and young people, by age group, 1990-2004



Source: IHS Diabetes Program Statistics

Diabetes Related Co-morbidity, Complications and Mortality in AI/ANs
In 2003, of AI/ANs aged 35 years or older with diabetes, nearly 70 percent had both diabetes and hypertension. Diabetes mortality is more than 3 times (3.1) higher in the AI/AN population than in the general U.S. population (1999-2001). Complications of diabetes lead to much higher incidence rates of blindness, vascular insufficiency leading to amputation, and End Stage Renal Disease (ESRD) than in the general U.S. population.

- For instance, in 2000 in New Mexico, the age-adjusted lower-extremity amputation rate was 3.5 times higher for American Indians (AI) with diabetes than for non-Hispanic whites (11.4 versus 3.3; $p<0.05$).
- In 2001, the age-adjusted ESRD incidence among AI in the Southwest was 2.4 times that of persons with diabetes in the U.S. (55.8 vs. 23.4/10,000 persons with diabetes).
- In 2002, one in every four (24.8 percent) AI/AN elders over age 65 years had coronary heart disease (or one of every five of those aged 55 and older).

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

IHS Division of Diabetes Treatment and Prevention

The mission of the IHS Division of Diabetes Treatment and Prevention is to develop, document, and sustain a public health effort to prevent and control diabetes in AI/ANs. This mission is accomplished by promoting collaborative strategies for the prevention of diabetes and its complications to over 1.8 million AI/ANs through its extensive diabetes network. In addition, the DDTP provides leadership and programmatic administrative oversight to the *Special Diabetes Program for Indians* grant program.

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 non-competitive and 66 competitive local IHS, Tribal and Urban Indian SDPI grant programs. The 66 competitive SDPI grant programs, awarded in FY 2004, are comprised of 30 CVD risk reduction demonstration projects and 36 diabetes prevention demonstration projects. This extensive diabetes network supports the *SDPI* grant programs by providing administrative support, training and technical assistance and the dissemination of the latest scientific findings and best practices to the programs. Now the most comprehensive rural system of care for diabetes in the U.S., the IHS combines both clinical and public health approaches to address the problem of diabetes and its complications.

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

information for outside organizations and agencies working on diabetes and disparities related to diabetes.

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

Special Diabetes Program for Indians

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

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

Targeted Demonstration Projects

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

Primary Prevention of Type 2 Diabetes
The results of the Diabetes Prevention Program (DPP), an NIH-funded multi-center double blind research study, were issued in the February 7, 2002 issue of the New England Journal of Medicine (which included 171 AI participants) and showed conclusively that type 2 diabetes could actually be prevented or delayed through lifestyle changes (58 percent reduction) or use of the medication Metformin (31 percent reduction). The DPP study has provided a new road map for diabetes prevention for the nation, including Indian health programs. Many of the IHS SDPI grant programs were working on diabetes prevention interventions prior to the publication of this study. Thus, the SDPI funds have provided the resources to build a much stronger diabetes infrastructure and launch diabetes prevention activities in AI/AN communities to translate these promising findings. In FY 2004, an overwhelming number of diabetes grant programs (96 percent) reported they now use SDPI funds to support some type of diabetes primary prevention activity, and 83 percent now target primary prevention efforts at AI/AN children and youth (compared with <10 percent in 1997).

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

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

SDPI Summary
The *SDPI* has brought Tribes together over these past 9 years, working toward a common purpose and sharing information and lessons learned along the way. The IHS has shown through its public health evaluation activities that these programs have been very successful in improving diabetes care and outcomes, as well as the start of primary prevention efforts, on reservations and in urban clinics. Our evaluation of *SDPI* and diabetes clinical measures suggests that population-level diabetes-related health is better

among our AI/AN patients since the implementation of *SDPI*. The greatest benefit for AI/AN 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. As a reflection of the global effect of quality of care and of resource allocation, these trends demonstrate the public health impact made possible when community, program, and congressional initiatives are focused on a common outcome.

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

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

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

- **Prevention Efforts.** Prior to the *SDPI*, AI/AN communities had few resources to devote to primary prevention of diabetes. An overwhelming number of diabetes grant programs (96 percent) report that they now use funds to support diabetes primary prevention activities in their communities. The IHS is currently developing two new curriculums – type 2 diabetes and children and diabetes prevention in youth – for dissemination in AI/AN communities. IHS has also developed and finalized

Standards of Care and clinical treatment guidelines for Pre-diabetes and Metabolic Syndrome and made them available through the I/T/U diabetes network.

The implementation of secondary prevention efforts – the prevention of complications such as kidney failure, amputations, heart disease and blindness – and tertiary prevention efforts to reduce morbidity and disability in those who already have complications from diabetes has also been a focus of *SDPI* activities. Improvement in the treatment for risk factors of cardiovascular disease, the detection and retardation of the progression of diabetic kidney disease, and the detection and treatment of diabetic eye disease have also been achieved since the implementation of *SDPI*.

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

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

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

- **Best Practices Approach.** Based upon Congressional direction, the IHS developed a consensus-based Indian health "best practices" approach to ensure dissemination of

successful community based interventions to the SDPI grant programs. This was accomplished by convening best practices workgroups, consisting of experts from IHS, Tribes, urban Indian organizations, the IHS Model Diabetes Programs, and project coordinators from *SDPI* grant sites. The workgroups developed 14 Best Practice Model approaches for successful diabetes prevention, treatment and education practices in AI/AN communities based on findings from the latest diabetes scientific research, outcomes studies, and their own successful experiences. The best practice models were used by applicants to identify strengths in diabetes resources and services in their communities, find gaps in diabetes services or programs, establish program priorities, find best practice models that could be applied within their own communities, and to begin a work plan to develop their own local best practice models. To assess use of the consensus-based Best Practice Models for AI/AN communities, IHS Area Chief Medical Officers and Area Diabetes Consultants completed assessments of Best Practice Model use with their review of each grant application. Data were then compiled. In 2003, elements of the Nutrition and Physical Fitness Best Practice Model approach were used by 70 percent of grant programs, the Diabetes Screening Best Practice Model approach was used by 70 percent of grant programs, and the Basic Diabetes Care and Education Best Practice Model approach was used by 55 percent of SDPI grantees.

- **Best Practice Models** – 14 Best Practice Models were originally developed in 2001 to assist SDPI grant programs, including:
  1. Basic diabetes care and education – a systems approach
  2. Cardiovascular disease and diabetes – screening, treatment, and follow-up
  3. Community Advocacy – winning support for your diabetes program
  4. Eye care for people with diabetes – screening, treatment, and follow-up
  5. Foot care for people with diabetes – screening, treatment, and follow-up
  6. Kidney disease – screening, prevention, treatment, and follow-up
  7. Medications for diabetes care
  8. Nutrition and physical fitness programs
  9. Pregnancy and diabetes – screening, management, and follow-up
  10. School health – nutrition and physical activity
  11. Diabetes screening programs
  12. Diabetes self-management education
  13. Type 2 diabetes in youth – prevention and screening
  14. Dental care for people with diabetes – screening, management and follow-up

  All the original Best Practice Models were updated in August 2005. In addition 4 new Best Practices were developed:

  15. depression,
  16. adult weight management,
  17. breastfeeding, and
  18. communication

- **CDC/Native Diabetes Wellness Program (formerly the National Diabetes Prevention Center).** Annually $1 million of the Balanced Budget Act funds have been allocated to the CDC Division of Diabetes for the development of a national focus on diabetes prevention in tribal communities. Based on input from SDPI grant programs nationwide, the Tribal Leaders Diabetes Committee, and the IHS, Native Diabetes Wellness Program (NDWP) has focused support for the dissemination of diabetes technical assistance resources including program evaluation, educational materials on diabetes and prevention of diabetes, and other diabetes data. The NDWP has provided support to the American Indian Higher Education Consortium (AIHEC) to develop a K-12 curriculum on diabetes and science called Diabetes Education in Tribal Schools Project (DETS). Of significance, is the development of a series of 4 children's books called the Eagle Books for use in a variety of settings aimed at diabetes awareness and encouraging healthy lifestyle habits in order to prevent diabetes and obesity. These books are currently being disseminated widely throughout Indian country and beyond, and have been featured in the national and international news.

- **Tribal Management of Local Grant Programs.** Eighty-one percent of the *SDPI* non-competitive grant recipients are Tribal programs while 10 percent were awarded to urban Indian programs and nine percent to IHS programs. To responsibly manage a health program requires data that supports an assessment of the health needs of the population. To meet this need, Tribal programs were well represented in the IHS 2005 Diabetes Care and Outcomes Audit of AI/AN with diagnosed diabetes and will have the opportunity to participate in the 2006 audit. Data gathered by these audits provides Tribes with information to guide the management of their diabetes programs.

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

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

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

development of a portable JVN for use in Alaska and sparsely populated sites in the lower 48.

- In addition to the Joslin Vision Network, the IHS is in its 6th year of partnering with the Joslin Diabetes Center, the Veterans Administration and the Department of Defense to deploy a web-based case management system called the Comprehensive Diabetes Management Program (CDMP). The CDMP is interactive with the IHS health information system (RPMS) and provides the latest patient health information at any location via the web to case managers. With this information and the CDMP case management software, the quality of care for individuals with diabetes can be improved and better coordinated between other diabetes providers. Recent enhancements to the core application in Version 4.1of CDMP includes a behavioral assessment; education needs assessment tool; nutrition assessment (2 levels); basic clinical information, including a patient snapshot, a care planning tool, a medication module and patient education materials. There is also a patient portal (DME), a Study Manager and a JVN Work Manager which is an interface between JVN and CDMP (diagnostic report, images and a reporting tool).

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

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

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

  The CDC has detailed one full time physician /medical epidemiologist who is board certified in Family Medicine and Preventive Medicine to the IHS DDTP and Epidemiology program from the CDC/CCDPHP/Division of Nutrition and Physical Activity since October 2004. Key elements from the interagency agreement covering this detail include supporting an evaluation of the Boys and Girls Club-based Diabetes Prevention Initiative, providing technical assistance to the IHS on diabetes data quality improvement, initiating a system of surveillance for childhood and adult obesity to guide program implementation and evaluation, providing technical

assistance to the IHS and Tribes on best practices for obesity prevention and early intervention, and facilitating collaborations among the IHS, CDC, Tribes, and States around obesity prevention. This interagency agreement was initiated in 2004 and can be renewed annually for 5 years.

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

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

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

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

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

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

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

- National Diabetes Education Program (NDEP), a joint program of the NIH and CDC. DDTP staff members serve on the Steering Committee as well as chair the American Indian/Alaska Native Workgroup of the NDEP.

FUNDING HISTORY -- The Special Diabetes Program for Indians grant was reauthorized in December 2002 (P.L. 107-360) for five years (FY 2004 – FY 2008) at $150 million per year.

Fiscal Year	Amount	FTE
2003	$100,000,000	0
2004	$150,000,000	0
2005	$150,000,000	0
2006	$150,000,000	0
2007 CR	$150,000,000	0

RATIONALE FOR THE BUDGET-

The IHS *Special Diabetes Program for Indians* FY 2008 budget of $150,000,000 and 0 FTE is the same as the FY 2007 Continuing Resolution level of $150,000,000 and 0 FTE.

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

The evaluation of the Special Diabetes Program for Indians (SDPI) and diabetes clinical measures suggests that population-level diabetes-related health is better among the AI/AN patients since the implementation of SDPI. The greatest benefit for AI/AN 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.

The IHS has demonstrated, through the SDPI, its ability to design, manage, and measure a complex, long-term project to address a chronic disease in partnership with Tribes and other Indian organizations as well as collaborative involvement of other federal agencies and private organizations in a successful manner. What's more, IHS has shown that it

can successfully work with tribal partners to help them progress from whatever their starting position – be it a fully functioning clinical diabetes program, a rudimentary community program, or no program at all – along a continuum of diabetes excellence so that all improve in some way. Significant infrastructure has been established where there was none. Basic programs have become centers of excellence. Innovation has become commonplace in these programs, and the sense of "tribal ownership" is now entrenched. And positive signs such as a decrease in incidence of diabetes-related End Stage Renal Disease among American Indians in the Southwest are starting to be seen. By continuing to support this program, Congress is investing in a true collaboration between the Tribes and the agency, one that has demonstrated positive outcomes and a proven track record that continues to show steady improvements, quantitatively and qualitatively, from year to year.

2008 Budget
Special Diabetes Program for Indians

CATEGORY	(Dollars in Millions)
Original Diabetes Grants (299 grants) Includes administrative funds to HQ, Areas, Tribal Leaders Diabetes Committee, and evaluation support contracts, etc.	$108.9
Targeted Demonstration Projects (66 grants) Includes administrative funds to HQ, Coordinating Center, support contracts, etc.	27.4
Urban Indian Health Program (34 grants)	7.5
Funds to strengthen the Data Infrastructure of IHS	5.2
Native Diabetes Wellness Center (CDC)	1.0
TOTAL:	**$150.0**

FUNDING AMOUNTS – FY 2007

FY 2007 Non-Competitive Diabetes Funds
Grants for Special Diabetes Programs for Indians by Area

Area	Number of Grantees	Federal Assistance Award
Aberdeen	25	$9,432,052
Alaska	24	$8,963,599
Albuquerque	32	$7,319,223
Bemidji	35	$7,777,210
Billings	12	$5,231,685
California	26 (5 sub-grantees)	$6,494,378
Nashville	2 (23 sub-grantees)	$5,462,038
Navajo	7	$14,056,955
Oklahoma	38 (7 sub-grantees)	$18,112,325
Phoenix	38 (4 sub-grantees)	$13,674,139
Portland	47	$5,729,734
Tucson	2	$2,539,246
Urban Programs	36	$7,343,507
	324	

FY 2007 CVD & DPP Diabetes Funds
Grants for Special Diabetes Programs for Indians by Area

CVD

Area	# of Grantees	Funding Amount
Aberdeen	1	$324,300
Alaska	1	$324,300
Albuquerque	4	$1,370,000
Bemidji	4	$1,370,000
Billings	3	$1,045,700
California	4	$1,370,000
Nashville	1	$324,300
Navajo	1	$397,100
Oklahoma	4	$1,442,800
Phoenix	3	$1,118,500
Portland	3	$1,045,700
Tucson	1	$397,100
	30	

DPP

Area	# of Grantees	Funding Amount
Aberdeen	5	$1,694,300
Alaska	4	$1,442,800
Albuquerque	2	$721,400
Bemidji	5	$1,621,500
Billings	1	$324,300
California	4	$1,370,000
Nashville	2	$721,400
Navajo	1	$397,100
Oklahoma	4	$1,588,400
Phoenix	2	$794,200
Portland	6	$2,091,400
Tucson	-0-	-0-
	36	

PERFORMANCE ANALYSIS

In accordance with the "One HHS" 20 Department-wide Objectives, the Indian Health Service is committed to implementing results-oriented management by achieving a 10 percent relative increase in program performance by FY 2007 in LDL (low-density lipoprotein cholesterol – the "bad" cholesterol) screening in patients with diabetes. Low cholesterol levels help to protect patients with diabetes from developing heart disease. Improved control of cholesterol levels reduces the risk of cardiovascular complications by 20 – 50 percent. In addition, national standards recommend that patients with diabetes keep their LDL cholesterol levels below 100, ideally. The average LDL value for AI/AN's from the IHS Annual Diabetes Care and Outcomes Audit data has decreased from 118 mg/dl in 1998 to 97 mg/dl in 2006.

Besides LDL screening, four other national diabetes performance measures are included within the annual Performance Budget of the Indian Health Service. These measures track different aspects of diabetes care, including blood sugar control. This extraordinary number of measures reflects the excessive diabetes disease burden in American Indian/Alaska Native communities. Despite this excessive diabetes disease burden, **the Indian Health Service met all performance targets for FY 2006 from the IHS Annual Diabetes Care and Outcomes.**

Emphasis and Role of Diabetes

Emphasis on diabetes care within IHS' Hospital and Health Clinics budget recognizes the role of diabetes as a major cofactor in morbidity as well as one of the major causes of mortality among AI/AN people. During the FY 2004 budget process, the IHS PART included a review of the IHS Direct Federal Programs and the Hospital and Clinics Budget, where the funding for diabetes care resides. The program received a rating of "Moderately Effective." IHS shared the PART review results with the clinical providers

and healthcare facilities of the Indian health system. These improved trends in diabetes care demonstrate the public health impact made possible when local, program, and departmental initiatives are focused on a common outcome. The PART review process has also focused attention on the continued importance of assuring valid and reliable performance data addressing diabetic care at all levels of the Indian health system (IHS, Tribal and Urban) and thus was addressed in both the Urban Indian Health Program and RPMS/IT PART reviews that were part of the FY 2005 budget process.

Diabetes Performance Measure: Ideal Glycemic Control (A1C < 7)
FY 2007 and 2008 Target: 37 percent for the IHS Diabetes Audit -- In FY 2006, 37 percent of AI/AN patients with diabetes achieved ideal glycemic control by having an A1C less than 7.0 percent on the 2006 IHS Annual Diabetes Care and Outcomes Audit, which is 1 percent above the rate of 36 percent in the 2005 audit. The 2006 IHS Annual Diabetes Care and Outcomes Audit was conducted in June, July and August 2006 in over 280 Indian health system facilities.

Diabetes Performance Measure: Dyslipidemia Assessment
FY 2007 and 2008 Target: 76 percent for the IHS Diabetes Audit -- In FY 2006, 73 percent of clients with diagnosed diabetes were assessed for dyslipidemia by having a low-density lipoprotein (LDL) cholesterol level done. This is 3 percent greater than the level achieved in the 2005 IHS Annual Diabetes Care and Outcomes Audit, representing care to more than 122,885 patients with diabetes seen in over 297 Indian health system facilities.

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

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

THIS PAGE LEFT BLANK INTENTIONALLY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2008 Performance Budget Submission

TABLE OF CONTENTS

THIS PAGE LEFT BLANK INTENTIONALLY

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

FACILITIES

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$353,211,000	$363,573,000	$339,196,000	($24,377,000)
FTE	1,274	1,280	1,301	21

SUMMARY OF THE BUDGET REQUEST:

The FY 2008 budget request of $339,196,000 is a decrease of $24,377,000 below the FY 2007 Continuing Resolution Level of $363,573,000.

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

THIS PAGE LEFT BLANK INTENTIONALLY

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$51,633,000	$52,254,000	$51,936,000	($318,000)
FTE	0	0	0	0

STATEMENT OF THE BUDGET REQUEST

The budget request of $51,936,000 for 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. 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.

PROGRAM DESCRIPTION

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

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

Facilities Engineering Program Plans (FEPPs) establish annual M&I workload targets and help determine the most prudent use of available resources. FEPPs are prepared by IHS Areas, service units, and Tribal programs to identify, delineate, and plan facilities

related activities and projects to be accomplished during the upcoming fiscal year with the M&I funds.

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

Status of Facilities

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

These surveys, together with routine observations by facilities personnel, identify deficiencies that are included in the Backlog of Essential Maintenance, Alterations, and Repair (BEMAR) database. The identified BEMAR for IHS and reporting Tribal facilities as of October 2006 was $408,965,000. The following table summarizes the BEMAR by category:

BEMAR [1]

PUBLIC LAW	
Life Safety Compliance	$17,849,000
General Safety	8,837,000
Environmental Compliance [2]	18,979,000
Handicapped Compliance	15,467,000
Energy Conservation	13,849,000
Seismic Mitigation [3]	71,728,000
Sub Total	**$146,709,000**
IMPROVEMENTS	
Patient Care	$26,525,000
Program Deficiencies	74,263,000
Sub Total	**$100,788,000**
MAINTENANCE & REPAIR [4]	
Architectural M&R	$12,632,000
Structural M&R	36,144,000
Mechanical M&R	59,252,000
Electrical M&R	19,479,000
Utilities M&R	6,977,000
Grounds M&R	18,542,000
Painting M&R	2,607,000

Roof M&R	5,835,000
Sub Total	**$161,468,000**

GRAND TOTAL	**$408,965,000**

[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.

M&I Funds Distribution Method

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

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

M&I Project Funds - IHS Area Facilities Engineers develop priority lists of larger projects to reduce the BEMAR. Although Tribes with Tribally-owned facilities may take their individual shares of the M&I project pool funds, 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.

Environmental Compliance Funds - Many IHS and Tribal facilities were constructed before the existence of current environmental laws and regulations. Since IHS is required to comply with current Federal, State, and local environmental regulations, the use of environmental assessments to identify and evaluate potential environmental hazards is important. These assessments form the basis of the IHS facilities environmental

remediation activities. The IHS has currently identified approximately $19 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 or obsolete and no longer needed. The number currently is estimated at over 70 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.

Funding History - Funding for the Maintenance and Improvement program during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2003	$49,507,000	0
2004	$48,897,000	0
2005	$49,204,000	0
2006	$51,633,000	0
2007 CR	$52,254,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $51,936,000 is a decrease of $318,000 below the FY 2007 Continuing Resolution Level of $52,254,000. This funding level will support the M&I program at the FY-2006 level which included approximately $37 million for routine maintenance, approximately $11 million for projects, $3 million for environmental remediation activities, and $500,000 for demolition activities.

PERFORMANCE ANALYSIS

A total of $51,633,000 was appropriated in FY 2006 and approximately $6,288,000 in quarters return funds was collected and distributed; quarters return funds are used only to maintain staff quarters. Approximately $37 million, identified as M&I routine maintenance, was provided to the IHS Areas and Tribes for daily maintenance activities and local projects to maintain the current state of health care facilities; approximately $11 million, identified as M&I project, was provided to the IHS areas and Tribes for projects to reduce the BEMAR deficiencies and to improve healthcare facilities to meet changing healthcare delivery needs.

In 2005, the Federal Real Property Council approved the Condition Index (CI) as the measure of a constructed asset's condition at a specific point in time. The CI is calculated as the ratio of Repair Needs (a.k.a. BEMAR) to Plant Replacement Value (PRV) [i.e., CI = (1 - $repair needs/$PRV) x 100)]. The CI is reported as a "percent condition" on a scale of 0 percent to 100 percent (positive whole numbers; for cases in which the calculation results in a negative number, the percentage should be reported as zero). The higher the CI, the better the condition the constructed asset is in.

The average CI for Government-owned facilities and selected Tribally-owned facilities that choose to maintain their deficiencies within our database system is as follows:

FY		2002	2003	2004	2005	2006
CI		74	78	79	80	83

The Department of Health and Human Services established two performance goals: first to sustain the condition of existing real property to prevent deterioration; and second to provide a strategy to increase the Condition Index of each facility to 90 or greater.

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. 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 sets aside approximately $3 million for environmental compliance projects and approximately $500,000 for demolition projects annually. In conjunction with improved management practices, energy conservation measures, and projects, IHS reduced the energy-related utility consumption for IHS-managed facilities from 2,150,000 BTU/SM in 2004 to 1,797,000 BTU/SM in 2006.

Steady State Condition

The Building Research Board of the National Academy of Sciences (NAS) (*Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings, 1990*) has determined that approximately 2 to 4 percent of current replacement value of supported buildings is required to maintain facilities in their current condition. Due to facility type, facility use, and facility location; the IHS projects it needs a higher percentage of the current plant replacement value than this 2-4 range to be maintain the IHS's facilities.

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

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.

IHS fully funds sustainment to maintain the facilities in their current condition. Historically, IHS funding levels have been less than five percent resulting in our current BEMAR and corresponding CI. The commercial healthcare sector level of funding establishes a reasonable backlog as five percent of the plant replacement value. The

current (2006) replacement value, of all M&I eligible facilities, is approximately $2.42 billion. Applying this level of five percent of our total plant replacement value yields a desired BEMAR of $121 million.

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

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

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$92,143,000	$93,259,000	$88,500,000	($4,759,000)
FTE	194	193	195	2

STATEMENT OF THE BUDGET REQUEST

The budget request of $88,500,000 for Sanitation Facilities Construction (SFC) supports essential sanitation facilities including water supply, sewage, and solid waste disposal facilities to AI/AN homes and communities. The SFC Program is a preventative health program that yields positive benefits in excess of the program costs. The SFC budget supports health priorities by providing water supply, sewage, and solid waste disposal facilities to AI/AN homes and communities. These services will implement strategies/activities to address the health disparities that exist in these areas.

Number of Homes Benefited				
	FY 2005 Actual	FY 2006 Actual	FY 2007 Estimate	FY 2008 Estimate
A. New/Like New				
HUD [1]	23	78	200	200
BIA/HIP	123	30	300	300
Tribal/Other	2249	1,303	3,300	2,300
Subtotal	2395	1,411	3,800	2,800
B. Existing Indian Homes				
First Service	2029	1,766	1,800	1,675
Upgraded/Emergency	19,648	20,913	16,900	16,900
Subtotal	21,677	22,679	18,700	18,575
Total [2]	**24,072**	**24,090**	**22,500**	**21,375**

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

PROGRAM DESCRIPTION

Sanitation Facilities Construction (SFC) is an integral component of the IHS disease prevention activity. 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.

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

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

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

Sanitation facilities projects are carried out cooperatively with the Indian people who are to be served by the facilities. Tribal involvement has been the keystone of the Sanitation Facilities Program since its inception in FY 1960. 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.

With completion of all projects approved through FY 2005, approximately 320,000 AI/AN homes will have been provided sanitation facilities since 1960. Experience shows that 60 to 70 percent of the actual construction is performed by Indian Tribes/firms.

Sanitation Facilities Needs

The Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L. 94-437) directed the IHS to identify the universe of Indian sanitation facilities needs for existing Indian homes. As of the end of FY 2006, the list of all documented projects totaled over $2.2 billion with those projects considered economically feasible totaling $1 billion. As of the end of FY 2006, there were over 155,000 AI/AN homes in need of sanitation facilities, including over 38,000 AI/AN homes without potable water.

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

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

Fiscal Year	Amount	FTE
2003	$93,217,000	195
2004	$93,015,000	198
2005	$91,767,000	198
2006	$92,143,000	194
2007 CR Level	$93,259,000	193

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $88,500,000 and 195 FTE is a decrease of $4,759,000 below the FY 2007 Continuing Resolution Level of $93,259,000.

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) $1,000,000 will be reserved at IHS Headquarters for special projects and for distribution to the Areas as needed to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situations that require immediate attention to minimize potential threats to public health. Emergency and special funds remaining at the end of the fiscal year will be distributed to the Areas to address the Sanitation Deficiency System (SDS) priority list of needs.

2) Up to $42,000,000 of the total FY 2008 SFC appropriation will be reserved to serve new and like-new homes. Some of these funds may also be used for sanitation facilities for the individual homes of the disabled or sick with a physician referral indicating an immediate medical need for adequate sanitation facilities in their home. As needed, amounts to serve new and like-new homes will be established by Headquarters after reviewing Area requests. Priority will be given to projects intended to provide sanitation facilities for the first time to homes in categories B, C, and D (new homes and homes receiving major renovation bringing the homes up to like new condition) under the BIA Housing Improvement Program (HIP). (NOTE: Homes in BIA/HIP Category A are considered existing homes. Category A homes needing service will be included in the SDS.)

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

3) Up to $46,000,000 of the amount appropriated in FY 2008 will be distributed to the Areas for prioritized projects to serve existing homes, based on a formula that considers, among other factors, the cost of facilities to serve existing homes that: (a) have not received sanitation facilities for the first time; or (b) are served by substandard sanitation facilities (water and/or sewer). Another distribution formula element is a weight factor that favors Areas with larger numbers of American Indian and Alaska Native (AI/AN) homes without water supply or sewer facilities, or without both. Up to $5,000,000 will be used for projects to clean up and replace open dumps on Indian lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994.

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

PERFORMANCE ANALYSIS

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. 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 2010; providing compassionate quality

health care through the provision of sanitation; and embracing innovation through prevention activities and increased partnerships with other federal agencies, States and Tribes. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts, as well as being a major factor in the quality of life of Indian people.

The SFC program has exceeded all GPRA, IHS, Departmental and OMB performance measures. In FY 2002, the SFC was reviewed through the OMB Program Assessment Rating Tool (PART) evaluation process (10000284). The SFC program received a score of 80 out of a possible 100, a rating of Moderately Effective, which was the second highest within the Department of Health and Human Services for that year. SFC completed all the PART follow-up recommendations including an independent evaluation and is scheduled to be re-assessed in FY 2008. Based on this evaluation the SFC program has begun a strategic planning process to improve performance.

Prior to FY 2004, IHS stated that 7.5 percent of AI/AN homes were without potable (safe and reliable) water. Based on end of year 2006 data, it is estimated that approximately 12 percent of AI/AN homes are without a safe and reliable water supply. This increase in the number of AI/AN homes lacking safe water is due to inflation, population growth, the age and condition of the existing infrastructure, high numbers of new and like new housing, and new environmental regulations including the new Arsenic and Surface Water Treatment rules promulgated by the Environmental Protection Agency.
In FY 2006, of the $92,143,000 appropriated for sanitation facilities, $45,365,760 was used to address the backlog of existing homes. This included funding to serve solid waste needs (included in the solid waste funding was approximately $492,000 to clean up open dumps identified by an interagency task force, the members of which included the Bureau of Indian Affairs, the Environmental Protection Agency, the Department of Agriculture and others). The remainder of the FY 2006 appropriation was used to provide $45,301,261 for sanitation facilities for new/like-new Indian homes and $1,475,979 for special projects, and emergency projects.

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

An efficiency measure was proposed and accepted by OMB in 2007 based on the average project duration. 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 nearly 4 years at the end of 2005 or about 12.5 percent per year increase. It is expected that the project duration will increase to at least 4.3 years prior to returning to 4 years.

In FY 2006, the IHS provided service to 24,090 homes, which exceeded GPRA measure 35: to provide sanitation facilities projects to serve 22,000 AI/AN homes with water, sewage disposal, and/or solid waste water facilities.

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 development of a marginal cost analysis also served as a milestone on the DHHS' President's Management Agenda score card for the third quarter of FY 2005. The OMB approved the analysis and its findings in June of 2006. The recommendations validated the existing IHS strategic goal and PART goal for the SFC Program.

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

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

Health Care Facilities Construction

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$37,779,000	$36,664,000	$12,664,000	($24,000,000)
FTE	0	0	0	0

HEALTH CARE FACILITIES CONSTRUCTION PROJECTS

Projects [1]	FY 2006 Actual [2]	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$37,779,000	$36,664,000	$12,664,000	--$24,000,000
Upper Santan, AZ–PIMC System–SE ACC	0	-	0	N/A
Komatke, AZ – PIMC System–SW ACC	7,882,000	-	0	N/A
Scottsdale, AZ – PIMC System NE ACC	0	-	0	N/A
Barrow, AK	7,882,000	-	12,664,000	N/A
Subtotal Inpatient	**15,764,000**	-	**12,664,000**	N/A
Kayenta, AZ	3,821,000	-	0	N/A
San Carlos, AZ	6,049,000	-	0	N/A
Subtotal Outpatient	**9,870,000**	-	**0**	N/A
Ft. Belknap, MT	3,277,000	-	0	N/A
Subtotal Staff Qtrs	**3,277,000**	-	**0**	N/A
Various Projects	6,897,000	-	0	N/A
Subtotal Small Ambulatory Program	**6,897,000**	-	**0**	N/A
Various Projects	1,971,000	-	0	N/A
Subtotal Dental Facilities Program	**1,971,000**	-	**0**	N/A
Various Projects	0	-	0	N/A
Subtotal Joint Venture Program	**0**	-	**0**	N/A

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

2 The FY 2006 Actual and the FY2007 President's Budget include all rescissions.

STATEMENT OF THE BUDGET REQUEST

The budget request of $12,664,000 for Health Care Facilities Construction (HCFC) continues to fund the construction of a health care facility where direct health care services will be provided to American Indian and Alaska Native (AI/AN) people. Construction of new and replacement health care facilities provides access to health care services for the AI/AN population allowing those communities to address their top health

priorities. These projects are from national priority lists or are competitively awarded based on objective criteria.

PROGRAM DESCRIPTION

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

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

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

Health Care Facilities Construction

During FY 1990, in consultation with the Tribes, the IHS revised its Health Facilities Construction Priority System (HFCPS) methodology. The HFCPS ranks proposals using factors reflecting the total amount of space needed; age and condition of the existing facility, if any; degree of the isolation of population to be served in the proposed facility; and availability of alternate health care resources. There are three phases to the HFCPS. During FY 1991, Phase I of the methodology was applied to 149 IHS Area-generated proposals to construct new or replacement health care facilities. Based on the Phase I result, the IHS proceeded with Phase II of the methodology, using a more detailed analysis of the 28 highest ranked proposals. During FY 1992, the IHS consulted with Tribes about incorporating additional flexibility into the HFCPS in order to give consideration to new concepts, such as low acuity beds in health centers, as directed by the Congress in the FY 1992 Conference Report on IHS appropriations. Few Tribes urged the IHS to make changes to the HFCPS. In FY 1993, 23 of the 28 proposals considered in Phase II were advanced to Phase III. IHS Area Offices were asked to

develop Program Justification Documents (PJDs) for each of the 23 proposed facilities. As PJDs are approved, projects are added to the respective Health Facilities Construction Priority List.

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

Where quarters are required as part of a health care facility project, the IHS completes a PJDQ as a part of the PJD for the health care facility and the quarters need is included with the facilities construction project on the respective Health Care Facilities Construction Priority List.

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

For the IHS Joint Venture Construction Program (JVCP), the Department of the Interior and Related Agencies Appropriations Act for FY 1991 (P.L. 101-512) authorized and partially funded a "joint venture demonstration program" to equip, supply, operate, and maintain up to three health centers. These health centers were to be selected on a competitive basis from those Tribal applicants agreeing to provide an appropriate facility for use as a health center for a minimum of 20 years, under a no cost lease. Beginning in FY 2003, Congressional language directed that staff quarters, if needed, were to be part of the health care facility under the Joint Venture Construction Program. The costs for facility design and construction and staff quarters, if any were to be borne by participating Tribes. The IHS was to be responsible for all costs associated with staffing, initially equipping, and operating the facilities. The authority for the current JVCP is Section 818(e) of the IHCIA, P.L. 94-437, as amended.

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

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

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

In FY 2003, the Department of Health and Human Services (DHHS) instituted a capital facilities programming and project review process, including a non-information technology Capital Investment Review Board (CIRB). Documentation requirements and approval authorities are defined in the DHHS June 2003 CIRB policy statement, and in the DHHS March 2004 Facility Project Approval Agreement policy statement. On June 28, 2004, the CIRB met and reviewed all projects being considered for inclusion in the FY 2006 budget request, which exceed $10,000,000, include land purchase, or otherwise fell under the Board's authority. On June 29, 2005 the CIRB met and reviewed projects being considered for inclusion in the FY 2007 budget request. In June 2006 the CIRB reviewed projects for consideration in the FY 2008 budget request.

FUNDING HISTORY

Funding for the Health Care Facilities Construction program during the last five years has been as follows:

Fiscal Year	Amount	FTE
2003	$81,585,000	0
2004	$94,554,000	0
2005	$88,596,800	0
2006	$37,779,000	0
2007 CR	$36,664,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $12,664,000 is a decrease of $24,000,000 below the FY 2007 Continuing Resolution Level of $36,664,000.

The request will provide resources to be used for the following project:

Barrow Hospital: +$12,664,000 -- Funds in this request will be used to continue construction of the Barrow Hospital, which received initial design and construction funding in 2005. This facility, to be located in Barrow, AK, will provide inpatient services for acute care nursing and labor and delivery (10 beds); endoscopy and limited outpatient surgery; ambulatory care; emergency and urgent care; ancillary services including diagnostic imaging, pharmacy, laboratory, dental, optometry, audiology, and physical therapy; community health services , including public health nursing, nutrition, health education, alcoholism, community health aide program and environmental health; and behavioral health and social services.

The proposed Barrow Hospital is planned to provide 9,326 gross square meters (GSM) of space to support a modern and adequately staffed health care delivery system. It will

serve a projected annual user population of 6,142 with 26,760 primary care provider visits and 40,167 outpatient visits each year. The facility will improve access to the health care services necessary to maintain and promote the health status and overall quality of life for the residents of the Barrow primary service area.

The proposed Barrow Hospital will replace an existing 1965 wood framed facility, which has a facility condition index of 80 percent and has a Backlog of Essential Maintenance and Repair (BEMAR) of $8 million. The existing facility provides 25 percent of the needed space to provide health care to the services area.

PERFORMANCE ANALYSIS

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

INDIAN HEALTH CARE FACILITIES CONSTRUCTED SINCE FY 1980

PROJECT LOCATION	FISCAL YEAR COMPLETED	TOTAL $ APPROPRIATED
	Hospitals	
Bethel, AK	1980	34,100,000
Ada, OK	1980	14,374,000
Cherokee, NC	1981	10,341,000
Red Lake, MN	1981	9,566,000
Chinle, AZ	1982	19,758,000
Tahlequah, OK	1983	21,334,000
Browning, MT	1985	15,086,000
Kanakanak, AK	1987	16,578,000
Crownpoint, NM	1987	17,734,000
Sacaton, AZ	1988	15,765,000
Rosebud, SD	1989	20,000,000
Pine Ridge, SD	1993	27,090,000
Shiprock, NM	1995	53,591,364
Crow Agency, MT	1995	23,091,000
Kotzebue, AK	1995	62,483,000
Anchorage, AK	1997	167,915,000
Ft. Defiance, AZ [1]	2002	117,763,797
Winnebago, NE [2]	2004	47,857,000
Subtotal		$694,427,161
	Health Centers	
Cibecue, AZ	1980	750,000
Lodge Grass, MT	1982	1,485,000
Inscription House, AZ	1983	3,890,000
Ft. Duchesne, UT	1984	2,220,000
Tsaile, AZ	1984	3,856,000
Huerfano, NM	1984	3,304,000
Ft. Thompson, SD	1988	3,449,000
Wolf Point, MT	1990	3,654,000
Kyle, SD	1990	3,209,000
Toppenish, WA	1990	9,350,000
Ft. Hall, ID	1990	6,002,000
Sallisaw, OK	1992	4,265,000
Puyallup, WA	1993	8,472,000
Taos, NM	1993	5,765,000
Wagner, SD	1993	6,119,000
Belcourt, ND (OPD)	1994	19,449,000
Tohatchi, NM	1995	9,502,682
Stilwell, OK	1995	7,663,000
Ft. Belknap, MT [3]		18,885,000
Hays, MT	1997	
Harlem, MT	1998	
White Earth, MN	1998	13,462,000
Lame Deer, MT	1999	14,100,000
Hopi, AZ	2000	34,558,000
Parker, AZ	2001	21,641,000
Pawnee, OK	2004	19,327,147
Pinon, AZ	2005	39,759,000
St. Paul, AK	2005	14,140,400
Metlakatla, AK	2006	20,011,000
Red Mesa, AZ	2006	64,102,000

INDIAN HEALTH CARE FACILITIES CONSTRUCTED SINCE FY 1980

PROJECT LOCATION	FISCAL YEAR COMPLETED	TOTAL $ APPROPRIATED
Health Centers (continued)		
Clinton, OK	2007	20,359,000
Sisseton, SD	2007	40,159,000
Subtotal		$422,908,229
Staff Quarters		
Chinle & Inscription House, AZ (design)		336,000
Inscription House, AZ (21)	1982	1,764,000
Chinle, AZ (161)	1983	12,236,000
Huerfano, NM (9) [4]	1983	
Ft. Duchesne, UT [4]	1984	
Crownpoint, NM (36)	1984	3,352,000
Tsaile, AZ (23)	1985	2,141,000
Ft. Thompson, SD (13)	1985	1,279,000
Kanakanak, AK (17)	1986	4,133,000
Browning, MT (26)	1987	2,470,000
Kyle, SD (24)	1987	1,615,000
Supai, AZ (2)	1990	246,000
Rosebud, SD (29 of 66)	1990	7,345,000
Neah Bay, WA (4)	1991	472,000
Dulce, NM (4)	1993	515,000
Barrow, AK (29)	1993	18,183,000
Rosebud, SD (remaining 37 units)	1993	7,695,000
Pine Ridge, SD (45)	1993	9,517,000
Kotzebue, AK (50)	1993	26,155,000
Belcourt, ND (21)	1997	3,912,000
Hopi, AZ (Polacca) (73) [5]	2001	4,995,000
Bethel, AK	2005	19,895,000
Zuni, NM	2006	5,410,000
Subtotal		$119,330,000
Youth Regional Treatment Centers		
Alaska - Fairbanks, AK	1993	1,466,000
Alaska – Mt. Edgecumbe, AK	1994	866,000
Phoenix – Sacaton, AZ	1994	2,357,000
Portland - Spokane, WA	1996	7,343,000
Aberdeen - Chief Gall, SD	1996	5,373,000
Subtotal		$ 17,405,000
Joint Venture Demonstration Projects		
Warm Springs, OR	1993	959,000
Poteau, OK	1994	700,000
Dulce, NM	2005	3,403,000
Idabel, OK	2005	2,272,500
Coweta, OK	2006	2,727,500
Subtotal		$ 10,062,000
GRAND TOTAL		**$1,264,132,390**

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

[2] The replacement hospital opened April 10, 2004. When the Drug Dependency Unit is completed the final project cost shown in this table will be adjusted to actual expenditures.

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

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

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

Present Health Care Facilities Priority Rankings

(January 2007)

Inpatient

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

Outpatient

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

Youth Regional Treatment Centers

Wadsworth, NV (Sacaton Satellite)**
California, Central-Southern
California, Northern

Joint Venture

Muskogee, OK ****
Lake County, CA ****

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

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$150,709,000	$160,046,000	$164,826,000	$4,780,000
FTE	1,080	1,087	1,106	19

STATEMENT OF THE BUDGET REQUEST

The Facilities and Environmental Health Support (FEHS) budget request of $164,826,000 supports personnel who provide facilities and environmental health services throughout the Indian Health Service (IHS) at the IHS Area, District, and Service unit levels, and operating costs associated with provision of those services and activities. The FEHS account is separated into **three sub-activities:** Facilities Support (FS), Environmental Health Support (EHS), and Office of Environmental Health and Engineering (OEHE) which provide support for the other activities within the facilities appropriation (e.g., Sanitation Facilities Construction) plus environmental health services. The injury prevention Program is funded through the Environmental Health Support sub-activity.

PROGRAM DESCRIPTION

The Indian Health Facilities programs, managed at IHS Headquarters by the OEHE and carried out by Area, Field, and Service unit staff, provide an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. Services are delivered directly by Federal or Tribal employees or 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 includes components in Rockville, Dallas, and Seattle. The staff has management responsibility for IHS facilities and environmental health programs, provides direct technical services and support to Area personnel, and performs critical management functions. Headquarters OEHE management activities include national policy development and implementation; budget formulation; project review and approval; congressional report preparation; quality assurance (internal control reviews, Federal Managers Financial Integrity Act activities, and other oversight); technical assistance (consultation and training for both Tribal and IHS personnel); long-range

planning; realty services; and recruitment and retention. OEHE Engineering Services staff located in Dallas, Texas, and Seattle, Washington, provide architectural, engineering, construction, contracting, and real property services to IHS and Tribal health care facilities programs.

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

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

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

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

FUNDING HISTORY – Funding for the Facilities and Environmental Health Support program during the last 5 years has been as follows:

Fiscal Year	Amount	FTE
2003	$132,963,000	1,113
2004	$137,803,000	1,065
2005	$141,669,000	1,214
2006	$150,709,000	1,080
2007 CR	$160,046,000	1,087

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $164,826,000 and 1,106 FTE is an increase of $4,780,000 and 19 FTE over the FY 2007 CR Level of $160, 046,000 and 1,087 FTE. The increase includes:

Adjustment of CR 2007 level to current services level: +$523,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Costs: +$2,771,000 - to fund pay increases for Federal and Tribal employees. Funding for pay costs is critical to maintain an appropriate level of funding to carry our programs. This also prevents having to expend program funds to pay personnel instead of projects and other related needs.

Staffing/Operating Cost Requirements for New Facilities: +$1,486,000 - to allow IHS to expand provision of health care in those areas where existing capacity is most overextended. The Cherokee Tribe has invested $25.4 million into the construction of this facility under a Joint Venture agreement. The funds will staff one new joint venture facility which will open in a full year in FY 2008. The following table displays the requested increase.

Facility	Amount	Federal FTE	Tribal Positions
Muskogee, OK Joint Venture	$1,486,000	0	9
Grand Total:	**$1,486,000**	**0**	**9**

PERFORMANCE ANALYSIS

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

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT
FACILITIES SUPPORT

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
Discretionary	$79,985,000	$86,348,000	$89,473,000	$3,125,000
FTE	570	578	591	13

STATEMENT OF THE BUDGET REQUEST:

The request of $89,473,000 will fund the costs of personnel and operation costs for Facilities Support at the Service unit and Area levels[1].

PROGRAM DESCRIPTION:

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

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

The IHS owns approximately 856,000 square meters of facilities (buildings and structures) and 724 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 1 year to more than 107 years. The average age of our health care facilities is 34 years.

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

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				
Type of Facility	Federally Owned	Direct Federal Lease	GSA Assigned	Tribal
Hospitals and Health Centers	430,000 M^2	75,000 M^2	-0-	268,000 M^2*
Staff Quarters	287,000 M^2	0 M^2	-0-	306 M^2
Other	139,000 M^2	36,000 M^2	61,000 M^2	303,000 M^2
Total	856,000 M^2	111,000 M^2	61,000 M^2	571,306 M^2

(FY 2006 end of year)

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

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

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

2. **Clinical Engineers --** 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.

3. **Realty Management** -- Area Realty Officers provide technical and management assistance for realty activities associated with direct-leased, GSA-assigned, and IHS-owned (and to some degree Tribally-owned) space. The program includes facility and land acquisitions and disposals, licensing/easement processing, use-permit issuance, quarters management and rent-setting activities, lease administration, and

budget functions. The program also helps Tribes and Tribal organizations acquire, administer, and/or manage excess Federally-owned and Tribally-leased real property.

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

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

Operations Costs

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

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

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

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

RATIONALE FOR THE BUDGET REQUEST:

The FY 2008 budget request of $89,473,000 and 591 FTE is an increase of $3,125,000 and 13 FTE over the FY 2007 Continuing Resolution Level of $86,348,000 and 587 FTE. The increase includes:

Adjustment of CR 2007 level to current services level: +$282,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Costs: +$1,357,000 - to fund pay increases for Federal and Tribal employees. The activity represents the pay costs for personnel that perform the facilities and environmental program.

Staffing/Operating Cost Requirements for New Facilities: +$1,486,000 - will allow IHS to expand provision of health care in those areas where existing capacity is most overextended. The Cherokee Tribe has invested $25.4 million into the construction of this facility under a Joint Venture agreement. The funds will staff 1 new joint venture facility which will open in a full year in FY 2008. The following table displays the requested increase.

Facility	Amount	Federal FTE	Tribal Positions
Muskogee, OK Joint Venture	$1,486,000	0	9
Grand Total:	**$1,486,000**	**0**	**9**

PERFORMANCE ANALYSIS:

In FY 2006, the Facilities Support budget continued to support Area Offices, service units and certain Tribal health care entities by funding staff, utilities, program supplies and equipment to maintain the health care buildings and grounds, and to service approximately $320,000,000 worth of medical equipment. Facilities supported include hospitals, health centers, staff quarters, health stations and school health clinics, and youth regional treatment centers.

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 approximately $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 2,150,000 BTU/SM in 2004 to 1,797,000 BTU/SM in 2006. 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 2008. However, this will only partially address the overall impact of expected increases in energy cost that are estimated to rise another 18 percent during the next year. During the period FY 2001 through FY 2006, total utility costs have increased 59 percent from $13.7 million to $21.8 million and total utility costs per GSM increased 42 percent from $24/GSM to $33 GSM. 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.

Modern health care facilities help with the recruitment and retention of health care professionals, which in turn can result in improved access and continuity of health care. In FY 2006 the Health Care Facilities Construction performance measure was simplified to track completion of projects, which means all phases completed. The measure was met in FY 2006. This measure also serves as the program's PART efficiency measure. In FY 2006, the program developed an innovative approach to measure clinical care and access to services at new facilities utilizing existing agency performance measures in the PART. Data reveals marked increases in access to care with new facilities.

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT
ENVIRONMENTAL HEALTH SUPPORT

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
Discretionary	$57,410,000	$59,893,000	$61,214,000	$1,321,000
FTE	429	428	433	0

STATEMENT OF THE BUDGET REQUEST:

The request of $61,214,000 will fund the costs of personnel who accomplish environmental health services, injury prevention activities, and sanitation facilities construction activities, at the IHS Area, District, and Service unit levels and to pay operating costs associated with provision of those services and activities.

PROGRAM DESCRIPTION:

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

PROGRAM EMPHASIS AREAS

The **Division of Environmental Health Services** (DEHS) is a consultative public health advisor to Tribes. DEHS staff lead in the assessment and identification of environmental hazards and risk factors facing Tribal groups and partner with Tribal groups in the development of sound public health strategies to prevent or mitigate environmental hazards. Strategies employed by DEHS staff include: maintaining surveillance of disease and injury incidence in communities; investigation of disease and injury incidents; 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. DEHS is administered through three program emphasis areas: General Environmental Health, Injury Prevention, and Institutional Environmental Health.

General Environmental Health staff are the lead environmental health professionals providing environmental health services to Tribes in issues 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. General Environmental Health staff are assigned at the Tribal, Service unit, District, and area levels.

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 is a GPRA measure for the IHS. In FY 2008, this web-based reporting system will be utilized to identify and environmental risk factors in communities.

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 2.6 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 grants to develop Tribal injury prevention infrastructure; and evaluation program initiatives. In FY 2006, 31 Tribal projects continued best practices in community-based IHS Tribal Injury Prevention Cooperative Agreements to develop Tribal infrastructure. The program awards consisted of 22 five-year programs and 9 three-year projects. There were no new awards in FY 2006. The next award cycle will be in 2008.

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.

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.

In 2003, the Institutional Environmental Health Program began implementation of 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 plans 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.

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

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

Both of these inventories are widely used by other governmental agencies in their evaluation and funding of sanitation projects.

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

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

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

TRIBAL HEALTH PROGRAMS

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

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

Area, District and Service unit environmental health personnel work with Tribes/Tribal organizations to encourage maximum participation in planning health services delivery programs. Also, they provide technical assistance to the Tribal officials who carry out administrative/management responsibilities associated with operation of federally supported programs. Their support of self-determination for Tribal organizations will continue. However, the extent to which there is participation in the self-determination process depends on, and is determined by, the individual Tribes/Tribal organizations.

RATIONALE FOR THE BUDGET REQUEST:

The FY 2008 budget request of $61,214,000 and 433 FTE is an increase of $1,321,000 and 5 FTE over the FY 2007 CR Level of $59,893,000 and 428 FTE. The increase includes:

Adjustment of CR 2007 level to current services level: +$196,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Costs: +$1,124,000 – to fund pay increases for Federal and Tribal employees. The activity represents the pay costs for personnel that perform the facilities and environmental program.

PERFORMANCE ANALYSIS:

The IHS Environmental Health Services Program supports the following performance measures:

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

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

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

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

Healthy People 2010 (HP 2010) - Injury and Violence Prevention are grouped as one of the 10 leading health measures. Thirty-one objectives within HP 2010 relate to injury or unintentional injury prevention. There are two injury prevention GPRA measures which relate to comprehensive community-based injury prevention efforts across IHS and Tribal settings. These have been met each year that data were available. In FY 2006, one of the injury measures changed to focus on development of a web-based data collection system to report injury prevention projects, this system has been implemented. In FY 2007, the target is for each Area to conduct at least three community injury prevention projects and report them utilizing the automated tracking system. In FY 2008 the measures will focus on motor vehicle injuries, in order to address the high motor vehicle mortality rate. These efforts are steps in addressing the increasingly disproportionate unintentional injury mortality rates within the AI/AN population.

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

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 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
Discretionary	$13,314,000	$13,805,000	$14,139,000	$334,000
FTE	81	81	82	1

STATEMENT OF THE BUDGET REQUEST:

The request of $14,139,000 will fund the Office of Environmental Health and Engineering Support which provides personnel, contracts, contractors, and operating costs for the Office of Environmental Health and Engineering (OEHE) Headquarters.

PROGRAM DESCRIPTION:

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

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

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

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

RATIONALE FOR THE BUDGET REQUEST:

The FY 2008 budget request of $14,139,000 and 82 FTE is an increase of $334,000 and 1 FTE over the FY 2007 Continuing Resolution Level of $13,805,000 and 81 FTE. The increase includes:

Adjustment of CR 2007 level to current services level: +$45,000 - These funds will restore the FY 2007 base to include the inflation increase over FY 2006. Inflation for FY 2007 is not included in the CR level, as the CR level is based on the FY 2006 enacted budget. Without restoration of FY 2007 inflation in addition to FY 2008 inflation, current services levels cannot be maintained.

Pay Costs: +$290,000 - to fund pay increases for Federal and Tribal employees. The activity represents the pay costs for personnel that perform the facilities and environmental program.

PERFORMANCE ANALYSIS:

In FY 2005, OEHE Support funded personnel who provided leadership and management, and carried out responsibilities for National policy development and implementation, budget formulation, congressional report preparation, health care facilities construction, and other national program-related duties.

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

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
Discretionary	$20,947,000	$21,350,000	$21,270,000	($80,000)
FTE	0	0	0	0

STATEMENT OF THE BUDGET REQUEST

The Equipment budget request of $21,270,000 supports maintenance and replacement of biomedical equipment at IHS and Tribal health care facilities.

PROGRAM DESCRIPTION

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

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

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

Fiscal Year	Amount	FTE
2003	$17,182,000	0
2004	$17,081,000	0
2005	$17,337,000	0
2006	$20,947,000	0
2007 CR Level	$21,350,000	0

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 budget request of $21,270,000 is a decrease of $80,000 below the FY 2007 Continuing Resolution Level of $21,350,000.

PERFORMANCE ANALYSIS

In FY 2006, the medical equipment program distributed approximately $15 million to IHS and tribal health programs to purchase new medical equipment, including replacement of existing equipment used in diagnosing and treatment of illnesses.

In FY 2006 Congress provided approximately $4.9 million for equipment to tribes or tribal organizations that seek construction funding outside of full funding through IHS. Using these funds, 27 awards were made to tribal organizations that funded and constructed clinics or clinic additions. Tribes plan on spending in excess of $62 million in construction projects using non-IHS funding sources to access these equipment funds. As a result, approximately 200,000 individual patients will be treated with updated medical equipment in these tribally-funded construction projects.

Tribes awarded for equipment funds in FY 2006 are as follows:

Bristol Bay Area Health Corp (4)	Kanza Health Center	Nisqually Indian Tribe
Canoncito Band of Navajos	Kipnuk Traditional Council	Norton Sound Health Corp (3)
Choctaw Nation (2)	Kotlik Traditional Council	Quartz Valley I.H.C.
Chugachmiut	Kwethluk IRA Council	Sac and Fox Tribe
Confederated Tribes of the Chehalis Reservati	Lac du Flambeau Band	Samish Nation
Council of Athabascan Tribal Governments	Lake County Tribal Health	Swinomish Ind. Tribal Comm.
Cowlitz Indian Tribe	Lower Elwha Klallam Tribe	Takotna Tribal Council

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

The remaining $1 million in FY 2006 funds were used to purchase new and like-new equipment from DOD through the TRANSAM program and to purchase ambulances for Tribal emergency medical services programs.

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

PERSONNEL QUARTERS/QUARTERS RETURN FUNDS

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

	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Increase or Decrease
BA	$6,288,000	$6,288,000	$6,288,000	0
FTE	0	0	0	0

STATEMENT OF THE BUDGET REQUEST

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

PROGRAM DESCRIPTION

Staff quarters' operation, maintenance, and improvement costs are funded with Quarters Return (QR) funds. An estimated $6,288,000 in QR funds will be collected from tenants of quarters during FY 2006. These funds will be used for the operation, management, and general maintenance of quarters, including temporary maintenance personnel services, security guard services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (stoves, water heaters, furnaces, etc.). In certain situations, M&I funds may be used, in conjunction with QR funds, to ensure adequate quarters maintenance; e.g., locations with few quarters where QR funds are not enough to pay for all required maintenance costs. These funds are distributed and used at the locality in which they are collected.

RATIONALE FOR THE BUDGET REQUEST

The FY 2008 estimate of $6,288,000 is the same as the FY 2007 Continuing Resolution Level of $6,288,000.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2008 Performance Budget Submission

TABLE OF CONTENTS

THIS PAGE LEFT BLANK INTENTIONALLY

INDIAN HEALTH SERVICE

Summary of Measures and Results Table

	Measures	Total Reported		Total Met	Total Not Met		
FY	Total in Plan	Results Reported	% Reported	Met	Improved	Total Not Met	% Met
2002	40	38	95%	31		7	78%
2003	41	38	93%	31		7	76%
2004	39	38	97%	28[1]		10	72%
2005	35[2]	34	97%	29	1	5	83%
2006	34[3]	33	97%	27	1	6	82%
2007	53[4]						
2008	54						

[1]Results of one measure revised from Not Met to Met in May 2005 based on provision of additional data.
[2]2005 total measures reduced by 2 from 2006 CJ for the following reasons: (a) consumer satisfaction measure, which was reported as discontinued in Exhibit W Changes and Improvements, was not deleted from Exhibit DD Summary of Measures and Results Table in the 2006 CJ; (b) influenza measure was placed on hold for 2005 based on projected national vaccine shortages, reducing total measures to 35.
[3]Total measures in 2006 were reduced by 1 from the 2008 CJ due to the Sanitation Improvement measure change from two distinct measures into a combined measure.
[4]Total measures in 2007 increased to 53 due to the inclusion of program measures in the overall count (Retired, Developmental, and Long term measures were excluded as required).

Detail of Performance Analysis

Introduction

Given the uncertainty of final FY 2007 appropriation levels at the time Indian Health Service (IHS) developed the performance targets for the FY 2008 Congressional Justification, the FY 2007 targets were not modified to reflect differences between the President's Budget and the Continuing Resolution funding levels. Enacted funding may require modifications of the FY 2007 performance targets. Performance measures that may be affected are footnoted throughout the Performance Detail section.

These are ambitious targets to achieve, particularly for high cost and labor-intensive treatment and screening measures such as colorectal screening, mammography, diabetic blood sugar control, blood pressure control, and the new nephropathy screening measure. Several emerging external factors make the accomplishment of these measures particularly challenging.

Vacancy rates for health care providers are near or at all-time high levels. Additionally, continued growth in the prevalence and incidence of diabetes and heart disease in the AI/AN population and its associated costs will place critical demands on the current system. Also, while the rate increases for Medicare and Medicaid seem to indicate increased collections, these may be offset by reduced numbers of eligible AI/AN people as a result of State Medicaid cost-containment actions.

Treatment Measures: Diabetes Group

Long Term Goal: By 2010, reduce the number of Years of Potential Life Lost (YPLL) due to diabetes.			
Measure	**FY**	**Target**	**Result**
Diabetes: A1c Measured: Proportion of patients who have had an A1c test. There is no measure or goal; this information is provided for context. IHS is well above the Healthy People 2010 Goal of 50 percent for A1c testing rates.	*2008*	N/A	Oct/2008
	2007	N/A	Oct/2007
	2006	N/A	79%
	2005	N/A	78%
	2004	N/A	77%
	2003	N/A	75%
Tribally-Operated Health Programs	*2008*	N/A	Oct/2008
	2007	N/A	Oct/2007
	2006	N/A	77%
	2005	N/A	76%
	2004	N/A	74%
	2003	N/A	73%
(1) Diabetes: Poor Glycemic Control: Proportion of patients with diagnosed diabetes that have poor glycemic control (A1c > 9.5). *First figure in results column is Diabetes audit data; second is CRS. [outcome]	*2008*	18/15%	Oct/2008
	2007	18/15%[1]	Oct/2007
	2006	18/15%	18/16%*
	2005	16/17%	18/15%*
	2004	Baseline	16[2]/17%*
	2003	N/A	N/A
Tribally-Operated Health Programs	*2008*	12%	Oct/2008
	2007	12%[1]	Oct/2007
	2006	12%	13%
	2005	17%	12%
	2004	Baseline	15%
	2003	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; diabetic registries; yearly IHS Diabetes Care and Outcome Audit.			
Data Validation: Annual comparison of CRS and Diabetes Audit results			
Cross Reference: Healthy People 2010; HHS Strategic Goal 3			

Reducing the number of patients with poor glycemic control will lower health care costs by reducing the prevalence of diabetes complications. It will also lower the number of diabetes-related deaths. The ultimate goal for this measure is to *lower* the A1c level of patients with diabetes with poor glycemic control. The FY 2006 target was not met, based on CRS data. In FY 2006, 16 percent of patients diagnosed with diabetes had poor glycemic control, as measured by the Hemoglobin A1c test that measures average blood sugar over the last 2-3 months. The rate represents an increase of 1% in the number of patients with diabetes whose blood sugar is in poor control. The FY 2007 target is to decrease this percentage to the FY 2005 rate of 15%. The FY 2008 performance target is

[1] Reducing the number of patients with poor glycemic control requires frequent medical visits and medications. This measure may be affected by Continuing Resolution funding levels.

[2] The FY 2004 rate reported did not include patients with A1c results between 9.5 and 10.0. The corrected 2004 rate is 19%, including patients with values between 9.5 and 10.

to maintain performance at a rate of 15 percent. The diabetes audit target of maintaining the percentage of patients with diabetes with poor glycemic control at 18% was met, and the FY 2007 and FY 2008 targets for the audit are to maintain this percentage. Audit data is based on different collection methods and exclusion criteria.

Long Term Goal: By 2010, increase the percentage of patients with diagnosed diabetes with ideal glycemic control to 40 percent.			
Measure	**FY**	**Target**	**Result**
(2) Diabetes: Ideal Glycemic Control: Proportion of patients with diagnosed diabetes with ideal glycemic control (A1c <7.0). *First figure in results column is Diabetes audit data; second is CRS. [outcome]	*2008*	37/33%	Oct/2008
	2007	37/32%[1]	Oct/2007
	2006	36/32%	37/31%*
	2005	34/27%	36/30%*
	2004	1%>2003	34/27%*
	2003	Maintain	31/28%*
Tribally Operated Health Programs	*2008*	33%	Oct/2008
	2007	33%[1]	Oct/2007
	2006	33%	33%
	2005	27%	33%
	2004	1%>2003	28%
	2003	Maintain	26%
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; diabetic registries; yearly IHS Diabetes Care and Outcome Audit.			
Data Validation: Annual comparison of CRS and Diabetes Audit results			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

Increasing the number of patients with diabetes with ideal control will lower health care costs and reduce the mortality rate from diabetes. Studies show that lower A1c levels are associated with lower heart-attack rates, lower rates of eye, kidney, and nerve disease, and fewer amputations among diabetics. The target for this measure was not met, but overall the percent of AI/AN patients with diabetes who had ideal glycemic control, as measured by the Hemoglobin A1c test that measures average blood sugar over the last 2-3 months, increased to 31%. This rate was 1% higher than the 30% reported in FY 2005, despite a significant increase in the number of patients with diabetes in the same period. The targets for FY 2007 and FY 2008 include a 1 percent increase each year. The diabetes audit target of maintaining the percentage of patients with diabetes with ideal glycemic control at 36% was met and exceeded by 1%. The FY 2007 and FY 2008 targets for the audit are to maintain performance at the FY 2006 level of 37%. Audit data is based on different collection methods and exclusion criteria.

[1] Increasing the number of patients with ideal glycemic control requires frequent medical visits and medications. This measure may be affected by Continuing Resolution funding levels.

Long Term Goal: By 2010, increase to 50 percent the proportion of patients with diagnosed diabetes with ideal blood pressure control.			
Measure	**FY**	**Target**	**Result**
(3) Diabetes: Blood Pressure Control: Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<130/80). *First figure in results column is Diabetes audit data; second is CRS. [outcome]	*2008*	38/37%	Oct/2008
	2007	38/37%[1]	Oct/2007
	2006	36/37%	38/37%*
	2005	34/35%	36/37%*
	2004	1%>2003	34/35%*
	2003	Maintain	33/37%*
Tribally-Operated Health Programs	*2008*	37%	Oct/2008
	2007	37%[1]	Oct/2007
	2006	36%	37%
	2005	35%	36%
	2004	1%>2003	33%
	2003	Maintain	32%
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; diabetic registries; yearly IHS Diabetes Care and Outcome Audit.			
Data Validation: Annual comparison of CRS and Diabetes Audit results			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

This measure is directed at reducing complications of diabetes. Lower blood pressure levels in people with diabetes reduce the risk of heart disease and stroke by 33-50 percent. Blood pressure control also reduces the risk of eye, kidney, and nerve disease by 33 percent. The target for this measure was met. During FY 2006, the percentage of patients who achieved good control remained at the FY 2005 rate of 37 percent. The FY 2007 and FY 2008 targets are to maintain this rate. The diabetes audit target of maintaining the percentage of patients with diabetes with blood pressure control at 36% was met and exceeded by 2%, and the FY 2007 and FY 2008 targets for the audit are to maintain performance at the FY 2006 level of 38%. Audit data is based on different collection methods and exclusion criteria. This measure will also be included in the 2008 HHS Annual Plan.

[1] Reducing the number of patients with poor blood pressure control requires frequent medical visits and medications. This measure may be affected by Continuing Resolution funding levels

Long Term Goal: By 2010, increase to 70 percent the proportion of patients with diagnosed diabetes who have been assessed for dyslipidemia (LDL cholesterol).			
Measure	**FY**	**Target**	**Result**
(4) Diabetes: Dyslipidemia Assessment: Proportion of patients with diagnosed diabetes assessed for dyslipidemia (LDL cholesterol). *First figure in results column is Diabetes audit data; second is CRS. [outcome]	*2008*	76/60%	Oct/2008
	2007	76/60%	Oct/2007
	2006	72/56%	73/60%*
	2005	69/53%	70/53%*
	2004	1%>2003	69/53%*
	2003	Maintain	65/48%*
Tribally-Operated Health Programs	*2008*	58%	Oct/2008
	2007	58%	Oct/2007
	2006	49%	58%
	2005	53%	48%
	2004	1%>2003	52%
	2003	Maintain	47%
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; diabetic registries; yearly IHS Diabetes Care and Outcome Audit.			
Data Validation: Annual comparison of CRS and Diabetes Audit results			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

Low cholesterol levels help to protect diabetic patients from developing heart disease. Diabetic patients are especially prone to develop heart disease and therefore identification and treatment of elevated lipids in diabetic patients is extremely important. The FY 2006 target of maintaining the number of patients assessed for dyslipidemia was met and exceeded. The number of patients screened for dyslipidemia increased from the 2005 rate of 53% to 60%. This measure is included in the "One HHS" 10 Department-wide Management Objectives to attain a 10 percent relative increase by FY 2007, and this relative increase has been attained in FY 2006. As a result, the FY 2007 target has been increased from 59% to 60%. For FY 2008, the target is 60%, which will maintain the target FY 2007 rate. The diabetes audit target of increasing the percentage of patients with diabetes assessed for dyslipidemia to 72% was met and exceeded by 1%. The FY 2007 and FY 2008 targets for the audit are to reach and then maintain a 76% target rate. Audit data is based on different collection methods and exclusion criteria.

Long Term Goal: By 2010, increase to 70 percent the proportion of diagnosed diabetic patients assessed for nephropathy.			
Measure	**FY**	**Target**	**Result**
(5) Diabetes: Nephropathy Assessment: Proportion of patients with diagnosed diabetes assessed for nephropathy. *First figure in results column is Diabetes audit data; second is CRS. [outcome]	*2008*	Baseline/Maintain	Oct/2008
	2007	61%/**Baseline**	Oct/2007
	2006	68/50%	61[1]/55%*
	2005	63/42%	68[1]/47%*
	2004	1%>2003	63[1]/42%*
	2003	Maintain	61[1]/38%*
Tribally-Operated Health Programs	*2008*	Maintain	Oct/2008
	2007	**Baseline**	Oct/2007
	2006	48%	52%
	2005	42%	48%
	2004	1%>2003	44%
	2003	Maintain	40%
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; diabetic registries; yearly IHS Diabetes Care and Outcome Audit.			
Data Validation: Annual comparison of CRS and Diabetes Audit results			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

Diabetes can cause kidney disease by damaging the parts of the kidneys that filter out wastes. Diabetic nephropathy, or kidney disease, can eventually lead to kidney failure. Early identification of at risk patients may help prevent or delay the need for costly care such as dialysis or renal transplant. The FY 2006 target of maintaining the number of patients assessed for nephropathy was met and substantially exceeded according to Clinical Reporting System data. In 2007 the target is to establish a new baseline rate, based on a significant change in the 2006 Diabetes Standards of Care. The new standard will ensure that patients at risk will have kidney function specifically identified by requiring quantitative testing instead of the previously acceptable screening method. As a result screening rates for this measure are expected to be lower while this change is being implemented. In FY 2008 the target is to maintain the rate established in FY 2007. The diabetes audit target of increasing the percentage of patients with diabetes assessed for nephropathy to 68% was not met. In FY 2006, 61% of patients were assessed for nephropathy. The FY 2007 target for the audit is to maintain a 61% rate. In FY 2008, the target will be to establish a baseline, based on the new recommendations in the 2006 Diabetes Standards of Care. Audit data is based on different collection methods and exclusion criteria.

[1] DDTP changed the methodology for nephropathy assessment in 2006 to coincide more closely with the CRS methodology. In order to compare nephropathy audit data on the same basis, reports using this methodology have been generated for 2003, 2004, and 2005 as follows: 2003-53%, 2004-55%, 2005-57%.

Long Term Goal: By 2010, increase to 70 percent the proportion of diagnosed diabetic patients who receive an annual diabetic retinal examination.			
Measure	**FY**	**Target**	**Result**
(6) Diabetic Retinopathy: Proportion of patients with diagnosed diabetes who receive an annual retinal examination. **FY 2006 target is to maintain at designated pilot sites and establish baseline at all sites. As of FY 2007, examination rates at designated pilot sites will not be reported separately.** *****For FY 2006, two numbers were required and reported: first figure represents results at designated sites, second is results for all sites. [outcome]	*2008*	49%	Oct/2008
	2007	49%	Oct/2007
	2006	50%/ **Baseline***	52%/49%*
	2005	55%	50%
	2004	61%	55%
	2003	58%	58%
Tribally-Operated Health Programs [1]FY 2005 results reported to OMB in PART submission are the established baseline for TOHP.	*2008*	48%	Oct/2008
	2007	48%	Oct/2007
	2006	50%[1]	48%
	2005	55%	50%
	2004	61%	45%
	2003	58%	47%
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases			
Data Validation: Annual comparison of CRS and Diabetes Audit results			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

Diabetes can affect vision by damaging the blood vessels inside the eye, a condition known as diabetic retinopathy (DR). Early detection of DR is a fundamental and critical part of the effort to reduce visual loss among people with diabetes. Clinical trials demonstrate that timely laser photocoagulation treatment of DR reduces vision loss by over 90 percent. IHS met the targets for this measure in FY 2006. The proportion of diabetic patients who received an annual diabetic retinal exam increased from 50 percent (FY 2005) to 52 percent (FY 2006) at designated demonstration sites using specified technologies. In FY 2006, the target for this measure also included a requirement to begin reporting this rate for all sites, regardless of the type or use of technology, and a baseline rate of 49% has been established. Beginning in FY 2007, the screening rate at designated sites will no longer be reported. The FY 2007 and FY 2008 targets for all sites will be to maintain the baseline rate established in FY 2006.

Treatment Measures: Cancer Screening Group

Long Term Goal: By 2010, increase to 90 percent the proportion of eligible women who have had a Pap screen within the previous three years.			
Measure	**FY**	**Target**	**Result**
(7) Pap Smear Rates: Proportion of eligible women who have had a Pap screen within the previous three years.	*2008*	60%	Oct/2008
	2007	60%[1]	Oct/2007
	2006	60%	59%
	2005	58%	60%
	2004	61%	58%
[outcome]	*2003*	62%	61%
Tribally-Operated Health Programs	*2008*	61%	Oct/2008
	2007	61%[1]	Oct/2007
	2006	61%	61%
	2005	58%	61%
	2004	61%	59%
	2003	62%	60%
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases.			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

In 2002, American Indian women had a cervical cancer mortality rate that exceeded the rate for US All Races. More than any other racial or ethnic group, American Indian women report having never had a Pap screen. Regular screening with a pap smear lowers the risk of developing invasive cervical cancer by detecting pre-cancerous cervical lesions that can be treated. In FY 2006 the Pap smear rate was 59%, a decrease of one percent from FY 2005. The FY 2007 target is to increase this rate to 60%. The FY 2008 target is to maintain performance at 60 percent.

[1] Pap testing is a high cost screening method. This measure may be affected by Continuing Resolution funding levels.

Long Term Goal: By 2010, increase to 70 percent the proportion of eligible women who have had a mammogram screening within the previous two years.			
Measure	**FY**	**Target**	**Result**
(8) Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. [outcome]	*2008*	41%	Oct/2008
	2007	41%[1]	Oct/2007
	2006	41%	41%
	2005	40%	41%
	2004	40%	40%
	2003	42%	40%
Tribally-Operated Health Programs	*2008*	44%	Oct/2008
	2007	44%[1]	Oct/2007
	2006	44%	44%
	2005	40%	44%
	2004	40%	43%
	2003	42%	44%
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases.			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

Breast cancer is the second leading cause of cancer death among U.S. women (lung cancer is first). Between 1992 and 2002, breast cancer mortality rates declined for all racial and ethnic groups except American Indian/Alaska Native women, who experienced no decline. Biennial screening of women between the ages of 50 and 69 has been shown to be a cost effective way to decrease breast cancer mortality. In FY 2006, the mammogram screening rate remained at the FY 2005 rate of 41%, meeting the established target. The FY 2007 and FY 2008 targets are to maintain this rate. The FY 2008 performance target is to maintain performance at the FY 2007 target level.

[1] Mammography is a high-cost screening method. This measure may be affected by Continuing Resolution funding levels.

Long Term Goal: By 2010, increase to 50 percent the proportion of eligible patients who have had appropriate colorectal cancer screening.			
Measure	**FY**	**Target**	**Result**
(9) Colorectal Cancer Screening Rates: Proportion of eligible patients who have had appropriate colorectal cancer screening. [outcome]	*2008*	22%	Oct/2008
	2007	22%[1]	Oct/2007
	2006	Baseline	22%
	2005	N/A	N/A
	2004	N/A	N/A
	2003	N/A	N/A
Tribally-Operated Health Programs	*2008*	26%	Oct/2008
	2007	26%[1]	Oct/2007
	2006	Baseline	26%
	2005	N/A	N/A
	2004	N/A	N/A
	2003	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases.			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

Colorectal cancers are the third most common cancer in the United States, and are the third leading cause of cancer deaths. Colorectal cancer rates among the Alaska Native population are well above the national average and rates among American Indians are rising. Yearly screening has been shown to result in a 33.4 percent reduction in colorectal mortality. In FY 2006, a baseline rate of 22% was established for this new measure. The target for both FY 2007 and FY 2008 is to maintain the baseline rate.

[1] Appropriate colorectal cancer screening involves high cost procedures. This measure may be affected by Continuing Resolution funding levels.

Treatment Measures: Alcohol and Substance Abuse Group

Long Term Goal: Assure quality and effectiveness of Youth Regional Treatment Centers.			
Measure	**FY**	**Target**	**Result**
(10) RTC Improvement/Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more).	*2008*	100%	Oct/2008
	2007	100%	Oct/2007
	2006	100%	100%
	2005	100%	100%
	2004	+2%	+2%
[output]	*2003*	+5%	+4%
Data Source: Reports from Youth Regional Treatment Centers			
Data Validation: Review by Division of Behavioral Health			
Cross Reference: HHS Strategic Goals 1, 3, 5			

This measure evaluates Youth Regional Treatment Centers (YRTC) and ensures that these programs are appropriately accredited. Successful completion of residential treatment can help reduce drug and alcohol use relapse in youths. Accreditation by the Joint Commission on Accreditation of Healthcare Organizations, Commission on Accreditation of Rehabilitation Facilities, or comparable State-accrediting bodies ensures that the YRTCs meet acceptable standards of treatment. The FY 2006 target was to assure that 100 percent of YRTC programs had accreditation; IHS met this goal. For FY 2007 and 2008, the target is to maintain 100 percent accreditation.

Long Term Goal: By 2010, reduce the rate of Fetal Alcohol Syndrome through appropriate screening and intervention for alcohol dependence in women of childbearing age.			
Measure	**FY**	**Target**	**Result**
(11) Alcohol Screening (FAS Prevention}: Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients.	*2008*	28%	Oct/2008
	2007	28%	Oct/2007
	2006	12%	28%
	2005	8%	11%
	2004	Baseline	7%
[outcome]	*2003*	Maintain	95%
Tribally-Operated Health Programs	*2008*	27%	Oct/2008
	2007	27%	Oct/2007
	2006	12%	27%
	2005	>7%	11%
	2004	Baseline	9%
	2003	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3, 5			

Heavy drinking during pregnancy can cause significant birth defects, including Fetal Alcohol Syndrome (FAS). FAS is the leading known, and preventable, cause of mental retardation. Rates of FAS are higher among American Indians and Alaska Natives than the general population. Screening with intervention has been shown to be effective in reducing alcohol misuse in pregnancy and to reduce the incidence of FAS. This measure is included in the "One HHS" 10 Department-wide Management Objectives to achieve a relative 10 percent increase by FY 2007. The agency already met and exceeded that targeted increase (.7%) in FY 2005, which resulted in an upward adjustment of targets for FY 2006 and FY 2007. Based on continued emphasis on the measures included in the "One HHS" objectives, the number of patients screened for alcohol use increased dramatically again, from 11% in FY 2005 to 28% in FY 2006, substantially exceeding the FY 2006 target rate of 12%. The FY 2007 and FY 2008 targets are to maintain the FY 2006 rate of 28%.

Treatment Measures: Oral Health Group

Long Term Goal: By 2010, improve the oral health of the AI/AN population.			
Measure	**FY**	**Target**	**Result**
(12) Topical Fluorides: Number of American Indian and Alaska Native patients receiving at least one topical fluoride application**.** The FY 2005 measure target included both number of applications and number of patients. Prior to FY 2005 this measure calculated increase in number of individuals with access to fluoridated water [outcome]	*2008*	95,439	Oct/2008
	2007	95,439[1]	Oct/2007
	2006	85,318	95,439
	2005	Baseline	113,324applications/ 85,318 patients
	2004	+1%	+0.1%
	2003	+1%	+0.37%
(13) Dental Access: Percent of patients who receive dental services. [outcome]	*2008*	24%	Oct/2008
	2007	24%[1]	Oct/2007
	2006	24%	23%
	2005	24%	24%
	2004	25%	24%
	2003	27.35%	25%
(14) Dental Sealants: Number of sealants placed per year in AI/AN patients. *****Data source changed from NPIRS to CRS in FY 2005; the FY 2004 CRS sealant result is 230,295 [outcome]	*2008*	246,645	Oct/2008
	2007	246,645[1]	Oct/2007
	2006	249,882	246,645
	2005	287,158/ 230,295*	249,882
	2004	243,499	287,158
	2003	227,945	243,499
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; sealant data from National Patient Information Reporting System (NPIRS) 2002-2004.			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

These measures are directed at improving the oral health status of the American Indian and Alaska Native populations. American Indians and Alaska Natives remain two of the most underserved groups for dental services. A recent study showed that American Indians and Alaska Natives have reported larger unmet dental health needs compared to Non-Hispanic Whites. However, according to Trends in Indian Health, the number of direct and contract dental service provided by Indian Health Service (IHS), Tribal, and Urban Programs has increased 272 percent since FY 1970 and in FY 2001, over 2.7 million dental services were provided.

Measure 12 tracks the number of patients receiving one or more fluoride applications to provide a measure of program efficacy. The FY 2006 goal was to provide fluoride treatments to the same number of patients as in FY 2005, an ambitious goal given the

[1]These measures require provision of high cost services and may be affected by Continuing Resolution funding levels.

continuing shortage of dentists within the I/T/U network. This target was met and exceeded by over 10,000 patients. The target for both FY 2007 and FY 2008 is to maintain the FY 2006 performance.

Measure 13 was established to ensure that the agency maintains adequate access to dental care for all patients. Increasing access to care should result in decreased intensity or severity of disease and lowered prevalence of disease. In FY 2006, IHS did not meet the target of maintaining the FY 2005 rate; the rate fell by 1% to 23%. The target for FY 2007 is to reach the FY 2005 rate of 24% again, and the FY 2008 target is to maintain that rate.

Measure 14 called for maintaining the number of dental sealants placed per year in American Indian and Alaska Native patients at the FY 2005 level. Dental sealants, a recognized standard in preventive dental care, are an effective measure for reducing dental decay rates. IHS did not meet this target in FY 2006 but came within just 3,237 sealants of the 249,882 target. The target for both FY 2007 and FY 2008 is to maintain the FY 2006 number of sealants placed.

(15) Diabetes: Dental Access: Eliminated in FY 2006

Treatment Measures: Family Abuse, Violence, Neglect Measure

Long Term Goal: By 2010, increase screening rates for intimate partner violence to 40 percent.			
Measure	**FY**	**Target**	**Result**
(16) Domestic (Intimate Partner) Violence Screening: Proportion of women who are screened for domestic violence at health care facilities. [outcome]	*2008*	28%	Oct/2008
	2007	28%	Oct/2007
	2006	14%	28%
	2005	4%	13%
	2004	15%	4%
	2003	60/85%	60/84%
Tribally-Operated Health Programs	*2008*	24%	Oct/2008
	2007	24%	Oct/2007
	2006	10%	24%
	2005	4%	9%
	2004	15%	5%
	2003	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3			

This measure is designed to help ascertain, evaluate and reduce the prevalence of family violence, abuse, and neglect in American Indian and Alaska Native communities. AI/AN women experience domestic violence at rates similar to or higher than the national average. In addition, this measure is included in the "One HHS" 10 Department-wide Management Objectives to attain a 10 percent relative increase by FY 2007. The DV/IPV measure has already reached and exceeded that original goal (4.4%), and has also exceeded the FY 2006 target of 14%, which was increased based on FY 2005 performance. The FY 2007 and FY 2008 targets are to maintain the FY 2006 rate of 28%.

Treatment Measures: Information Technology Development

Long Term Goal: By 2010, improve treatment and prevention effectiveness through development and deployment of enhanced automated health systems to all IHS direct, Tribal and Urban sites using RPMS.			
Measure	**FY**	**Target**	**Result**
(17) Data Quality Improvement: Number of GPRA clinical measures that can be reported by CRS software. [Output]	*2008*	Eliminate	Oct/2008
	2007	All	Oct/2007
	2006	Increase	+1
	2005	+2	+4
	2004	+2	+2
	2003	Baseline	baseline
(18) Behavioral Health: Proportion of adults ages 18 and over who are screened for depression. Prior to 2006 this measure tracked the number of programs reporting minimum agreed-to behavioral health-related data to warehouse. *** Revised from 2.3 percent, 5/2005; changes FY 2004 performance from Not Met to Met**. [outcome]	*2008*	15%	Oct/2008
	2007	15%	Oct/2007
	2006	**Baseline**	15%
	2005	Increase	+4%
	2004	+5%	**+7%***
	2003	+3%	+3%
Tribally-Operated Health Programs	*2008*	14%	Oct/2008
	2007	14%	Oct/2007
	2006	**Baseline**	14%
	2005	N/A	N/A
	2004	N/A	N/A
	2003	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases			
Data Validation: CRS quality control			
Cross Reference: HHS Strategic Goals 3, 5			

These measures are designed to improve the quality of care through the use of appropriate technology. Measure 17 is designed to improve passive extraction of GPRA clinical data from RPMS health information system. In FY 2006, IHS met this measure by adding one new measure of automated data quality assessment. The FY 2007 target is to assure that all GPRA clinical performance measures based on RPMS data can be reported by CRS software. In FY 2008, this measure will be eliminated, as the goal of the measure will be attained in FY 2007.

As of FY 2006, measure 18 tracks the rate of annual screening for depression in adults ages 18 and over. In FY 2006, the baseline rate of screening was 15%. The target for both FY 2007 and FY 2008 is to maintain this rate.

(19) Urban Program: Eliminated in FY 2006.

Treatment Measures: Quality of Care Group (21 is RPMS Efficiency in FY 2006)

Long Term Goal: Maintain 100 percent accreditation of all IHS hospitals and outpatient clinics.			
Measure	**FY**	**Target**	**Result**
(20) Accreditation: Percent of hospitals and outpatient clinics accredited (excluding tribal and urban facilities). [output]	*2008*	100%	Oct/2008
	2007	100%	Oct/2007
	2006	100%	100%
	2005	100%	100%
	2004	100%	100%
	2003	100%	100%
(21) Medical Error Improvement: Number of Areas with a medical error reporting system. **In FY 2007 measure changes to Patient Safety: Development and deployment of patient safety measurement system.** Prior to FY 2006, this measure tracked the number of Areas with a medication error reporting system. [outcome] *RPMS efficiency (RPMS-E) in FY 2006	*2008*	+10 sites	Oct/2008
	2007	7 sites	Oct/2007
	2006	**3 Areas**	3 Areas
	2005	6 Areas	All Areas
	2004	4 Areas	4 Areas
	2003	Baseline	Pilot Established
Data Source: Reports from hospitals and clinics			
Data Validation: JCAHO and AAAHC web sites			
Cross Reference: HHS Strategic Goals 3, 5			

Accreditation is essential for maximizing third-party collections, and contributes both directly and indirectly to improved clinical quality. The local I/T/U multidisciplinary team approach to accreditation and ongoing quality management has been the mainstay of success in this important activity. IHS met the target of maintaining 100% accreditation in FY 2006. For FY 2007 and 2008, the target is to continue to maintain 100 percent accreditation.

The IHS met measure 21, Medical Error Improvement, in FY 2006 by establishing, deploying, and evaluating a medical error reporting system at 3 Areas. In 2007 this measure changes to development and deployment of a patient safety measurement system. Through the implementation of this system, leaders, providers and staff at all levels, including local service units, Area offices, and headquarters will be able to report proactively, trend, benchmark, and evaluate actual and potential patient adverse medical event data. This information will be used to reduce risk, prevent events, inform and train leaders and staff, and build a baseline of information of information from which improvements can be measured. System development was completed ahead of schedule in FY 2006. For FY 2007, the target is to deploy the system to 7 sites, which will bring the total number of sites to 10. For FY 2008, the target is deployment of the reporting system to an additional 10 sites.

Long Term Goal: By 2010, increase the number of scholarship placements to 50 percent.			
Measure	**FY**	**Target**	**Result**
(42) Scholarships: Proportion of Health Professional Scholarship recipients placed in Indian health settings within 90 days of graduation. [Outcome]	*2008*	45%	Oct/2008
	2007	42%	Oct/2007
	2006	32%	37%
	2005	22%	30%
	2004	Baseline	20%
	2003	Develop nurse retention plan	Nurse retention plan developed
Data Source: Scholarship program data system			
Data Validation: Clinic employment records			
Cross Reference: HHS Strategic Goals 3, 8			

The FY 2006 target was to increase efficiency in placing Health Profession Scholarship recipients in Indian health settings within 90 days of graduation by 2 percent over the FY 2005 result of 30%. This target was met and exceeded, with 37 percent of graduates placed in Indian health settings within 90 days of graduation. This represents an increase of 17% overall from the baseline rate of 20% in FY 2004. Increased efficiency in placing health profession scholarship recipients can and will help improve the health care delivery system at I/T/U facilities. The FY 2007 target is to increase the rate to 42%. For FY 2008, the target is to increase the rate to 45%.

Prevention Measures: Public Health Nursing Measure

Long Term Goal: By 2010, decrease YPLL by 20 percent over the 2002 level.			
Measure	**FY**	**Target**	**Result**
(23) Public Health Nursing: Implement a data system capable of recording the time spent and nature of public health activities other than one-on-one patient care, with an emphasis on activities that serve groups or the entire community Prior to FY 2006 this measure tracked the number of public health nursing services (primary and secondary treatment and preventive services) provided by public health nursing. [outcome]	*2008*	+ 5%	Oct/2008
	2007	Baseline	Oct/2007
	2006	Data system	Data system
	2005	423,379	438,376
	2004	359,089	423,379
	2003	343,844	359,089
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases			
Data Validation: CRS quality control			
Cross Reference: HHS Strategic Goals 1, 3, 5			

The purpose of this measure is to improve the health status of American Indian and Alaska Native people through maintaining access to services associated with improved health outcomes. Public health nurses provide health assessment, health promotion, disease prevention, and infectious disease management. In FY 2006, this measure changed to implement a data system capable of recording the time spent and nature of public health activities other than one-on-one patient care, with an emphasis on activities that serve groups or the entire community. This data system was implemented. In FY 2007, the target will be to establish a baseline of PHN activities that contribute to the accomplishment of many GPRA outcome measures, particularly immunizations and health promotion/disease prevention activities. In FY 2008, the target will be to increase 5% over the FY 2007 baseline. The effectiveness of this program is reflected in the results of these other outcome measures.

Prevention Measures: Immunization Group

Long Term Goal: By 2010, increase childhood combined immunization rates to 80 percent.			
Measure	**FY**	**Target**	**Result**
(24) Combined (4:3:1:3:3) immunization rates for AI/AN children patients aged 19-35 months. *Vaccination rates for children ages 3-27 months **Vaccination rates for children ages 19-35 months [outcome]	*2008*	78%	Oct/2008
	2007	78%[1]	Oct/2007
	2006	75%	78%/80%**
	2005	72%	75%**
	2004	82%	81%*/72%**
	2003	80%	80%*
Tribally-Operated Health Programs	*2008*	74%	Oct/2008
	2007	74%[1]	Oct/2007
	2006	54%	74%
	2005	N/A	54%
	2004	N/A	N/A
	2003	N/A	N/A
Data Source: Measures 25 and 26: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; Measure 24: quarterly Immunization Reports – 2002 through 2006.			
Data Validation: Immunization Program reviews			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3, 5			

Routine immunizations represent a cost-effective public health measure that significantly improves the health of children. This measure tracks the percentage of children who receive the combined 4:3:1:3:3 series, which includes 4 doses of DTaP, 3 doses of IPV, 1 dose of MMR, 3 doses of Hep B, and 3 doses of Hib. The FY 2006 target for childhood vaccination was met and exceeded, with the percentage of children ages 19-35 months receiving recommended vaccines at 80%, an increase of 5 percent over the FY 2005 rate of 75%. These immunization rates for GPRA were calculated using the Immunization Report, not CRS. However, as of FY 2007, these rates will be calculated using CRS, and an FY 2006 baseline CRS rate of 78% was calculated in order to establish a target for FY 2007. The FY 2007 and FY 2008 targets are to maintain the previous year's rate.

[1] Providing all recommended immunizations requires multiple visits and vaccines; this measure may be affected by Continuing Resolution funding levels.

Measure	FY	Target	Result
(25) Influenza vaccination rates among adult patients aged 65 years and older. *Measure on hold in FY 2005 due to influenza vaccine shortage.* [outcome]	*2008*	59%	Oct/2008
	2007	59%	Oct/2007
	2006	59%	58%
	2005	On Hold	On Hold (59%)
	2004	51%	54%
	2003	51%	51%
Tribally-Operated Health Programs	*2008*	54%	Oct/2008
	2007	54%	Oct/2007
	2006	54%	53%
	2005	On Hold	On Hold (54%)
	2004	51%	53%
	2003	51%	51%
(26) Pneumococcal vaccination rates among adult patients aged 65 years and older. [outcome]	*2008*	76%	Oct/2008
	2007	76%	Oct/2007
	2006	72%	74%
	2005	69%	69%
	2004	65%	69%
	2003	64%	65%
Tribally-Operated Health Programs	*2008*	69%	Oct/2008
	2007	69%	Oct/2007
	2006	63%	69%
	2005	69%	62%
	2004	65%	69%
	2003	64%	66%
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases			
Data Validation: Immunization Program reviews			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3, 5			

Elders who get influenza are at increased risk of hospitalization and death from heart disease and stroke. Influenza vaccination reduces that risk. In FY 2006, 58 % of eligible patients received influenza vaccine, a 1 percent decline from FY 2005, in which the measure was placed "on hold" due to vaccine shortages. For FY 2007, the target is to raise the rate to 59%. The FY 2008 target is to maintain the 59% rate.

Vaccination of the elderly against pneumococcal disease is one of the few medical interventions found to improve health and save on medical costs. In FY 2006, 74% of eligible patients had received the pneumococcal vaccine, an increase of 2% over FY 2005. This measure is included in the "One HHS" 10 Department-wide Management Objectives to attain a 10 percent relative increase by FY 2007. The target for FY 2007 is 76%. The FY 2008 target is to maintain performance at the FY 2007 level.

Prevention Measures: Injury Prevention Group

Long Term Goal: By 2010 decrease YPLL by 20 percent over the 2002 level.			
Measure	**FY**	**Target**	**Result**
(27) Injury Intervention: Number of community-based injury prevention programs (measure will reflect number of projects per area starting in FY 2007). **In FY 2008 measure changes to Injury Intervention (Motor Vehicle Injuries):** Occupant protection restraint use [output]	*2008*	Survey	Oct/2008
	2007	3 projects per area	Oct/2007
	2006	Implement web system	Web system implemented
	2005	37	37
	2004	36	37
	2003	36	36
(28) Unintentional Injury Rates: Unintentional injuries mortality rate in AI/AN people. For all years, three-year rates centered on mid-year are used rather than one-year rates to stabilize rates due to a small population. [outcome]	*2008*	93.8	Dec/2012
	2007	93.8	Dec/2011
	2006	93.8	Dec/2010
	2005	93.8	Dec/2009
	2004	93.8	Dec/2008
	2003	93.8	Dec/2007
	2002	N/A	93.8
	2001	N/A	90.1
	2000	N/A	89.0
Data Source: OEHE Environmental Health Program; National Center on Vital Health Statistics			
Data Validation: Environmental Health Program reviews; IHS Division of Program Statistics			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3, 5; IHS Strategic Goal 1			

Injury prevention interventions are projects that address a specific injury pattern, employ a multiple-strategy approach, are based on a proven, effective injury prevention strategy; or are identified epidemiologically from local data and design based on a proven prevention approach. Examples of projects include Sleep Safe Project sites, national IHS Part II Injury Infrastructure Grants, and Injury Prevention Specialist Fellowships. The FY 2006 target was to implement a web-based reporting system, and the target was met. The FY 2007 target is for each Area to conduct at least three community injury prevention projects and report them using an automated tracking system. In FY 2008, the measure will focus on motor vehicle injuries, in order to address the high motor vehicle mortality rate. (The 1999-2001 average mortality rate for American Indians and Alaska natives was 2.9 times the 2000 rate for All Races.) The 2008 target will be to administer a recognized occupant protection survey in 11 IHS Areas, in order to establish a baseline for restraint use.

For measure 28, Unintentional Injury Rates, no data is currently available to report on the 2006 target for unintentional injuries, which is to maintain the mortality rate for unintentional injuries at the same rate as the previous year. Data is generally available three years later but is reported four years later as the midyear of a three-year rate. Three-year rates are a more stable basis for assessing long-term trends in performance monitoring for such a small population. The most recent data shows a continued upward trend in unintentional injury mortality rates.

Prevention Measures: Suicide Prevention Measure

Long Term Goal: By 2010 decrease YPLL by 20 percent over the 2002 level.			
Measure	**FY**	**Target**	**Result**
(29) Suicide Surveillance: Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals.	*2008*	1683	Oct/2008
	2007	1603	Oct/2007
	2006	Baseline	1603
	2005	Integrate tool	Integrated (met)
	2004	Plan	Plan
[Changes to output in FY 2006]	*2003*	+5%	+30%
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases.			
Data Validation: Division of Behavioral Health			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

This measure is part of an expanding systematic effort at reducing the prevalence of suicide in the American Indian and Alaska Native population. The suicide death rate for the American Indian and Alaska Native population increased in the 1990s and is currently 72 percent greater than the national average. In FY 2005 the target for this measure was to integrate the Behavioral Health suicide reporting tool into RPMS. Suicide surveillance data can currently be entered electronically into the RPMS Behavioral Health System (BHS) by all providers - medical and behavioral. Baseline data was collected in FY 2006; 1603 suicidal behavior report forms were collected. In FY 2007, the target will be to maintain the reporting rate at that baseline. The FY 2008 goal will be to raise that reporting rate to 1683. The reduction of suicidal behavior is a long-term goal for the Agency.

Prevention Measures – CVD-Related Group

Long Term Goal: By 2010 decrease YPLL by 20 percent over the 2002 level.			
Measure	**FY**	**Target**	**Result**
(30) CVD Prevention: Cholesterol: Proportion of patients ages 23 and older who receive blood cholesterol screening. (Prior to FY 2005 measure was: Number of community-directed pilot cardiovascular disease prevention programs.) **In FY 2007 measure changes to CVD Comprehensive Assessment: Proportion of at risk patients who have a comprehensive assessment for all CVD-related risk factors.** [outcome]	*2008*	Maintain	Oct/2008
	2007	**Baseline**[1]	Oct/2007
	2006	44%	48%
	2005	Baseline	43%
	2004	1 site	2 sites
	2003	1 site	4 sites
Tribally-Operated Health Programs	*2008*	Maintain	Oct/2008
	2007	**Baseline**[1]	Oct/2007
	2006	N/A	N/A
	2005	N/A	N/A
	2004	N/A	N/A
	2003	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3			

Cardiovascular disease represents the leading cause of death for American Indian and Alaska Native people above 45 years of age. In FY 2006, the target was to increase the proportion of patients ages 23 and older that receive blood cholesterol screening by 1% over the FY 2005 rate of 43%. The agency met and exceeded the target, with 48% of eligible patients screened. In FY 2007, this measure will focus on comprehensive cardio-vascular disease assessment, and the target is to establish a baseline of at-risk patients who have a comprehensive CVD assessment. The FY 2008 performance target is to maintain the rate established in FY 2007.

[1] Providing comprehensive CVD assessment for at risk patients requires multiple visits and screenings; this measure may be affected by Continuing Resolution funding levels.

Long Term Goal: By 2010 decrease YPLL by 20 percent over the 2002 level.			
Measure	**FY**	**Target**	**Result**
(31) Childhood Weight Control: Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher. In FY 2004 and FY 2005 this measure tracked the proportion of patients for whom BMI (Body Mass Index) data can be measured. Prior to FY 2004 measure was: Develop and implement pilot obesity prevention programs. [outcome]	*2008*	24%	Oct/2008
	2007	24%[1]	Oct/2007
	2006	Baseline	24%
	2005	65%	64%
	2004	Baseline	60%
	2003	Implement plan	Met
Tribally-Operated Health Programs	*2008*	25%	Oct/2008
	2007	25%[1]	Oct/2007
	2006	Baseline	25%
	2005	65%	63%
	2004	Baseline	59%
	2003	Pilot sites	N/A
(32) Tobacco Cessation Intervention: Proportion of tobacco-using patients that receive tobacco cessation intervention. In FY 2004 and FY 2005 this measure tracked the proportion of patients ages 5 and above who are screened for tobacco use. Prior to FY 2004, measure was: Support local level initiatives directed at reducing tobacco usage**.** [outcome]	*2008*	12%	Oct/2008
	2007	12%[1]	Oct/2007
	2006	Baseline	12%
	2005	27%	34%
	2004	Baseline	27%
	2003	Plan	Met
Tribally-Operated Health Programs	*2008*	10%	Oct/2008
	2007	10%[1]	Oct/2007
	2006	Baseline	10%
	2005	27%	34%
	2004	Baseline	28%
	2003	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3			

Obesity is a risk factor for type 2 diabetes, high blood pressure, asthma, arthritis, coronary heart disease, stroke, colon cancer, post-menopausal breast cancer, endometrial cancer, gall bladder disease, and sleep apnea. Rates of obesity among American Indian and Alaska Native populations exceed the national averages. Rates of overweight among AI/AN children also exceed national averages. In FY 2006, this measure established a baseline of the proportion of children, ages 2-5 years, with a BMI of 95 percent or higher,

[1] Both of these measures require multiple visits and interventions and may be affected by Continuing Resolution funding levels.

with the goal of using this data to plan an effective program for childhood weight control. This baseline rate was 24%. The performance targets for FY 2007 and FY 2008 are to maintain this baseline rate.

The use of tobacco represents the second largest cause of preventable deaths for American Indian and Alaska Native people. Lung cancer is the leading cause of cancer death among AI/ANs. Cardiovascular disease is the leading cause of death among AI/ANs, and tobacco use is an important risk factor for this disease. In FY 2006, this measure established a baseline rate of 12% of tobacco-using patients who received tobacco cessation intervention. The performance targets for FY 2007 and FY 2008 are to maintain this baseline rate.

Prevention Measures: HIV / AIDS Group

Long Term Goal: By 2010 decrease YPLL by 20 percent over the 2002 level.			
Measure	**FY**	**Target**	**Result**
(33) HIV Screening: Proportion of pregnant women screened for HIV. Prior to FY 2005, measure was: Screen for HIV infections in high risk groups at designated sites. [outcome]	*2008*	65%	Oct/2008
	2007	65%	Oct/2007
	2006	55%	65%
	2005	Baseline	54%
	2004	10 sites	Not Met
	2003	5% increase	.1% increase
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases.			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010			

The HIV/AIDS epidemic represents a growing threat to American women of childbearing age. HIV infections in newborn children are one potential consequence of higher HIV infection rates among women of childbearing age. Routine prenatal HIV testing of all pregnant women is the best way to avoid transmission of HIV from mother to infant. The IHS has developed guidance regarding universal prenatal HIV testing using the "opt-out" approach, consistent with CDC guidance. Information regarding HIV is included as part of a patient's prenatal education. As more practitioners adopt opt-out testing, prenatal HIV screening rates should increase.

The target for Measure 33 in FY 2006 was to increase the proportion of pregnant women screened for HIV by 1% over the 2005 baseline rate of 54%. The Agency met and exceeded this target, increasing the screening rate to 65%. The performance targets for FY 2007 and FY 2008 are to maintain this rate. This screening is a priority and is part of a standard set of laboratory screenings recommended for prenatal patients.

Prevention Measures: Environmental Surveillance Measure

Long Term Goal: Provide quality health information for decision making to patients, providers and communities through improved information systems.			
Measure	**FY**	**Target**	**Result**
(34) Environmental Surveillance: Number of environmental health programs with automated web-based environmental health surveillance data collection system (webEHRS). **In FY 2008 measure changes to Environmental Surveillance: Identify and address environmental risk factors in communities.** [output] * Developmental measure in FY 2008	*2008* *2007* *2006* *2005* *2004* *2003*	**Baseline*** 29 18 12 15 22	Oct/2008 Oct/2007 20 12 15 22
Data Source: Web-based Environmental Health Reporting System (WebEHRS)			
Data Validation: Site inspection			
Cross Reference: HHS Strategic Goals 3, 4			

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

The FY 2006 target was to have 18 environmental health programs reporting regionally appropriate environmental health priorities based on current community data into webEHRS. This target was met and exceeded, with 20 programs reporting. In FY 2007, the target is to increase the number of environmental health programs reporting priorities above the FY 2006 level to a total of 29.

By the end of 2007, the webEHRS system will be in wide use, and the focus of this measure will shift from increasing the number of programs using the webEHRS system to identifying and addressing environmental risk factors in communities, based on the comprehensive community dataset that has been developed. The 2008 target is to establish a baseline of common environmental risk factors in communities.

Capital Programming / Infrastructure Measures

Long Term Goal: Increase the percentage of American Indian/Alaska Native (AI/AN) homes with sanitation facilities to 90 percent by 2010.			
Measure	***FY***	**Target**	**Result**
(35) Sanitation Improvement: Number of new or like-new and existing AI/AN homes provided with sanitation facilities. [outcome]	*2008*	21,375	Oct/2008
	2007	22,500	Oct/2007
	2006	22,000	24,090
	2005	20,000	24,072
	2004	22,000	24,928
	2003	15,255	22,750
(35A) Percent of existing homes served by the program at Deficiency Level 4 or above as defined by 25 USC 1632. [outcome]	*2008*	35%	Oct/2008
	2007	35%	Oct/2007
	2006	20%	35%
	2005	N/A	38%
	2004	N/A	N/A
	2003	N/A	N/A
Data Source: The SFC Sanitation Deficiency System (SDS) and Project Data System			
Data Validation: Site inspection			
Cross Reference: Healthy People 2010; HHS Strategic Goal 3			

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

The FY 2006 target for Measure 35 to provide sanitation facilities to 22,000 homes was exceeded by servicing 24,090 homes. These homes are served with water, sewer and solid waste facilities. This significant increase in existing homes was the result of funding more projects to upgrade existing community sanitation facilities infrastructure. In addition, for the backlog of needs for existing homes (regular funds), 35% were at Deficiency Level 4 or above. The FY 2007 target is to provide sanitation services to 22,500 homes; 35% of the existing homes that are serviced will be at Deficiency Level 4 or above. The FY 2008 performance target is to provide sanitation services to 21,375 homes; 35% of the existing homes that are serviced will be at Deficiency Level 4 or above.

Efficiency Measure	**FY**	**Target**	**Result**
(36) Health Care Facility Construction: Number of health care facilities construction projects completed. *This measure also serves as the Healthcare Facilities Construction Program's Efficiency Measure (HCFC-E).	*2008*	3	Oct/2008
	2007	2	Oct/2007
	2006	3	3*
	2005	21*	15*
	2004	4*	4*
	2003	12*	12*
Data Source: Project Data System			
Data Validation: Site inspection			
Cross Reference: Healthy People 2010; HHS Strategic Goal 3			

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

Until FY 2005, this measure tracked completion of construction phases on numerous projects. Starting in FY 2006, this measure was simplified to track final completion of projects, which means all phases are competed. The FY 2006 target for construction was met, with all three planned health care facilities construction facilities for which funding was provided completed.

*Target and result numbers reflect the number of construction projects being tracked for GPRA purposes. However, because the projects vary dramatically in terms of complexity, cost, and timeline, these numerical targets alone do not provide a meaningful picture of the work represented by this measure. A complete list of projects for any given year is available upon request.

Health Care Facilities Construction Program Measures

Efficiency Measure	**FY**	**Target**	**Result**
(HCFC-E) Health Care Facilities Construction: Percent of health care facilities construction projects completed on time.	*2008*	100%	Oct/2008
	2007	100%	Oct/2007
	2006	100%	100%
	2005	100%	80%
	2004	100%	100%
	2003	100%	100%
Data Source: Project Data System			
Data Validation: Site inspection			
Cross Reference: Healthy People 2010; HHS Strategic Goal 3			

Long Term Goal: Increase proportion of patients with diagnosed diabetes with ideal blood sugar control (A1c<7) within 7 years of opening a new facility, achieving a 10 percent increase by 2010. Reduce the YPLL rate within 7 years of opening a new facility, achieving a 10 percent decrease by 2010.

Measure	**FY**	**Target**	**Result**
(HCFC-1) Diabetes: Ideal Glycemic Control: Proportion of patients with diagnosed diabetes with ideal glycemic control. *First figure in results column is performance measure results; second is increased access from baseline.		Facility A	Facility A
	2008	30	Oct/2008
	2007	30	Oct/2007
	2006	32	30/58*
	2005	28	32/47*
	2004	Exempt	N/A
	2003	Exempt	N/A
	2002	Baseline	28
		Facility B	Facility B
	2008	44	Oct/2008

	2007	44	Oct/2007
	2006	6	43/23*
	2005	Exempt	N/A
	2004	Exempt	N/A
	2003	Baseline	6
		Facility C	Facility C
	2008	30	Oct/2008
	2007	30	Oct/2007
	2006	33	29/16*
	2005	Exempt	N/A
	2004	Exempt	N/A
[outcome]	*2003*	Baseline	33
(HCFC-2) Pap Smear Rates: Proportion of eligible women who have had a Pap screen within the previous three years. *First figure in results column is performance measure results; second is increased access from baseline.		Facility A	Facility A
	2008	62	Oct/2008
	2007	62	Oct/2007
	2006	65	62/43*
	2005	70	65/41*
	2004	Exempt	N/A
	2003	Exempt	N/A
	2002	Baseline	70
		Facility B	Facility B
	2008	37	Oct/2008
	2007	37	Oct/2007
	2006	32	36/25*
	2005	Exempt	N/A
	2004	Exempt	N/A
	2003	Baseline	32
		Facility C	Facility C
	2008	56	Oct/2008
	2007	56	Oct/2007
	2006	58	55/14*
	2005	Exempt	N/A
	2004	Exempt	N/A
[output]	*2003*	Baseline	58
(HCFC-3) Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. *First figure in results column is performance measure results; second is increased access from baseline.		Facility A	Facility A
	2008	44	Oct/2008
	2007	44	Oct/2007
	2006	41	44/60*
	2005	59	41/52*
	2004	Exempt	N/A
	2003	Exempt	N/A
	2002	Baseline	59
		Facility B	Facility B
	2008	48	Oct/2008
	2007	48	Oct/2007
	2006	44	47/33*
	2005	Exempt	N/A
	2004	Exempt	N/A
	2003	Baseline	44
		Facility C	Facility C

	2008	23	Oct/2008
	2007	23	Oct/2007
	2006	32	22/28*
	2005	Exempt	N/A
	2004	Exempt	N/A
[output]	*2003*	Baseline	32
(HCFC-4) Alcohol Screening (FAS Prevention}: Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients. *First figure in results column is performance measure results; second is increased access from baseline.		Facility A	Facility A
	2008	35	Oct/2008
	2007	35	Oct/2007
	2006	4	35/39*
	2005	6	3/39*
	2004	Exempt	N/A
	2003	Exempt	N/A
	2002	Baseline	2
		Facility B	Facility B
	2008	30	Oct/2008
	2007	30	Oct/2007
	2006	5	29/11*
	2005	Exempt	N/A
	2004	Exempt	N/A
	2003	Baseline	1
		Facility C	Facility C
	2008	19	Oct/2008
	2007	19	Oct/2007
	2006	50	18/9*
	2005	Exempt	N/A
	2004	Exempt	N/A
[output]	*2003*	Baseline	46
(HCFC-5) Combined* immunization rates for AI/AN children patients aged 19-35 months: Immunization rates for AI/AN children patients aged 19-35 months. *First figure in results column is performance measure results; second is increased access from baseline. † Rate changes prior to 2006 are not comparable due to CRS logic changes; increase in access rates could not be calculated.		Facility A	Facility A
	2008	98	Oct/2008
	2007	98	Oct/2007
	2006	†	98/†
	2005	54	79/12*
	2004	Exempt	N/A
	2003	Exempt	N/A
	2002	Baseline	54
		Facility B	Facility B
	2008	100	Oct/2008
	2007	100	Oct/2007
	2006	†	100/†
	2005	Exempt	N/A
	2004	Exempt	N/A
	2003	Baseline	33
		Facility C	Facility C
	2008	95	Oct/2008
	2007	95	Oct/2007
	2006	†	94/†
	2005	Exempt	N/A
	2004	Exempt	N/A

[output]	*2003*	Baseline	31
(HCFC-6) Influenza vaccination rates among adult patients aged 65 years and older. *First figure in results column is performance measure results; second is increased access from baseline. [output]		Facility A	Facility A
	2008	67	Oct/2008
	2007	67	Oct/2007
	2006	65	67/74*
	2005	60	65/66*
	2004	Exempt	N/A
	2003	Exempt	N/A
	2002	Baseline	60
		Facility B	Facility B
	2008	61	Oct/2008
	2007	61	Oct/2007
	2006	46	60/23*
	2005	Exempt	N/A
	2004	Exempt	N/A
	2003	Baseline	46
		Facility C	Facility C
	2008	59	Oct/2008
	2007	59	Oct/2007
	2006	49	58/18*
	2005	Exempt	N/A
	2004	Exempt	N/A
	2003	Baseline	49
(HCFC-7) Pneumococcal vaccination rates among adult patients aged 65 years and older. *First figure in results column is performance measure results; second is increased access from baseline. [output]		Facility A	Facility A
	2008	77	Oct/2008
	2007	77	Oct/2007
	2006	70	77/74*
	2005	70	67/66*
	2004	Exempt	N/A
	2003	Exempt	N/A
	2002	Baseline	70
		Facility B	Facility B
	2008	56	Oct/2008
	2007	56	Oct/2007
	2006	24	55/23*
	2005	Exempt	N/A
	2004	Exempt	N/A
	2003	Baseline	21
		Facility C	Facility C
	2008	53	Oct/2008
	2007	53	Oct/2007
	2006	53	52/18*
	2005	Exempt	N/A
	2004	Exempt	N/A
	2003	Baseline	50
(HCFC-8) Tobacco Use Assessment: Proportion of patients ages 5 and above who are screened for tobacco use. (Prior to 2004, measure was Support local level		Facility A	Facility A
	2008	3	Oct/2008
	2007	3	Oct/2007

initiatives directed at reducing tobacco usage). **In 2006 measure changes to Tobacco Cessation Intervention: Proportion of tobacco-using patients that receive tobacco cessation intervention.**	*2006*	†	1/†
	2005	2	4/38*
	2004	Exempt	N/A
	2003	Exempt	N/A
	2002	Baseline	2
		Facility B	Facility B
*First figure in results column is performance measure results; second is increased access from baseline.	*2008*	5	Oct/2008
	2007	5	Oct/2007
	2006	†	3/†
	2005	Exempt	N/A
†Rate changes prior to 2006 are not comparable due to CRS logic changes; increase in access rates could not be calculated.	*2004*	Exempt	N/A
	2003	Baseline	49
		Facility C	Facility C
	2008	15	Oct/2008
	2007	15	Oct/2007
	2006	†	13/†
	2005	Exempt	N/A
	2004	Exempt	N/A
[output]	*2003*	Baseline	54

Long Term Measure	**FY**	**Target**	**Result**
(HCFC-9) Percent reduction of the YPLL rate within 7 years of opening the new facility [outcome]	*2010*	-10%	
(HCFC-10) Percent increase in the proportion of diagnosed diabetics demonstrating ideal blood sugar control within 7 years of opening the new facility. [outcome]	*2010*	10%	
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; diabetic registries; yearly IHS Diabetes Care and Outcome Audit; IHS service population data, 2000 Census bridged-race file, mortality data from CDC National Center for Health Statistics			
Data Validation: Annual comparison of New Facility Construction CRS data; IHS Division of Program Statistics			
Cross Reference: Healthy People 2010; HHS Strategic Goal 3			

FY 2002 and FY 2003 serve as the baseline year (pre-construction) for three newly constructed I/T healthcare facilities (Facility A, Facility B, and Facility C). Each facility reported on eight performance measures with documented increases in access to services. Although some slight decreases were noted in FY 2006 for selected performance measures, substantial increases to user population, which translates into improved access to care, may have masked actual increases in the number of AI/AN patients who received these services.

Tribally-Operated Health Program Measures

Efficiency Measure	**FY**	**Target**	**Result**
(TOHP-E) Tribally Operated Health Programs: Hospital admissions per 100,000 diabetics per year for long-term complications of diabetes.	*2008*	62.9	Sep/2010
	2007	63.5	Sep/2009
	2006	64.1	Sep/2008
	2005	64.7	Sep/2007

	2004	Baseline	65.4
Data Source: National Health Disparities Report			
Data Validation: IHS Division of Program Statistics			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3			

Tribally Operated Health Programs established a baseline rate for hospital admissions per 100,000 diabetics per year for long-term complications of diabetes in 2003. This measure indirectly assesses the effectiveness of diabetic care by calculating the rate of hospitalizations for diabetic complications. The FY 2006 target represents a commitment to reducing admissions by approximately one percent and ultimately reducing the cost of managing diabetic patients

Tribally Operated Health Programs (TOHP) Measures

Long-Term Goal: Increase the percent of AI/AN patients with diagnosed diabetes served by tribal health programs (TOHP) that achieve ideal blood sugar control to 40 percent by FY 2014. Reduce the Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) populations served by tribal health programs to 55.3 by 2012.			
Annual Measure	**FY**	**Target**	**Result**
(TOHP-1) Percentage of TOHP clinical user population included in GPRA data. *Results not comparable to subsequent years. ** New methodology for changes in data collection and analysis; adjusted targets are at the same incremental increase for performance. [output]	*2008*	81%	Oct/2008
	2007	78%	Oct/2007
	2006	77%	77%
	2005	Baseline	74%*
	2004	N/A	78%*
	2003	N/A	N/A
(TOHP-2) Number of designated annual clinical performance goals met. [outcome]	*2008*	14/17	Oct/2008
	2007	14/16	Oct/2007
	2006	11/13	10/13
	2005	11/14	11/14
	2004	baseline	7/10
	2003	N/A	N/A
Long Term Measure	**FY**	**Target**	**Result**
(TOHP-3) Percentage of AI/AN patients with diagnosed diabetes served by tribal health programs that achieve ideal blood sugar control. [outcome]	*2014*	40%	Jan/2015
	2006	None	33%
	2005	None	33%
	2004	None	28.1%
	2003	baseline	26.1%
(TOHP-4) Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) populations served by tribal health programs. Three year rate centered on midyear. [outcome]	*2012*	55.3	Jan/2015
	2002	None	63.8
	2001	None	61.4
	1998	None	61.8
	1995	None	67.6
	1993	None	68.7
Data Source: Clinical Reporting System; IHS service population data, 2000 Census bridged-race file, mortality data from CDC National Center for Health Statistics			

Data Validation: CRS quality control; IHS Division of Program Statistics
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3

Tribally-Operated Health Programs (TOHP) demonstrated several significant accomplishments in FY 2006. First, the proportion of the AI/AN population served by TOHP for which performance data is voluntarily submitted increased from 74 percent in FY 2005 to 77 percent in FY 2006. In addition, the number of TOHP submitting a performance report increased by 8% over FY 2005. This increase reflects a strong commitment to performance management.

The TOHP missed the target for the number of designated annual clinical performance goals met, but only by one measure.

Resource Patient Management System (RPMS) Measures

Long Term Goals: Deploy Electronic Health Record (EHR) to all direct sites by 2008.			
Long Term Measure	**FY**	**Target**	**Result**
(RPMS-1) Develop comprehensive electronic health record (EHR) with clinical guidelines for select chronic diseases. [outcome]	*2008*	Comprehensive EHR	Oct/2008
	2007	Maintain All	Oct/2007
	2006	Cardiovascular	Met
	2005	Obesity	met
	2004	HIV/AIDS	not met
	2003	EHR/Asthma	met
(RPMS-2) Derive all clinical measures from RPMS and integrate with EHR. *Clinical Measures/Area [outcome]	*2008*	41/12	Oct/2008
	2007	41/12	Oct/2007
	2006	38/12	41/12*
	2005	37/12	41/12*
	2004	37/12	37/12*
	2003	34/12	34/12*
(RPMS-3) Number of sites to which electronic health record is deployed. [output]	*2008*	All direct sites	Oct/2008
	2007	40	Oct/2007
	2006	40	40
	2005	20	20
	2004	N/A	N/A
	2003	N/A	N/A
Data Source: RPMS data; Office of Information Technology records			
Data Validation: RPMS software; OIT program reviews			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3			

The Office of Information Technology was able to meet all of the FY 2006 performance goals for RPMS. IHS continues to emphasize the further development and deployment of the electronic health record. In addition, the suite of RPMS applications has expanded to include additional case management tools, as well as the Clinical Reporting System (CRS). CRS was nationally recognized with the receipt of the Davies Award for Excellence in public health software applications during 2005.

RPMS-E: See Measure 21.

IHS Sanitation Facilities Measures

Efficiency Measure	FY	Target	Result
(SFC-E) Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion.	*2011*	4.0 yrs	Apr/2012
	2010	4.1 yrs	Apr/2011
	2009	4.2 yrs	Apr/2010
	2008	4.3 yrs	Apr/2009
	2007	4.2 yrs	Apr/2008
	2006	4.1 yrs	Apr/2007
[outcome]	*2005*	N/A	3.8 yrs
Data Source: The SFC Sanitation Deficiency System (SDS) and Project Data System (PDS).			
Data Validation: Site inspection			
Cross Reference: Healthy People 2010; HHS Strategic Goal 3			

Long Term Goal: Increase the percentage of American Indian/Alaska Native (AI/AN) homes with sanitation facilities to 90 percent by 2010.			
Measure	**FY**	**Target**	**Result**
(SFC-1) Sanitation Improvement: Number of new or like-new and existing AI/AN homes provided with sanitation facilities.	*2008*	21,375	Oct/2008
	2007	22,500	Oct/2007
	2006	20,000	24,090
	2005	20,000	24,072
	2004	22,000	24,928
[outcome]	*2003*	15,255	22,750
(SFC-2) Percent of existing homes served by the Sanitation Facilities Construction Program at Deficiency Level 4 or above as defined by 25 USC 1632.	*2008*	35%	Oct/2008
	2007	35%	Oct/2007
	2006	20%	35%
	2005	N/A	38%
	2004	N/A	N/A
[outcome]	*2003*	N/A	N/A
Long Term Measure	**FY**	**Target**	**Result**
(SFC-3) Percent of American Indian/Alaska Native (AI/AN) homes with sanitation facilities.	*2010*	90%	Dec/2010
	2006	None	88%
	2003	None	88%
[outcome]	*2000*	None	92.5
Data Source: The SFC Sanitation Deficiency System (SDS) and Project Data System			
Data Validation: Site inspection			
Cross Reference: Healthy People 2010; HHS Strategic Goal 3			

Improved sanitation is recognized as a significant factor in the rate reduction of infant mortality, gastroenteritis morbidity, and other environmentally-related diseases by as much as 80 percent since 1973. American Indian and Alaska Native homes are twelve times more likely to be without clean water than other homes in the rest of the U.S. Since 2002, the percentage of homes served with sanitation facilities including potable water facilities annually has increased, except for the period 2002 to 2003, when changing regulations resulted in a negative change. This change, along with increased housing

construction activity and increasing AI/AN populations since 2003, have resulted in less than 90 percent of the AI/AN homes having sanitation facilities.

Federally-Administered Activities Program Measures

Efficiency Measure	**FY**	**Target**	**Result**
(FAA-E) Hospital admissions per 100,000 service population for long term complications of diabetes in federally administered facilities.	*2008*	149.5	Sep/2010
	2007	151.0	Sep/2009
	2006	152.5	Sep/2008
	2005	154.0	Sep/2007
	2004	Baseline	155.6
Data Source: National Health Disparities Report			
Data Validation: IHS Division of Program Statistics			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3			

Long Term Goal: By FY 2010, reduce the proportion of children ages 2-5 with a BMI of 95 percent or higher by 16 percent			
Annual and Long Term Measure	**FY**	**Target**	**Result**
(FAA-1) Children ages 2-5 years with a BMI of 95 percent or higher.	*2010*	-16%	Oct/2010
	2009	23%	Oct/2009
	2008	23%	Oct/2008
	2007	23%	Oct/2007
	2006	Baseline	23%
[outcome]	*2005*	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3			

Long Term Goal: By FY 2012, reduce the Years of Potential Life Lost (YPLL) in American Indian/Alaska Native population to 63.4			
Long Term Measure	**FY**	**Target**	**Result**
(FAA-2) Years of Potential Life Lost in American Indian/Alaska Native population (three year rates centered on mid-year).	*2012*	68.1	Jan/2015
	2003	N/A	Sept/2007
	2002	N/A	77.9
	2001	N/A	75.7
	2000	N/A	75.1
	1998	N/A	75.1
[outcome]			
(FAA-3) Unintentional Injury Rates: Unintentional injuries mortality rate in AI/AN population.	*2006*	89.8	Dec/2010
	2005	89.8	Dec/2009
	2004	89.8	Dec/2008
	2003	89.8	Dec/2007
	2002	86.8	89.8
	2001	85.5	86.8
	2000	97.2	85.5
	1997	N/A	97.2
	1998	N/A	94.7

Data Source: IHS service population data; 2000 Census bridged-race file; mortality data from CDC National Center for Health Statistics
Data Validation: IHS Division of Program Statistics
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3, 5; IHS Strategic Goal 1

CHANGES AND IMPROVEMENTS OVER PREVIOUS YEARS

FY 2008 Performance Plan

The FY 2008 Performance Plan represents our ongoing linkage of annual performance measures to the long-term health outcome goals of the IHS Strategic Plan. This plan and its performance measures are partially based on our key external factors influencing success and the level of attainment of related FY 2007 performance measures.

The FY 2008 Performance Plan includes a total of 54 measures, 5 of which are efficiency measures and one of which is developmental. Although this number is significantly higher than the numbers reported in plans just a few years ago, many programs within Indian Health Service utilize the same measures to evaluate their performance. For instance, ideal glycemic control is a performance measure tracked for all IHS facilities, for Health Care Facilities Construction, and for Tribally-operated health programs. The targets for each differ, based upon specific program performance goals. Since results for these clinical measures are passively extracted from the Resources and Patient Management System databases using Clinical Reporting System software application, reporting is simplified. In addition, these common measures can provide a basis of comparison between and among programs.

Revisions to FY 2007 Performance Plan

The table that follows includes a summary of significant changes in content or magnitude to FY 2007 measures originally submitted with the FY 2007 budget. In addition to the changes outlined below, the FY 2007 targets for some measures were increased, based on the FY 2006 results exceeding both the FY 2006 and FY 2007 targets. These changes only appear in the Detail of Performance Analysis section.

Table of Changes to the FY 2007 IHS Performance Measures

Original FY 2007 Measure	Revised FY 2007 Measure	Rationale for Change
Diabetes: Ideal Glycemic Control: During FY 2007, increase the proportion of patients with diagnosed diabetes with A1c<7 to 34%	**Diabetes: Ideal Glycemic Control:** During FY 2007, increase the proportion of patients with diagnosed diabetes with A1c<7 to 32%	Because increasing the proportion of patients with ideal glycemic control requires both patient compliance and expensive drug treatment, it is extremely difficult to significantly increase this proportion in a year. The new target represents an increase of 1% over the FY 2006 results and will be a challenge to meet.
Diabetes: Nephropathy Assessment: Proportion of patients with diagnosed diabetes assessed for nephropathy.	**Diabetes: Nephropathy Assessment:** Proportion of patients with diagnosed diabetes assessed for nephropathy (according to	Although the description of this measure is the same, the 2006 Diabetes Standards of Care require quantitative testing in addition to or instead of the previous

Original FY 2007 Measure	Revised FY 2007 Measure	Rationale for Change
	new standard)	screening method. This is a significant change that will ensure patients at risk are accurately identified. However, during implementation, screening rates for this measure are expected to be lower, so the new target is to establish a baseline.
Medical Error Improvement: During FY 2007, maintain a medical error reporting system at three Areas	**Patient Safety Measurement System:** During FY 2007, develop and deploy a patient safety measurement system.	The Patient Safety Measurement System includes reporting of medical errors as well as other patient safety issues. This system will be used to facilitate increased reporting of medical errors as well as confidential and anonymous reporting.
Scholarships: During FY 2007, increase the number of scholarship recipients placed in Indian health settings within 90 days of graduation.	**Scholarships:** During FY 2007, Increase the number of scholarship recipients placed in Indian health settings within 90 days of graduation to 42%	This measure was modified to identify a specific percentage target.
Health Care Facility Construction: During FY 2007, complete construction of replacement health centers at Sisseton, SD and Phoenix-Nevada Youth Regional Treatment Centers	**Health Care Facility Construction:** During FY 2007, complete construction of 2 replacement health centers (at Sisseton. SD and Clinton, Oklahoma)	Projections of sites that will be completed in 2007 have been adjusted.

Program Assessment Rating Tool Summary
Indian Health Service
CY 2002 – CY 2006
(Dollars in Millions)

Program	FY 2007 CR Level	FY 2008 Request		Narrative Rating
		Total	+/- FY 2007 CR Level	
CY 2002 PARTs				
Federally Administered Activities	$1923.9	$2033.1	+$109.2	Moderately Effective
Sanitation Facilities Construction	$93.3	$88.5	-$4.8	Moderately Effective
CY 2003 PARTS				
Urban Indian Health Program	$32.7	$0	-$32.7	Adequate
Resource & Patient Management System	$54.5	$69.2	+$14.7	Effective
CY 2004 PARTs				
Health Care Facilities Construction	$36.7	$12.7	-$24.0	Effective
CY 2005 PARTs				
Tribally Operated Health Programs	$1774.3	$1923.8	+$149.5	Adequate

THIS PAGE LEFT BLANK INTENTIONALLY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2008 Performance Budget Submission

TABLE OF CONTENTS

THIS PAGE LEFT BLANK INTENTIONALLY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
FY 2008 Discretionary State/Formula Grants
(dollars in hundreds)

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

STATE/MANDATORY	FY 2006 Actual	FY 2007 CR	FY 2008 Pres. Budget	Difference +/- 2007
Alaska	$10,730,700	$10,730,700	$10,730,700	$0
Arizona	$32,768,552	$32,768,552	$32,768,552	$0
California	$11,444,479	$11,444,479	$11,444,479	$0
Colorado	$728,212	$728,212	$728,212	$0
Iowa	$254,197	$254,197	$254,197	$0
Idaho	$1,083,771	$1,083,771	$1,083,771	$0
Illinois	$226,282	$226,282	$226,282	$0
Kansas	$1,092,910	$1,092,910	$1,092,910	$0
Massachetts	$142,066	$142,066	$142,066	$0
Michigan	$2,497,177	$2,497,177	$2,497,177	$0
Minnesota	$5,095,852	$5,095,852	$5,095,852	$0
Mississippi	$397,100	$397,100	$397,100	$0
Montana	$6,882,348	$6,882,348	$6,882,348	$0
North Carolina	$1,143,625	$1,143,625	$1,143,625	$0
North Dakota	$2,968,297	$2,968,297	$2,968,297	$0
Nebraska	$1,914,873	$1,914,873	$1,914,873	$0
New Mexico	$9,029,891	$9,029,891	$9,029,891	$0
Nevada	$3,155,431	$3,155,431	$3,155,431	$0
New York	$791,612	$791,612	$791,612	$0
Oklahoma	$20,193,190	$20,193,190	$20,193,190	$0
Oregon	$2,592,818	$2,592,818	$2,592,818	$0
South Dakota	$6,809,117	$6,809,117	$6,809,117	$0
Texas	$436,765	$436,765	$436,765	$0
Utah	$1,841,840	$1,841,840	$1,841,840	$0
Washington	$5,897,398	$5,897,398	$5,897,398	$0
Wisconsin	$4,063,532	$4,063,532	$4,063,532	$0
Wyoming	$747,878	$747,878	$747,878	$0
Subtotal:	$134,929,913	$134,929,913	$134,929,913	$0
Indian Tribes	$35,598,771	$35,598,771	$35,598,771	$0

INDIAN HEALTH SERVICE
DETAIL OF PERMANENT POSITIONS

	2006 Actual	FY 2007 CR	2008 Budget
ES-5	2	2	2
ES-4	3	3	3
ES-3	4	4	4
ES-2	5	5	5
ES-1	7	7	7
Subtotal	21	21	21
Total - ES Salaries	$3,438,284	$3,513,926	$3,619,344
GS/GM-15	411	411	411
GS/GM-14	416	416	416
GS/GM-13	388	389	394
GS-12	791	793	803
GS-11	1,294	1,297	1,314
GS-10	469	470	476
GS-9	1,389	1,395	1,413
GS-8	235	236	239
GS-7	895	899	911
GS-6	1,135	1,138	1,152
GS-5	1,959	1,965	1,990
GS-4	1,128	1,131	1,145
GS-3	213	214	216
GS-2	43	43	44
GS-1	1	1	1
Subtotal	10,767	10,798	10,923
Total - GS Salaries	$614,578,274	$629,707,245	$655,083,338
Assistant Surgeon General CO-08	5	5	5
Assistant Surgeon General CO-07	3	3	3
Director Grade CO-06	435	435	439
Senior Grade CO-05	598	595	601
Full Grade CO-04	561	558	563
Senior Assistant Grade CO-03	398	398	402
Assistant Grade CO-02	135	135	136
Junior Grade CO-01	13	13	13
Subtotal	2,148	2,142	2,162
Total - CO Salaries	$128,107,000	$130,567,513	$135,703,656
Ungraded	1,270	1,270	1,286
Total - Ungraded Salaries	$32,258,580	$32,968,269	$33,957,317
Average ES level	ES-02		
Average ES salary	$163,728		
Average GS grade	8.2		
Average GS salary	$51,879		

INDIAN HEALTH SERVICE
Performance Budget Crosswalk
(Dollars in Thousands)

Performance Program Area	Budget Activity	FY 2006 Enacted	FY 2007 CR	FY 2008 PB
Treatment	Hospitals & Health Clinics	$1,339,488	$1,339,488	$1,493,534
	Dental Health	117,731	117,731	135,755
	Mental Health	58,455	58,455	64,538
	Alcohol & Substance Abuse	143,198	143,198	161,988
	Contract Health Services	517,297	520,548	569,515
	Urban Health	32,744	32,744	0
	Indian Health Professions	31,039	31,039	31,866
	Tribal Management	2,394	2,394	2,529
	Self Governance	5,668	5,668	5,928
	Contract Support Costs	264,730	264,730	271,636
	Medicare/Medicaid/Private Insurance Collections	579,211	595,250	595,250
	Direct Operations	62,194	62,194	64,632
	Special Diabetes	150,000	150,000	150,000
	Subtotal	3,304,149	3,323,439	3,547,171
Prevention	Public Health Nursing	48,959	48,959	56,825
	Health Education	13,584	13,584	15,229
	Community Health Representatives	52,946	52,946	55,795
	Immunization AK	1,621	1,621	1,760
	OEHE Support	666	690	707
	Environmental Health Support	20,094	20,963	21,425
	Subtotal	137,870	138,763	151,741
Capital Programming/ Infrastructure	Maintenance & Improvement	51,633	52,254	51,936
	Sanitation Facilities	92,143	93,259	88,500
	Health Care Facilities Construction	37,779	36,664	12,664
	Facilities Support	79,985	86,348	89,473
	Environmental Health Support	37,316	38,930	39,789
	OEHE Support	12,648	13,115	13,432
	Equipment	20,947	21,350	21,270
	Medicare/Medicaid/Private Insurance Collections	102,214	105,044	105,044
	Quarters	6,288	6,288	6,288
	Subtotal	440,953	453,252	428,396
IHS Total Program Level Funding		$3,882,972	$3,915,454	$4,127,308

INDIAN HEALTH SERVICE
SUMMARY OF FULL COST
(Dollars in Millions)

Performance Program Area	FY 2006	FY 2007	FY 2008
TREATMENT and PREVENTION	3,442.0	3,462.2	3,698.9
Measures 1-6	838.8	856.3	1,071.8
Measures 7-9	27.8	28.8	49.2
Measure 10	19.9	20.0	19.7
Measure 11	1.6	2.0	26.1
Measures 12-15	118.9	128.4	137.8
Measure 16	2.4	2.5	2.4
Measure 19	5.0	5.5	6.6
Measure 18	10.2	20.2	22.5
Measure 20	648.2	648.2	684.1
Measure 21	6.1	6.1	6.2
Measure 23	49.5	53.6	57.0
Measure 24-26	9.7	9.9	35.7
Measure 27-28	42.0	44.0	256.8
Measure 29*	28.5	28.5	28.5
Measure 30	n/a	213.8	217.0
Measure 31-32	4.9	3.4	38.0
Measure 33	2.0	2.0	2.0
Measure 34	0.3	0.3	0.2
Measure 42	0.7	0.7	14.2
CAPITAL PROGRAMMING/INFRASTRUCTURE	441.0	453.2	428.4
Measure 35	93.1	95.0	95.8
Measure 36	38.2	38.2	40.5
Full Cost Total	3,883.0	3,915.5	4,127.3

Allocation Methodology Explanation:

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

Full cost data for the measures under each performance program are shown as non adds. The sum of full costs of performance measures may not equal the full cost of the performance area. This reflects the extent to which the program has elements that have no current performance measures. Many of the cost estimates are evolving and will not be precise until most sophisticated cost estimates are developed. Significant increases will be noted due to changes in assumptions.

SPECIAL REQUIREMENTS

Financial Management Systems

UFMS Development and Implementation
The Unified Financial Management System (UFMS) is being implemented to replace five legacy accounting systems currently used across the Operating Divisions (Agencies). The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. The system will also facilitate shared services among the Agencies and thereby, help management reduce substantially the cost of providing accounting service throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable the component agencies and program administrators to make more timely and informed decisions regarding their operations. UFMS has been in production for the CDC and FDA for over a year, with new functionality releases of Grants and IVR in October 2005 and eTravel in April 2006. The PSC implementation was moved to production on October 16, 2006.

UFMS Operations and Maintenance (O&M)
The PSC has the responsibility for ongoing Operations and Maintenance (O & M) activities for UFMS. The scope of O & M services includes post deployment support and ongoing business and technical operations services. Post-deployment services include supplemental functional support, training, change management and technical help-desk services. On-going business operation services involve core functional support, training and communications, and help desk services. On-going technical services include the operations and maintenance of the UFMS production and development environments, on-going development support, and backup and disaster recovery services. In accordance with Federal and HHS policy, the UFMS application is under an approval to operate through February 16, 2007 by the designated Certifying Authority and Designated Approving Authority (DAA). The UFMS application will be approved for operation for 1 year after this date. After October 2007, when all OPDIVs will be operational on UFMS, then a 3-year certification will be completed. This approval to operate assures that the necessary security controls have been properly reviewed and tested as required by the Federal Information Security Management Act (FISMA). Indian Health Service requests $5,219,151 to support these efforts in FY 2008.

Administrative Systems
With the implementation of a modern accounting system, HHS has efforts underway to consolidate and implement automated administrative systems that share information electronically with UFMS. These systems will improve the business process flow within the Department, improve Funds Control and provide a state of the art integrated Financial Management System encompassing Finance, Budget, Acquisition, Travel and Property. As the UFMS project is nearing completion, the integration of administrative systems is the next step in making these processes more efficient and effective. Indian Health Service requests $3,432,636 to support these efforts in FY 2008.

HHS Consolidated Acquisition System

The HHS Consolidated Acquisition System (HCAS) initiative is a Department-wide contract management system that will integrate with the Unified Financial Management System (UFMS). The applications within the HCAS are Compusearch PRISM and a portion of the Oracle Compusearch Interface (OCI). PRISM is a federalized contract management system that helps streamline the procurement process. The implementation of PRISM includes the functionality of contract writing, simplified acquisitions, electronic approvals and routing, pre-award tracking, contract monitoring, post award tracking, contract closeout and reporting. Major functions once integrated with the UFMS include transfer of iProcurement requisition for commitment accounting and funds verification to PRISM and transmission of the award obligation from PRISM to Oracle Financials.

Benefits:
The following benefits will be realized by the Department and the individual OPDIVs/STAFFDIVs once the HCAS system is fully implemented and integrated with UFMS:

- Commitment Accounting
- Integration to other HHS Administrative Systems
- Decreased Operational Costs
- Increased Efficiency and Productivity
- Improved Decision Making – Unified systems
  - Data Integrity
  - Reporting
  - Performance Measurement
  - Financial Accountability
- Standardization
  - Business Processes
  - Information Technology
- Consistent Customer Service Levels
- Refocus personnel efforts on value-added tasks
- Knowledge Sharing
- System Enabled Work
  - HHS Acquisition Personnel – contracting
  - Customers in requirement preparation – requisitioning
- Meets Organizational Drivers and Goals (President's Management Agenda, One-HHS, OMB Line of Business)

The HCAS team is working closely with the UFMS PMO and HHS PMO to ensure a smooth roll out of both PRISM and iProcurement. An integrated team, including personnel from UFMS, Acquisition and Assets has been formed to ensure maximum utilization of in-house expertise. **IHS requests $1,060,195 to support these efforts in FY 2008.**

Department of Health & Human Services
Indian Health Service

Service Units and Facilities
Operated by IHS and Tribes -- October 1, 2005

2008 CJ

Type of Facility	TOTAL	IHS	TRIBAL			
		Total	Total	Title I [a]	Title V [b]	Other [c]
Service Units	**163**	63	100			
Hospitals	**48**	33	15	3	12	0
Ambulatory	**603**	92	511	195	310	6
Health Centers	272	52	220	105	115	0
School Health Centers	11	2	9	7	2	0
Health Stations	154	38	116	75	41	0
Alaska Village Clinics	166	0	166	8	152	6

[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

Indian Health Service
Summary of Inpatient Adms and Outpatient Visits
Federal and Tribal
FY 2005

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**38,477**	**20,524**	**59,001**
Aberdeen	5,313		5,313
Alaska		10,253	10,253
Albuquerque	2,297		2,297
Bemidji	597		597
Billings	2,546		2,546
California			*
Nashville		1,281	1,281
Navajo	13,689	3,796	17,485
Oklahoma	6,439	4,726	11,165
Phoenix	6,744	468	7,212
Portland			*
Tucson	852		852

* No inpatient facilities in FY 2005

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	**4,470,163**	**5,326,571**	**9,796,734**
Aberdeen	721,423	84,712	806,135
Alaska	**	1,403,044	1,403,044
Albuquerque	429,494	68,672	498,166
Bemidji	214,547	605,138	819,685
Billings	487,094	116,990	604,084
California	**	503,642	503,642
Nashville	5,372	349,185	354,557
Navajo	1,014,028	223,974	1,238,002
Oklahoma	656,671	1,205,383	1,862,054
Phoenix	610,794	241,336	852,130
Portland	239,331	488,354	727,685
Tucson	91,409	36,141	127,550

** No IHS facilities in FY 2005

Indian Health Service
Estimated Expenditures for Immunizations

	FY 2005 Estimated	FY 2006 Estimated	FY 2007 Estimated	FY 2008 Estimated	Increase or Decrease
Infants and Children ($)	$10,781,190	$11,136,969	$11,582,447	$12,068,909	+$486,462
Adults ($)	1,492,786	1,542,048	1,603,729	1,671,086	+67,357
HPV*	0	0	0	8,587,800 *	+$8,587,800
TOTAL:	$12,273,976	$12,679,017	$13,186,176	$22,327,795	+$9,141,619

* HPV estimated expenditures is a new licensed vaccine and does not include medical inflation.

The following method was used to estimate expenditures for immunization services in the Indian Health Service (IHS). Since the IHS patient care data system is not structured to measure itemized costs for the treatment of various conditions, an indirect method was used to compute this estimate based on estimates of the patient population and the amount of staff time required to administer the immunizations as well as the cost of those immunizations not available through the Vaccines for Children Program.

Immunization costs were categorized into two target populations. These include 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 IHS immunization expenditures in FY 2004. A medical inflation rate of 3.7 percent was added to the FY 2004 estimates to arrive at the FY 2005 estimated expenditures. The medical inflation rate of 3.3 percent was added to the FY 2005 estimates to arrive at the FY 2006 estimated expenditures. The medical inflation rate of 4 percent was added to FY 2006 to arrive at the FY 2007 estimated expenditures.

FY 2008 was increased by 4.2 percent, for medical inflation, over the FY 2007 amounts. In addition to the medical inflation rate increase, the adult vaccine amount of $8,587,800 was added to include the cost to provide the newly licensed vaccine for Human Papilloma Virus (HPV) to females 19 – 26 years. Costs were calculated based on the following assumptions: a). 20 percent coverage of the 19 – 26 year old female user population (~23,855), and b) cost of a 3 dose series of the vaccine at $360.00.

These amounts are likely an under estimate for several reasons: 1) Individuals outside these target groups are regular recipients of immunizations (e.g., HBg immunization for health care workers and those at specific risk for other vaccine-preventable diseases), however, there is not a good way to estimate the size of these groups; 2) no measure is available for the cost of monitoring (e.g., immunization registries); and 3) no attempt was made to estimate indirect costs or administrative overhead associated with the administration of immunizations, or operation of the immunization program.

Indian Health Service
FY 2006 Self-Governance Funding Agreements
By Area

Jan 11, 2007

Area	Tribal User Population	Program Tribal Shares	Area Tribal Shares	Headqtrs Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	TOTAL
Alaska	$116,385	$341,130,000	$12,047,000	$11,591,000	$19,909,000	$62,725,000	$447,402,000
Aberdeen	0	0	128,000	0	0	0	128,000
Bemidji	29,091	33,319,000	4,716,000	1,631,000	1,308,000	3,318,000	44,292,000
Billings	15,096	13,957,000	1,777,000	809,000	1,451,000	3,345,000	21,339,000
California	9,307	31,550,000	2,494,000	1,775,000	1,528,000	9,895,000	47,242,000
Nashville	29,844	46,554,000	5,475,000	1,817,000	2,561,000	7,545,000	63,952,000
Oklahoma	237,023	167,812,000	8,421,000	9,323,000	7,677,000	23,346,000	216,579,000
Phoenix	21,120	35,950,000	1,497,000	1,408,000	2,336,000	6,086,000	47,277,000
Portland	39,676	58,861,000	4,841,000	2,863,000	4,448,000	15,865,000	86,878,000
Total, IHS	**$497,542**	**$729,133,000**	**$41,396,000**	**$31,217,000**	**$41,218,000**	**$132,125,000**	**$975,089,000**

Indian Health Service
Self Governance Funded Compacts - FY 2006

Jan 11, 2007

By State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	TOTAL
Alabama	**$3,112,000**	**$220,000**	**$115,000**	**$610,000**	**$4,057,000**
Poarch Band of Creek Indians	3,112,000	220,000	115,000	610,000	4,057,000
Alaska	**$344,184,000**	**$20,584,000**	**$19,909,000**	**$62,725,000**	**$447,402,000**
Alaska Native Tribal Health Consortium	99,408,000	14,782,000	3,230,000	5,229,000	122,649,000
Aleutian/Pribilof Islands Association, Inc.	2,112,000	62,000	251,000	523,000	2,948,000
Arctic Slope Native Association	6,996,000	63,000	907,000	2,366,000	10,332,000
Bristol Bay Area Health Corporation	18,901,000	649,000	1,577,000	5,454,000	26,581,000
Chugachmiut	3,434,000	53,000	193,000	1,131,000	4,811,000
Copper River Native Association	1,765,000	24,000	158,000	487,000	2,434,000
Council of Athabascan Tribal Government	1,032,000	8,000	29,000	460,000	1,529,000
Eastern Aleutian Tribes, Inc.	2,672,000	24,000	91,000	332,000	3,119,000
Kenalitze Indian Tribe	1,434,000	9,000	37,000	181,000	1,661,000
Ketchikan Indian Corporation	4,425,000	107,000	733,000	1,620,000	6,885,000
Kodiak Area Native Association	5,481,000	79,000	324,000	1,135,000	7,019,000
Maniilaq Association	23,732,000	565,000	2,009,000	7,640,000	33,946,000
Metlakatla Indian Community	5,171,000	723,000	109,000	554,000	6,557,000
Mount Sanford Tribal Consortium	654,000	2,000	46,000	174,000	876,000
Native Village of Eklutna	148,000	1,000	4,000	19,000	172,000
Norton Sound Health Corporation	19,074,000	478,000	1,438,000	4,026,000	25,016,000
Seldovia Village Tribe	776,000	9,000	18,000	248,000	1,051,000
Southcentral Foundation	50,561,000	637,000	2,616,000	11,339,000	65,153,000
Southeast Alaska Regional Health Corporation	31,543,000	874,000	2,272,000	5,684,000	40,373,000
Tanana Chiefs Conference	26,305,000	109,000	1,235,000	3,475,000	31,124,000
Yakutat Tlingit Tribe	267,000	7,000	22,000	72,000	368,000
Yukon-Kuskokwim Health Corporation	38,293,000	1,319,000	2,610,000	10,576,000	52,798,000
Arizona	**$19,123,000**	**$2,758,000**	**$1,229,000**	**$3,113,000**	**$26,223,000**
Gila River Indian Community	19,123,000	2,758,000	1,229,000	3,113,000	26,223,000
California	**$34,374,000**	**$1,445,000**	**$1,528,000**	**$9,895,000**	**$47,242,000**
Consolidated Tribal Health Project, Inc.	3,011,000	153,000	77,000	799,000	4,040,000
Hoopa Valley Tribe	4,080,000	308,000	183,000	944,000	5,515,000
Indian Health Council, Inc.	4,403,000	196,000	137,000	1,122,000	5,858,000
Karuk Tribe of California	2,186,000	182,000	66,000	1,025,000	3,459,000
Northern Valley Indian Health, Inc.	1,704,000	174,000	52,000	589,000	2,519,000
Redding Rancheria	4,903,000	98,000	406,000	1,629,000	7,036,000
Riverside-San Bernardino County Indian Health, Inc.	14,087,000	334,000	607,000	3,787,000	18,815,000
Connecticut	**$1,618,000**	**$12,000**	**$0**	**$31,000**	**$1,661,000**
Mohegan Tribe of Indians of Connecticut	1,618,000	12,000	0	31,000	1,661,000
Florida	**$6,342,000**	**$354,000**	**$193,000**	**$956,000**	**$7,845,000**
Seminole Tribe of Florida	6,342,000	354,000	193,000	956,000	7,845,000
Kansas	**$2,067,000**	**$13,000**	**$5,000**	**$19,000**	**$2,104,000**
Prairie Band of Potawatomi Nation	2,067,000	13,000	5,000	19,000	2,104,000
Idaho	**$11,456,000**	**$812,000**	**$848,000**	**$1,582,000**	**$14,698,000**
Coeur D'Alene Tribe	4,406,000	315,000	492,000	889,000	6,102,000
Kootenai Tribe of Idaho	474,000	26,000	54,000	85,000	639,000
Nez Perce Tribe	6,576,000	471,000	302,000	608,000	7,957,000
Louisana	**$989,000**	**$89,000**	**$36,000**	**$167,000**	**$1,281,000**
Chitimacha Tribe of Louisana	989,000	89,000	36,000	167,000	1,281,000
Maine	**$2,562,000**	**$242,000**	**$128,000**	**$525,000**	**$3,457,000**
Penobscot Indian Nation	2,562,000	242,000	128,000	525,000	3,457,000
Massachusetts	**$530,000**	**$35,000**	**$162,000**	**$246,000**	**$973,000**
Wampanoag Tribe of Gay Head	530,000	35,000	162,000	246,000	973,000
Michigan	**$14,898,000**	**$1,087,000**	**$678,000**	**$1,624,000**	**$18,287,000**
Grand Traverse Band of Ottawa and Chippewa Indians	2,189,000	256,000	46,000	422,000	2,913,000
Keweenaw Bay Indian Community	2,407,000	219,000	72,000	309,000	3,007,000
Sault Ste. Marie Tribe of Chippewa Indians	10,302,000	612,000	560,000	893,000	12,367,000
Minnesota	**$12,263,000**	**$975,000**	**$389,000**	**$1,100,000**	**$14,727,000**
Bois Forte Band of Chippewa Indians	1,959,000	174,000	56,000	302,000	2,491,000
Fond du Lac Band of Lake Superior Chippewa	6,437,000	372,000	268,000	523,000	7,600,000
Mille Lacs Band of Ojibwe	3,064,000	393,000	53,000	227,000	3,737,000
Shakopee Mdewakanton Sioux Community	803,000	36,000	12,000	48,000	899,000
Mississippi	**$13,168,000**	**$916,000**	**$943,000**	**$1,784,000**	**$16,811,000**
Mississippi Band of Choctaw Indians	13,168,000	916,000	943,000	1,784,000	16,811,000

Indian Health Service
Self Governance Funded Compacts - FY 2006

Jan 11, 2007

By State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	TOTAL
Montana	**$15,607,000**	**$1,071,000**	**$1,378,000**	**$3,283,000**	**$21,339,000**
Chippewa Cree Tribe of the Rocky Boy's Reservation	8,185,000	454,000	804,000	1,676,000	11,119,000
Confederated Salish and Kootenai Tribes of Flathead	7,422,000	617,000	574,000	1,607,000	10,220,000
Nevada	**$15,988,000**	**$986,000**	**$1,107,000**	**$2,973,000**	**$21,054,000**
Duck Valley Shoshone-Paiute Tribe	6,009,000	634,000	574,000	1,398,000	8,615,000
Duckwater Shoshone Tribe	872,000	55,000	144,000	555,000	1,626,000
Ely Shoshone Tribe	959,000	40,000	45,000	259,000	1,303,000
Las Vegas Paiute Tribe	2,622,000	58,000	97,000	254,000	3,031,000
Washoe Tribe of Nevada and California	3,990,000	126,000	172,000	236,000	4,524,000
Yerington Paiute Tribe of Nevada	1,536,000	73,000	75,000	271,000	1,955,000
New York	**$5,825,000**	**$350,000**	**$181,000**	**$440,000**	**$6,796,000**
St. Regis Mohawk Tribe	5,825,000	350,000	181,000	440,000	6,796,000
North Carolina	**$16,108,000**	**$1,350,000**	**$756,000**	**$2,857,000**	**$21,071,000**
Eastern Band of Cherokee Indians	16,108,000	1,350,000	756,000	2,857,000	21,071,000
Oklahoma	**$174,217,000**	**$9,259,000**	**$7,672,000**	**$23,327,000**	**$214,475,000**
Absentee Shawnee Tribe of Oklahoma	4,542,000	112,000	585,000	474,000	5,713,000
Cherokee Nation	40,592,000	1,635,000	1,120,000	4,370,000	47,717,000
Chickasaw Nation	36,630,000	2,187,000	1,574,000	6,132,000	46,523,000
Choctaw Nation of Oklahoma	45,704,000	4,248,000	2,371,000	5,205,000	57,528,000
Citizen Potawatomi Nation	7,171,000	286,000	570,000	1,277,000	9,304,000
Kaw Nation	936,000	68,000	143,000	196,000	1,343,000
Kickapoo Tribe of Oklahoma	4,033,000	84,000	112,000	1,130,000	5,359,000
Modoc Tribe of Oklahoma	109,000	0	4,000	35,000	148,000
Muscogee (Creek) Nation	20,701,000	473,000	845,000	2,607,000	24,626,000
Northeastern Tribal Health System	5,373,000	70,000	111,000	752,000	6,306,000
Ponca Tribe of Oklahoma	2,752,000	21,000	118,000	394,000	3,285,000
Sac and Fox Nation	4,388,000	21,000	93,000	504,000	5,006,000
Wyandotte Nation	1,286,000	54,000	26,000	251,000	1,617,000
Oregon	**$17,905,000**	**$913,000**	**$1,785,000**	**$6,035,000**	**$26,638,000**
Coquille Indian Tribe	1,497,000	71,000	167,000	708,000	2,443,000
Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians of Oregon	1,362,000	38,000	158,000	316,000	1,874,000
Confederated Tribes of Grand Ronde	4,367,000	230,000	391,000	2,384,000	7,372,000
Confederated Tribes of Siletz Indians of Oregon	5,562,000	171,000	539,000	1,254,000	7,526,000
Confederated Tribes of the Umatilla Reservation	5,117,000	403,000	530,000	1,373,000	7,423,000
Washington	**$32,307,000**	**$2,438,000**	**$1,815,000**	**$8,982,000**	**$45,542,000**
Jamestown S'Klallam Indian Tribe	809,000	55,000	66,000	267,000	1,197,000
Kalispel Tribe of Indians	739,000	68,000	18,000	65,000	890,000
Lower Elwha Klallam Tribe	1,381,000	106,000	73,000	293,000	1,853,000
Lummi Indian Nation	5,949,000	530,000	186,000	1,495,000	8,160,000
Makah Indian Tribe	634,000	76,000	36,000	129,000	875,000
Muckleshoot Indian Tribe	3,359,000	110,000	151,000	0	3,620,000
Nisqually Indian Tribe	1,583,000	82,000	84,000	495,000	2,244,000
Port Gamble S'Klallam Tribe	1,532,000	130,000	103,000	457,000	2,222,000
Quinault Indian Nation	4,188,000	394,000	166,000	1,950,000	6,698,000
Shoalwater Bay Indian Tribe	1,522,000	53,000	212,000	638,000	2,425,000
Skokomish Indian Tribe	1,550,000	77,000	85,000	350,000	2,062,000
Squaxin Island Indian Tribe	2,235,000	185,000	149,000	805,000	3,374,000
Suquamish Tribe	1,197,000	54,000	112,000	496,000	1,859,000
Swinomish Indian Tribal Community	1,930,000	175,000	134,000	651,000	2,890,000
Tulalip Tribes of Washington	3,699,000	343,000	240,000	891,000	5,173,000
Wisconsin	**$9,736,000**	**$759,000**	**$241,000**	**$670,000**	**$11,406,000**
Forest County Potawatomi Community	860,000	112,000	10,000	22,000	1,004,000
Oneida Tribe of Indians of Wisconsin	8,876,000	647,000	231,000	648,000	10,402,000
GRAND TOTAL	**$754,379,000**	**$46,668,000**	**$41,098,000**	**$132,944,000**	**$975,089,000**

Indian Health Service
Self-Governance
Reserve Fund Account -- FY 2006 Expenditure

Sep 30, 2006

	Date	Vendor / Description	Obligation		Adjustment	Balance
1	10/1/05	Beginning Balance				$4,447,000
2	10/1/05	Congressional Increases/Decreases			96,025	4,543,025
	12/30/05	Cong. 2nd Rescission	0		(45,573)	4,497,451
3	10/1/05	Salish&Kootenai FA Neg 1995 User Pop	13,221	x		4,484,230
4	3/23/06	Cherokee 1994 Base User pop/OEHE	0			4,484,230
5	10/3/05	Choctaw 1995 Base Budget	21,058	x		4,463,172
6	10/1/05	Jamestown S'Klallam 1997 HQ TSA adj.	1,584	x		4,461,588
7	10/1/05	Mississipp Choctaw 1997 HQ TSA adj.	7,688	x		4,453,900
8	10/1/05	Penobscot 1997 HQ TSA adj	12,680	x		4,441,220
8	10/1/05	Forest County Transition 2nd yr.	7,807	x		4,433,413
9	11/22/05	SGCE cont. agmt Lummi Tribe passthru	150,000	x		4,283,413
10	12/14/05	PHX Area reimb Mark Downing trvl ALN cur	2,109	x		4,281,304
11	12/20/05	CAO Consolidated THP conv.HQ TS	11,754	x		4,269,550
12	12/21/05	GPRA Pilot Proj ANTHC	249,000	x		4,020,550
13	12/21/05	GPRA Pilot Proj USET	249,000	x		3,771,550
14	12/21/05	GPRA Pilot Proj Rocky Boy	42,000	x		3,729,550
15	12/21/05	GPRA Pilot Proj Kaw	42,000	x		3,687,550
16	12/21/05	GPRA Pilot Proj Mississippi Choctaw	42,000	x		3,645,550
17	1/24/06	BAO CHS start-up at FH&RB	225,000	x		3,420,550
18	3/28/06	TSGAC (Lummi) trvl/logistics/meetings	95,000	x		3,325,550
19	4/12/06	Negotiation Award Pawnee Nation OK	20,000	x		3,305,550
20	4/12/06	Planning Award Sac Fox of Miss Aberdeen	50,000	x		3,255,550
21	4/26/06	JST Portland Best Prac/ Trbl-State	10,000	x		3,245,550
22	5/30/06	PAO Kalispel Tribe for TSA	111,999	x		3,133,551
23	6/22/06	Prompt pay to Bemidji Area - CHS	936	x		3,132,615
24	7/7/06	PAO Kalispel Tribe add'l exp. at Wellpoint HC	49,240	x		3,083,375
25	7/7/06	PAO Makah transfer	695,868	x		2,387,507
26	7/18/06	Ambulances	500,000	x		1,887,507
27	6/22/06	Annual Report to Congress ANTHC-AK	125,000	x		1,762,507
28	7/7/06	Forest County Pilot Project	52,000	x		1,710,507
29	7/18/06	EMS -	45,000	x		1,665,507
30	8/2/06	Prairie Band Potawatomi Conversion-OK Area	474,444	x		1,191,063
31	8/2/06	Planning Award AK - Knik Tribal Council	50,000	x		1,141,063
32	8/3/06	Bem. Red Lake SU asst. req OD	520,000	x		621,063
33	8/29/06	PKW PCS transfer/pay cost	10,000	x		611,063
34	9/8/06	PAO - Jamestown Tech wkgp logistics	70,000			541,063
35	9/8/06	BAO - CHS additional costs at FH&RB	200,000			341,063
36	9/18/06	NAS - Penobscot for MicMac members	50,000			291,063
37	9/18/06	OK - Choctaw for cont Implem. of Title V	50,000			241,063
38	9/27/06	Aberdeen - CHR trng; IHS/VA IAG	100,000			141,063
39	9/27/06	Transferred to OTSG office budget	141,063			0
		Total spent to date:	$4,497,451			

THIS PAGE LEFT BLANK INTENTIONALLY

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, the ISDA, as amended, builds upon IHS policy that 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 recognized 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 $1.6 billion. The IHS currently administers contracts and AFAs with 245 tribes or tribal organizations pursuant to Title I of the ISDEAA Title V provides authorization to sign self-governance compacts for a specific number of tribes who meet certain criteria. Seventy-two compacts and 93 funding agreements have been negotiated to date with 322 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 CHR program and community-based components of the alcohol programs have been almost 100 percent tribally operated. Tribally operated hospitals have 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 that have in turn enabled them 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 all areas.

The primary growth in CSC since 2003 can be attributed to the need to maintain the current level of services. Additional increased needs for CSC is attributed to increased contracting and compacting by T/TO under both Title I and V of the ISDA, a stated goal of both the Congress and the IHS. 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 are continuing 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.