“Putting Health Care First”

Annual California Tribal Leaders’ Consultation Conference

Margo D. Kerrigan, MPH
Director
IHS California Area Office

March 15, 2011
Chukchansi Gold Resort/Casino
Coarsegold, California

Agency Priorities

1. To renew and strengthen our partnership with Tribes

2. To reform the IHS

3. To improve the quality of and access to care

4. To make all our work accountable, transparent, fair and inclusive

Profile of the California Area

103 Federally-recognized tribal governments

81, 594 AI/AN active users residing on or near reservations/rancherias served by 29 tribal health programs

6,356 AI/AN served by 6 urban Indian health programs

Profile of the California Area

Outpatient visits:
565,461

Dental visits:
199, 484

Never had IHS or tribal hospitals

100% CHS dependent

Our Mission

- To raise the physical, mental, social, and spiritual health of American Indian and Alaska Natives to the highest level

Our Goal

- To assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people

Our Foundation

- To uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures

- To honor and protect the inherent sovereign rights of Tribes

Our Core Values

Excellence	Exceeding expectations
Innovation	New and better ways to serve
Respect	Everyone all the time
Ethical	Honesty, fairness, dignity
Leadership	Enhancing health services

To renew and strengthen our partnership with Tribes

DHHS Secretary's Tribal Advisory Committee

- Arch Super (California Primary)
- Stacy Dixon (California Alternate)
- Reno Franklin (At-Large)

Current Tribal Consultations

- IHS Office of Information Technology, Listening Session with Tribal Leaders on March 17, 2011 at the Annual Tribal Leaders' Consultation Conference
- Tribal Epidemiology Centers (TECs), comments or suggestions by March 24, 2011
- Contract Health Service Work Session, meeting on March 30, 2011 in Sacramento
- IHS Director's Tribal Consultation Advisory Workgroup, comments or suggestions on-going

To renew and strengthen our partnership with Tribes

California Area Tribal Advisory Committee (CATAC)

Northern Region:

Primary Representatives	Alternates
John Green (Elk Valley Rancheria)	**Stacy Dixon** (Susanville Rancheria)
Diane Holiday (Blue Lake Rancheria)	**Russell Eleck** (Pit River Tribe)
Peter Masten Jr. (Hoopa Valley Tribe)	**Angela Martin** (Greenville Rancheria)

East Central Region:

Primary Representatives	Alternates
Rachel Joseph (Lone Pine Reservation)	**David Moose** (Big Pine Reservation)
Rick Maddux (Fort Independence Reservation)	**Elaine Fink** (North Fork Rancheria)
Robert Marquez (Cold Springs Rancheria)	**Dixie Jackson** (Picayune Rancheria)

West Central:

Primary Representatives	Alternates
Judy Anderson (Robinson Rancheria)	**Geraldine Johnson** (Elem Indian Colony)
Reno Franklin (Kashia Band of Pomo Indians)	**Silver Galleto** (Cloverdale Rancheria)
Debra Ramirez (Redwood Valley Reservation)	**Beverly Rodriquez** (Hopland Reservation)

Southern Region

Primary Representatives:	Alternates
Diane Chihuahua (Torres-Martinez Reservation)	**Patricia Schoolcraft** (Agua Caliente Band of Cahuilla Indians)
Chris Devers (Pauma Yuima Band of Mission Indians)	**Robert Smith** (Pala Band of Mission Indians)
Johnny Hernandez (Iipay Nation of Santa Ysabel)	**Mark Romero** (Mesa Grande Band of Mission Indians)

Urban Program Representatives:

Primary Representative	Alternate
Britta Guerrero (Sacramento Native American Health Clinic)	**Dave Rambeau** (United American Indian Involvement Inc.)

National Indian Health Board Inc., Representative: **Reno Franklin** (Kashia Band of Pomo Indians)

Unaffiliated California Indian Representative: **Rosemary Nelson**

To renew and strengthen our partnership with Tribes

California Representatives to National HHS & IHS Workgroups

CMS TTAG
James Crouch, California Representative
James Russ - Alternate

Contract Support Cost (CSC) Workgroup
No formal tribal representative, but all programs are invited. Regular attendees include Representatives from NVIH, Karuk, Redding and CRIHB.

Health Promotion/Disease Prevention Policy Advisory Committee (HP/DP PAC)
Barbara Bird

IHS Budget Formulation Workgroup (BFWG)
Rachel Joseph, Stacy Dixon

IHS Contract Health Services Workgroup (CHS)
Technical: Molin Malicay,
Jim Crouch - Alternate
Tribal: Johnny Hernandez,
Chris Devers - Alternate

IHS Facilities Appropriation Advisory Board (FAAB)
Peter Masten,
Reno Franklin - Alternate

IHS National Behavioral Health Workgroup (BHWG)
Rachel Joseph

IHS Tribal Consultation Workgroup
Arch Super, Johnny Hernandez

Tribal Leaders Diabetes Committee (TLDC)
Rosemary Nelson
Diana Chihuahua - Alternate

Tribal Self-Governance Advisory Committee (TSGAC)
Leonard Masten,
Robert Smith - Alternate

Regional Caucuses

- Elect Regional CATAC Representatives
- Review and comment:
  - Tribal Consultation Policy
  - CATAC Policy
  - California Representatives to DHHS and IHS Workgroups Policy
- Open consultation period May 7 – June 30, 2010

Signed on March 23, 2010:

- Affordable Care Act
- Indian Health Care Improvement Act
- Section 157 Access to Federal Insurance – U.S. Office of Personnel Management (OPM)

Internal IHS Reform

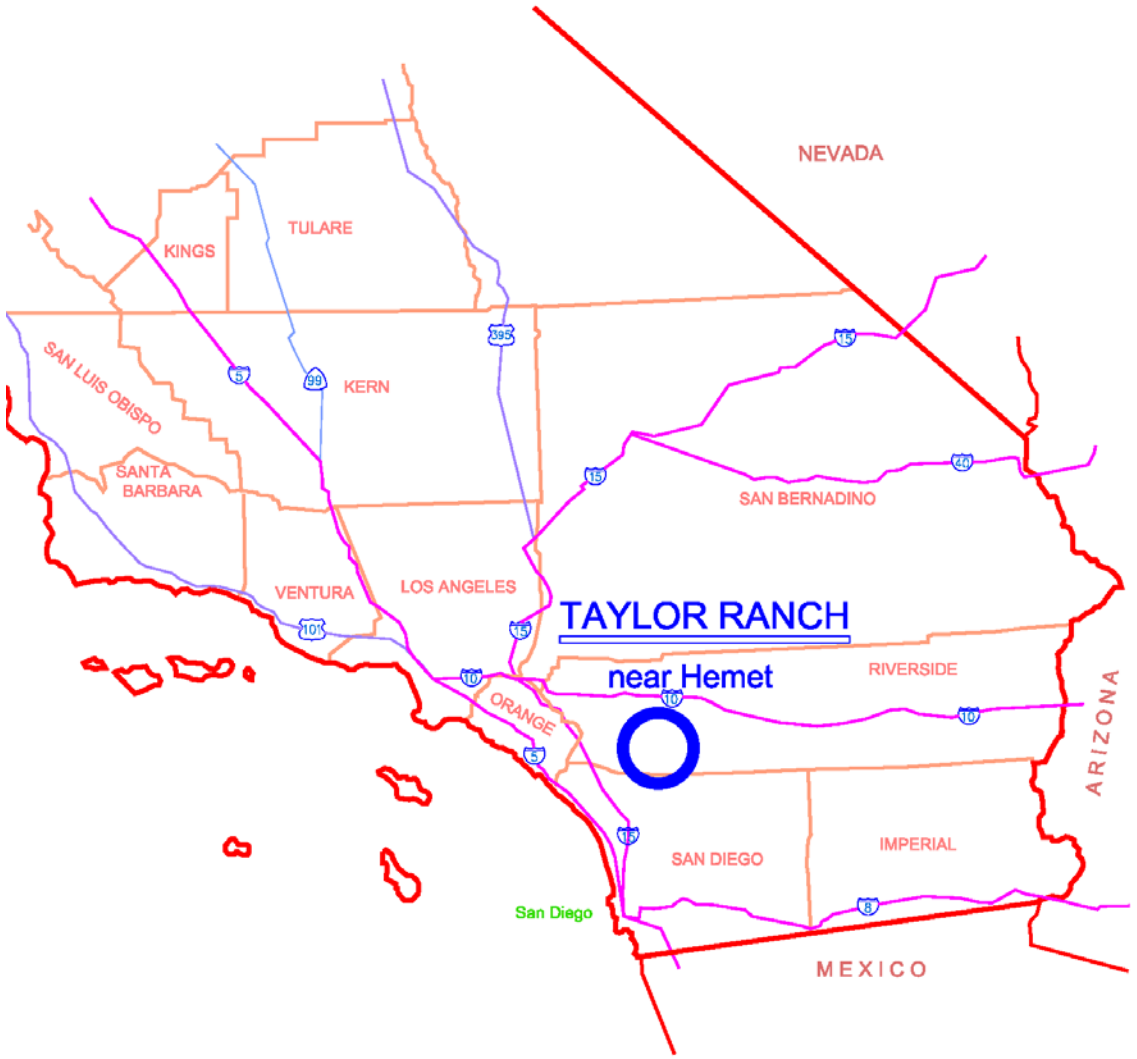
- CAO no longer relying on the IHS Phoenix Area for finance support and by the IHS Albuquerque Area
- CAO now makes payments itself
  - Timeframes reduced dramatically
  - Most payments made within a few days
- Some support still provided by Albuquerque Area Office

California YRTC Project

- Southern YRTC: Taylor Ranch, Riverside County
  - Best Road issue resolved
  - Due diligence completed
  - Property ready for purchase
  - Needs advance approval from House Committee on Appropriations
  - Final step in land acquisition: Department of Justice for title approval
  - FY 2012 IHS Budget Justification - $ 2 million to initiate design and site grading

To improve the quality of and access to care

Southern YRTC



To improve the quality of and access to care

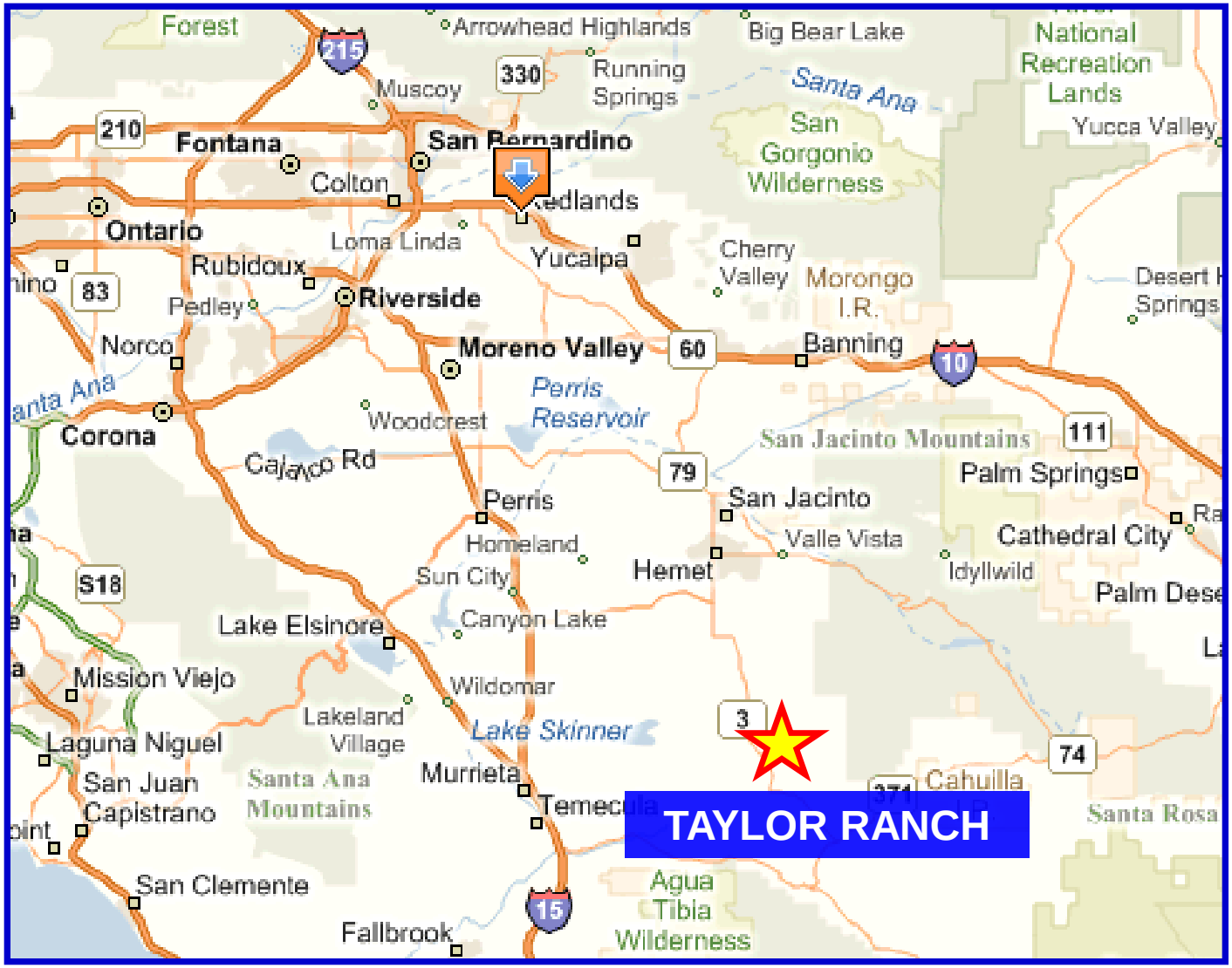
Southern YRTC

TAYLOR RANCH – Hemet, Riverside County

- 18 Acres
- Flat Ranch Land
- 2 wells; 2 septic systems
- 76 miles to ONT
  Ontario Airport
- 60 miles to PSP
  Palm Springs Airport
- Towns:
  Hemet (17 miles)
  Temecula (21 miles)

To improve the quality of and access to care

Southern YRTC

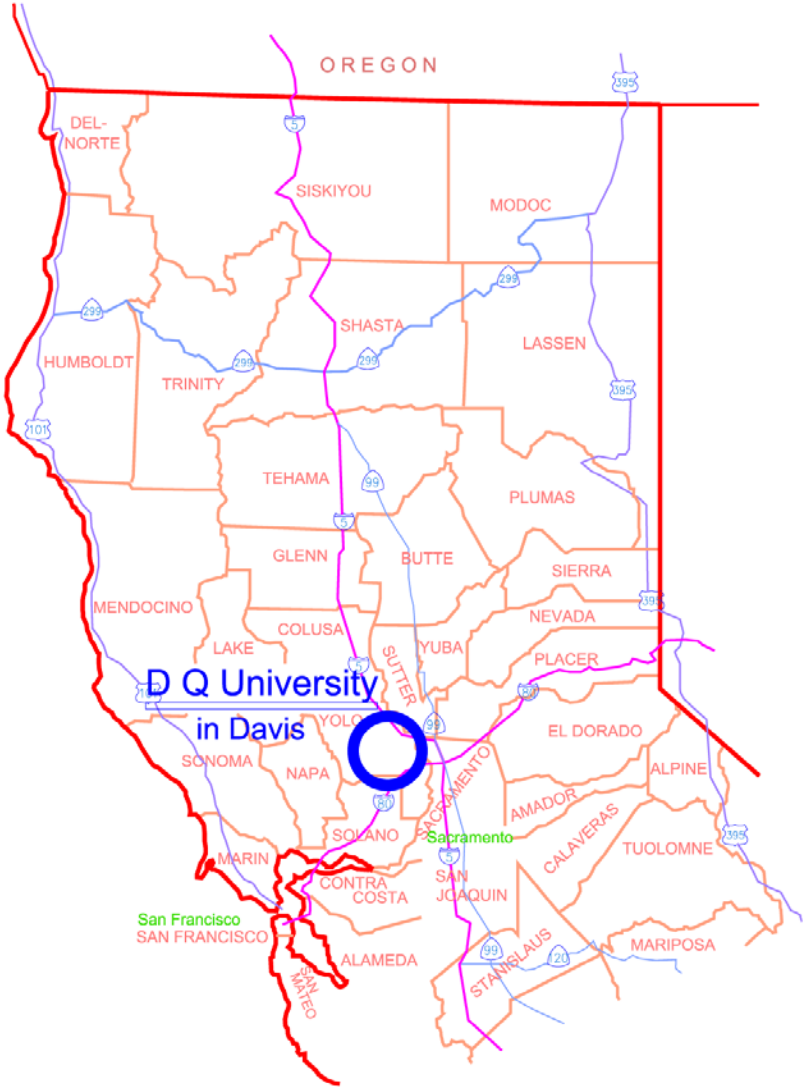


California YRTC Project

- Northern YRTC: DQ University, Yolo County
  - Extensive community and political support
  - Congressman Mike Thompson (D-District 1)
  - Yolo County Board of Supervisors
  - Transfer of property by GSA; no proceeds to DQ from sale of property
  - Separate governance and administration
  - Needs advance approval from House Committee on Appropriations
  - DQU must revert 12 acres to GSA
  - Next step: IHS purchases the 12 acres from GSA
  - DQU Board of Trustees to meet March 19

To improve the quality of and access to care

Northern YRTC



CALIFORNIA AREA INDIAN HEALTH SERVICE - MARCH 2011

Northern YRTC

DQ University– Davis, Yolo County

- 12 of 320 Acres
- Flat Ranch Land
- No improvements
- 26 miles to SMF
  Sacramento Airport
- Towns:
  Davis (6 miles)
  Sacramento (26 miles)

To improve the quality of and access to care

Northern YRTC

Facilities Construction

- Health Facilities Construction Projects
- Sanitation Facilities Construction Projects
- Small Ambulatory Grant Program – Shingle Springs
- Joint Venture Construction Program – Lake County Tribal Health
- Justifying an IHS hospital

To improve the quality of and access to care

Sanitation Facilities Construction Projects

- $ 4,068,000 IHS ARRA Funds
- $ 7,969,000 EPA ARRA Funds
- Funded 20 projects, 20 awarded, 6 complete
- Use of existing IHS Sanitation Deficiency System (SDS) to establish priorities

- Round Valley
  - 14 million gallon wastewater retention pond
  - Pump station
  - 5-acre infiltration basin
  - Serving 160 homes
- Tule River – Largest ARRA project by EPA/IHS in the U.S.
  - $ 11.6 million total cost
  - 6.9 miles of sewer main (basically through solid rock) throughout the reservation
  - State-of-the-art wastewater treatment plant
  - Will serve 371 homes
  - Groundbreaking held on February 18

To improve the quality of and access to care

Small Ambulatory Grant Program

Indian Health Council - Santa Ysabel	2001	$ 809,000
Karuk Tribe - Yreka	2001	750,000
MACT Health Board - Mariposa	2001	312,816
Riverside/San Bernardino - Pechanga	2002	2,000,000
Southern Indian Health Council - Campo	2002	1,275,000
Shingle Springs	2005	2,000,000
	Total:	$ 7,146,816

Joint Venture Construction Program – IHS/Lake County Tribal Health

- $ 7,000,000 Construction Cost to Lake County
- 18,000 Square Foot Expansion
- IHS Pays Staffing/Operation for Minimum 29 Years
- 46 Staff Increase
- $ 4,500,000 Increase in Operational Funding
- Open House September 2010

To improve the quality of and access to care

American Recovery & Reinvestment Act (ARRA) California Projects

- Maintenance & Improvement
  - $ 3,020,000 for health program projects
  - 29 projects approved/24 completed

- Medical Equipment
  - $ 584,333 for health program equipment
  - $ 10,000 minimum per equipment item
  - 36 medical equipment items purchased
  - Initiative 100% complete

- Information Technology Equipment
  - $ 557,771 for information technology upgrades
  - 38 tribal and urban Indian health programs served

BIA Hospitals In California

- Hoopa
- Fort Bidwell
- Soboba
- Sherman Indian School
- Congress closed these hospitals during the termination era
- Only Fort Yuma remains open

Justifying an IHS Hospital in California

- Absence of documented CHS deferrals and denials data
- Absence of documented inpatient days paid by CHS
- Availability of private sector health services
- Dispersed, lack of a concentrated population
- 60 mile/60 minute rule
- Full Service Hospitals
- Alternative Rural Hospitals
- Regional Specialty Diagnostic Treatment and Ambulatory Surgery Services – IHS Portland Area pilot
- Replicate study for California

Justifying an IHS Hospital in California

- Area Health Services Master Plan (feasibility study) defines need
- IHS prepares a program justification document (PJD) that defines project
- Health Facilities Priority System determines eligibility for funding
- Congress must authorize and appropriate resources to acquire property, unless it is trust land
- IHS prepares Program of Requirements (POR) detailing services to be provided, staffing requirements, and facility space allocation
- Congress must authorize and appropriate new funds to design, build, and staff

To improve the quality of and access to care

California
Contract Health Service Delivery Area (CHSDA)
25 USC Sec. 1680

- The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura **shall be designated as a contract health service delivery area (CHSDA) by the IHS for the purpose of providing contract health services to Indians in such State**
- Originally defined on September 30, 1976, P.L. 94-437
- IHCIA, permanently authorized March 23, 2010

Definition of Unaffiliated Indians

- Unaffiliated Indians are all Indians in the CHSDA that are not members of a California Indian Tribe that is federally-recognized
  - Descendants of California Indians
  - Holders of public domain, national forest, or reservation allotments in California
  - Indians listed on judgment rolls
  - Members of out-of-state federally-recognized Indian Tribes

CHS Residency Requirement

- To be CHS eligible, a patient must be a member or a descendant of an enrolled member of a federally-recognized Tribe; **and** **permanently** reside on a reservation/rancheria within a Contract Health Service Delivery Area (CHSDA); or
  - Does not reside on a reservation but resides within a CHSDA and:
    - Are members of the Tribe located on that reservation/rancheria; or
    - Maintain close economic and social ties with that Tribe
  - The CHSDA consists of a county which includes all or part of a reservation/rancheria and any county or counties which have a common boundary with the reservation/rancheria

CHS Funds Distribution

- The principle used to establish funds for AI/AN health programs was based on the healthcare needs for each designated population within an Area
- The distribution of CHS funds is based on each Area and Tribes established funding base
- The established historical funding base or “fixed amount” does not change
- Initially, no one funding formula was used to establish the base that we are aware of
- New distribution formulas/methodology are applied to new funding increases while current service increases are applied to the base

Overview of CHS Allocation Methodology (New Funding Increases)

IHS distribution methodology is divided into three parts:

- Congressional earmarks
- Inflation funding
- New formula

Earmarks: New Tribes / CHEF	+	Inflation: (OMB) Rate	+	New Formula

New Funding Formula

New formula consists of three basic factors multiplied together:

- Active user population
- Cost of purchasing health cares services within a geographical area
- Access to the nearest care

Annual Request for CHS Data

DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service

NOV 0 4 2009

Indian Health Service
Rockville MD 20857

TO: Area Contract Health Services Officer/Coordinator

FROM: Director, Division of Contract Care

SUBJECT: FY 2009 – CHS Budget Information Tables

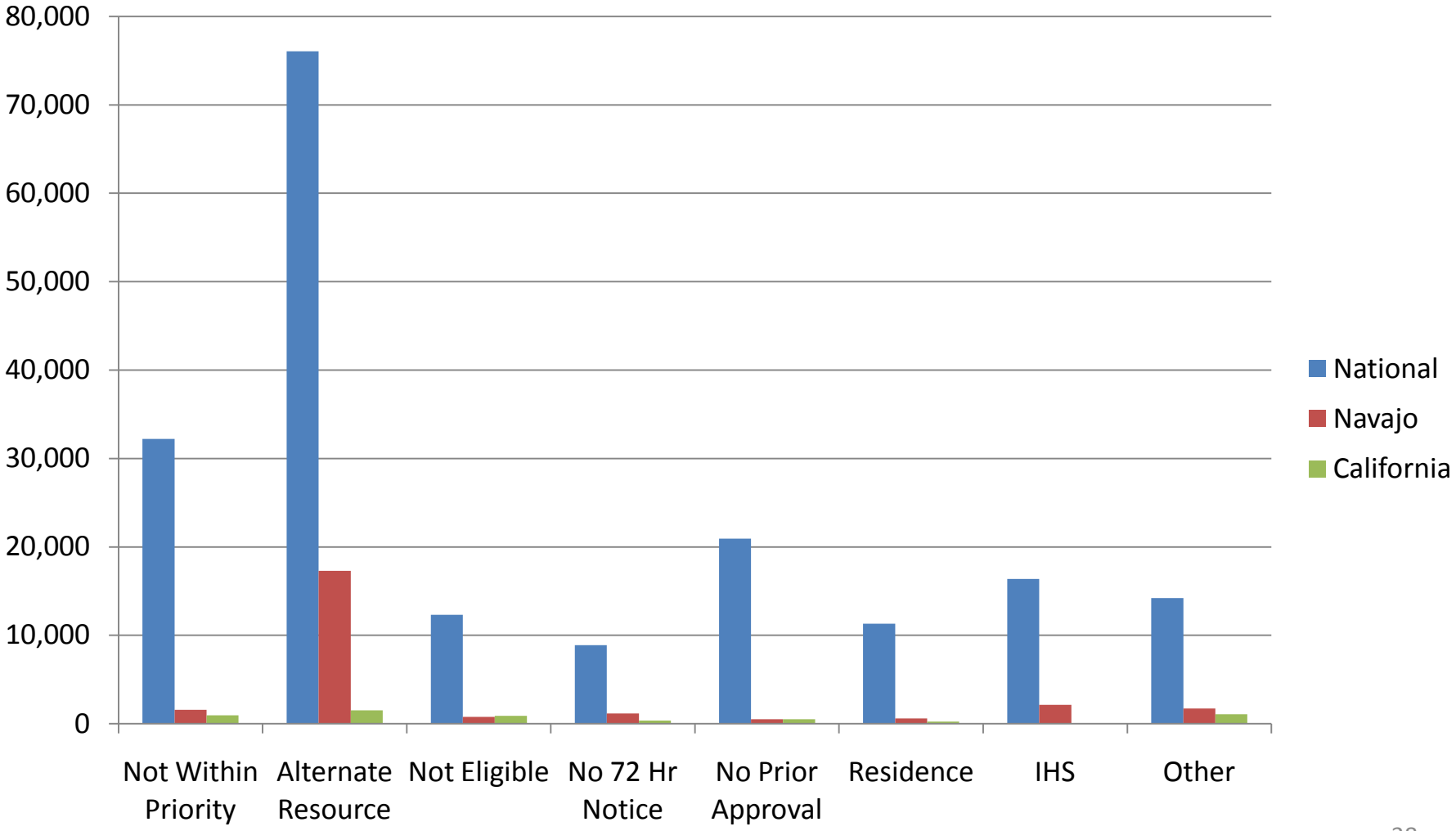
I am requesting all Area Contract Health Services (CHS) programs, both IHS and Tribes, to provide the CHS Budget Information and Deferred Services reports for fiscal year (FY) 2009 by **COB November 30, 2009.**

The data and information on Deferred Services, Denials, and CHS information from these reports will be used to support **unmet CHS financial needs** and in preparing budget justifications for the CHS program. The reporting procedures have not changed and Areas may continue to use their established formats as they have in previous years.
The parts are as follows:

Contract Health Services

- Deferrals and denials are not routinely tracked in tribal health programs
- CAO is developing a manual tracking tool and providing training on how to use the RPMS CHS Management Information System
- Need to document deferrals and denials as a measure of unmet need (Congress and the GAO)
- CHS Work Session scheduled March 30 – Doubletree Hotel, Sacramento
- Other IHS Areas in comparison

CHS Denials
2010



Example Log

CHS Denial and Deferred Services Log

Program Name:

Fiscal Year:

Name	Vendor Name	Contact Date	Date of Service	Denial/Deferred Code(s)	
Example - Demo, Patient	Inpatient Hospital	3/8/2011	3/1/2011	DN-D	

Contract Health Services

Different Measures of Unmet Need

Formula	Unmet Need
Contract Health Services	$ 80.5 million
Hospitalization Unmet Need	$ 134 million
Indian Health Care Improvement Fund (LNF)	$ 128.5 million

Range: $ 120.5 to $ 134 million

CHS Denials

- Reasons for denials
  - –No prior authorization for non-emergency services
  - –Not within medical priority
  - –Not CHS eligible
    - Non-beneficiary
    - Does not reside within the CHSDA
  - –IHS facility available
  - –No 72 hour notification for emergencies
    - 30 day notification for disabled & elderly
  - – Funding availability

CHS Deferred Services

- Guidelines for recording and reporting:
  - Accessed the health care system during reporting period
  - Health service is not emergent or urgent
  - Health service required cannot be accessible or available in local direct system
  - Health service/treatment deferred must be within IHS medical priorities

IHS Medical Priorities

- Level I - Emergent or acutely urgent care, e.g. bone fracture, acute pneumonia
- Level II - Preventive services, e.g. mammography, colonoscopy
- Level III - Primary and secondary services, e.g. arthroscopic surgery, hearing aids
- Level IV - Chronic tertiary, e.g. rehabilitation, joint replacement, obesity surgery
- Level V - Excluded services that are purely cosmetic or experimental

Excluded Services (Level V)

- Experimental as defined by Centers for Disease Control
- Procedures that have no medical benefit
- Alternative medical practices (homeopathy, acupuncture, naturopathy)

Examples include:

- Tattoo
- Tattoo removal
- Dermabrasion
- Breast augmentation
- Face lift
- Tummy tuck
- Cosmetic surgery (not reconstructive)

IHS/Veteran's Administration MOU

- Estimated 17,000 Indian vets in California
- CAO data match with VISN 21 to identify dual-eligibles
- Shared services agreements can be arranged locally with the VA in your respective area
- Indian health programs need accreditation to obtain reimbursement from the VA for shared health services provided to vets and must meet Joint Commission standards

IHS/Veteran's Administration MOU

Members of the IHS/CAO VA Workgroup

Pedro Molina
Assistant Secretary Veterans Affairs
State of California

David Rambeau
Director
United American Indian Involvement

Ron Sisson
IHS Self-Governance Coordinator
Redding Rancheria

Maria Hunzeker
Director
Feather River Tribal Health

David Sprenger, MD
Chief Medical Officer
IHS/CAO

Commissioned Corps

FY 2011
Administrative Fee Calculation

Administrative Function	Direct Fee	Fee
Office of Commissioned Corps Operations	$ 3,650	
Regional Commissioned Officer Liaison	$ 805	
Executive Direction		$ 359
Clinical Support		$ 559
Finance		$ 640
Human Resource		$ 722
	$ 4,455	$ 2,280

Annual Cost Per Officer $ 6,735
Salary Range $ 93,000 to $ 250,000
Comparable to the IHS Bemidji Area

Special Diabetes Programs for Indians

- Tribal programs receive $ 6,494,378
  - Community Directed Diabetes
- Urban programs receive $ 1,670,141
  - Community Directed Diabetes
- Diabetes Prevention Initiative $ 2,018,600
  - Formally Competitive Grant
- Healthy Heart Initiative $ 1,369,900
  - Formally Competitive Grant

Diabetes Prevention Initiative

California Programs

- Chapa-De (new in FY 2010)
- Hoopa Valley – Kima:w Medical Center
- Indian Health Center of Santa Clara Valley
- Lake County Tribal Health (new in FY 2010)
- Sonoma County Indian Health
- United American Indian Involvement (UAII)
- United Indian Health Services (UIHS)

Healthy Heart Initiative

California Programs

- Indian Health Council, Inc.
- Redding Rancheria/Hoopa Valley (consortium)
- Riverside-San Bernardino County Indian Health, Inc.
- Toiyabe Indian Health Project, Inc.

Methamphetamine Suicide Prevention Initiative (MSPI)

- P.L. 110-161 Consolidated Appropriations Act of 2008: IHS received $ 13.7 million to create the MSPI in an annual competitive grant process

- California received $ 1,110,105 in year 1 to serve tribal and urban Indian populations
  - Hoopa Valley Tribe $ 154,109
  - San Manuel Band of Mission Indians $ 133,430
  - Toiyabe Indian Health Project $ 38,888
    (an increase of $ 129,112 in year 2)
  - United Indian Health Services $ 106,560
  - California Area Indian Health Service $ 272,227
  - Friendship House in San Francisco $ 100,000
  - United American Indian Involvement in Los Angeles $ 100,000
  - American Indian Health & Services in Santa Barbara $ 100,000
  - San Diego American Indian Health Center $ 100,000

Improving Patient Care (IPC3)

- To improve access and continuity of care, decrease the need for and utilization of emergent and urgent care, improve clinical staff satisfaction, and improve health care outcomes
- Nationally there are 90 sites in the IPC3
  - California IPC3 sites:
    - K'ima:w Medical Center (Hoopa)
    - Lassen Indian Health Center
    - Riverside/San Bernardino County Indian Health
    - Sacramento Native American Health Center
- All tribal and urban sites in California and IHS by 2015

Let's Move in Indian Country!

- To end childhood obesity among AI/AN youth within a generation
- Combines comprehensive strategies with common sense approaches
- Gives parents helpful information and nurtures environments to support healthy choices

Four main goals:

1. Creating a healthy start in life by promoting breastfeeding, one proven strategy for reducing the risk of childhood obesity
2. Developing healthy schools because the school environment can have a strong impact on behavior, health and well-being of children
3. Improving physical health by promoting regular physical activity five days a week
4. Fostering health and comprehensive food system policies by recommending that tribal and urban Indian communities establish food policy councils

Government Performance and Results Act (GPRA)

- GPRA clinical measures are indicators of basic quality of care
- 2010 California GPRA performance:
  - OMB moved the targets commensurate with new funding levels
  - Prior year increases were in contract support costs and contract health services (difficult to measure)
- For more information about GPRA performance, contact your tribal or urban Indian health program director

Government Performance and Results Act (GPRA)

Clinical GPRA measures where we excelled:

- Poor Glycemic Control (blood sugar)
- Ideal Glycemic Control (blood sugar)
- Dental Access
- Cardiovascular Disease Comprehensive Assessment
- Childhood Weight Control

Clinical GPRA measures where we need work:

- Controlled Blood Pressure <130/80
- LDL Assessed (bad cholesterol)
- Nephropathy Assessed (kidney function)
- Retinopathy (diabetic eye) Exam
- Immunizations (influenza 65+, pneumovax 65+, childhood)
- Pap screening
- Mammography screening
- Colorectal cancer screening
- Tobacco cessation
- Alcohol screening
- Domestic violence/intimate partner violence screening
- Depression screening
- Prenatal HIV screening

Current Communications and Innovations

- Web Site: www.ihs.gov/California
  - Enhanced web page, navigation tools
  - Dear Tribal Leader Letters (e-mails) are posted from the Area Director
  - YRTC updates
  - Expansion of website in 2011
- Established video conferencing capability
  - Benefits
  - Leveraging of ARRA funds
  - Telemedicine
- Network security is ongoing in a continuous monitoring mode; always searching for viruses

Electronic Health Record (EHR)

- CAO supports implementation and maintenance of the RPMS EHR
- 14 clinics utilize RPMS EHR, 10 additional non-RPMS
- 7 additional clinics in process of implementing RPMS EHR
- 5 clinics utilize VistA imaging which transfers documents and images into the RPMS EHR

Meaningful Use

- Meaningful use of an electronic health record (EHR) is part of a national initiative that strives to improve patient care and reduce health care costs by expanding the use of health information technology

Telemedicine and eHealth Services

- Purchased and placed 30 retinal screening cameras, allowing clinics to screen for diabetic retinopathy detecting early signs to prevent blindness
- Installed 30 videoconferencing units in 20 health programs
  - Sonoma County Indian Health has provided a training site for multi-site video conference training
- 8 sites receiving specialty care telemedicine services in the areas of endocrinology, nutrition, psychiatry, dermatology, and genetic counseling
  - Utilizing 2 telemedicine providers: UC Davis Medical Center and City of Hope

Accredited Indian Facilities

American Association for Ambulatory Health Centers (AAAHC)

- Central Valley Indian Health, Inc.
- Chapa-De Indian Health Program, Inc.
- Consolidated Tribal Health Project, Inc.
- Feather River Tribal Health
- Indian Health Center of Santa Clara Valley, Inc.
- Indian Health Council, Inc.
- The Karuk Tribe of California
- Redding Rancheria Indian Health Service
- Riverside/San Bernardino County Indian Health, Inc.
- Sacramento Native American Health Center
- Sonoma County Indian Health
- Southern Indian Health Council, Inc.

Joint Commission

- K'ima:w Medical Center

Commission on Accreditation of Rehabilitation Facilities (CARF)

- Friendship House Association of American Indians
- Native Directions, Inc.

Senate Committee on Indian Affairs

- On December 28, 2010, Senator Dorgan (R-South Dakota) issued "In Critical Condition: The Urgent Need to Reform the IHS's Aberdeen Area"
  - Transfers, Details and Reassignments
  - Employees Place on Lengthy Periods of Administrative Leave
  - Increased Equal Employment Opportunity Complaints
  - Increased Employee Grievances and Other Filings
  - Missing or Stolen Narcotics and Other Controlled Substances
  - Substantial Diverted Health Care Services
  - Mismanagement of Contract Health Service Funding
  - At-Risk: Facility Accreditation or Certification
  - Expired Health Care Provider Licenses and Other Credentials
  - Disciplinary Actions Taken Against Provider Licenses
  - Employee Misconduct and Poor Performance
  - Hiring Excluded Employees or Those with Unsuitable Criminal Records
  - Mismanagement of Third Party Billing
  - Staff Vacancies
  - Use of Locum Tenens
  - Agency Directives Inhibit Employee Communications with Congress

California Area

- California completed a written Area Office Administrative Review (self-assessment tool) on February 28, 2011
  - Pre-Employment Suitability Assessment
  - Administrative Leave Assessment
  - Administrative Control of Funds
  - Contract Health Services Assessment
  - Pharmacy Control Assessment
  - Health Professional Licensure Assessment
  - Accreditation of IHS Facilities
- California scheduled for actual investigative review in May/June 2012

To make all our work transparent, fair and inclusive

Budget Transparency

California Indian Health Service
Budget
Fiscal Year 2011

Activity		Fiscal Year 2010 Recurring Budget		Funded thru Mar 18 Based on Continuing Resolution 46.30%
Clinical Services	$	84,940,291	$	39,327,355
Preventive Health		2,945,457		1,363,747
Contract Health Care		40,773,077		18,877,935
Contract Support Cost		37,277,108		17,259,301
Direct Operations		1,552,091		718,618
Urban Health		6,505,586		3,012,086
Envr Hlth Support		2,716,063		1,257,537
Facilities Support		697,638		323,006
Total Recurring Budget	$	177,407,311	$	82,139,585

To make all our work transparent, fair and inclusive

Comparison of Workload:

1993 to 2010

	1993	2010	% increase
Total Number of Tribes	99	103	4.0%
Total AI/AN Population (Census)	309,238	738,978	139.0%
Pop served by Urban programs	5,390	10,758	99.6%
Number of Tribal/ Urban Facilities	61	94	54.1%
IHS User Pop Comparisons:			
California	62,569	81,594	30.4%
IHS All	1,192,537	1,523,564	27.8%
% California of All	5.2%	5.4%	27.8%

Comparison of Funding and Human Resources:
1993-2010

	1993	2010	% increase
Total IHS Funds in Tribal & Urban Programs	$70.1 M	$184.7 M	163.4%
Construction Workload	$4.2 M	$10.9 M	159.5%
Full Time Permanent CAIHS Staff			
OEH&E Staff	32	51	56.2%
Other Staff	31	41	35.5%
Commissioned Officer MOAs	2	8	300%

Allocation of Funds

FY Ending September 30, 2010