DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year 2023

Indian Health Service

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville, MD 20857

April 25, 2022

I present the Indian Health Service (IHS) Fiscal Year (FY) 2023 Congressional Justification. The FY 2023 budget proposes the first-ever mandatory budget for the IHS. This is a historic step forward in securing stable and predictable funding to improve the overall health status of American Indians and Alaska Natives.

In FY 2023, the budget includes a total of $9.3 billion in mandatory funding for the IHS, which is $2.5 billion above FY 2022 enacted. This mandatory budget proposal culminates in a total funding level of approximately $36.7 billion in FY 2032. When compared with the FY 2022 enacted level of $6.8 billion, the FY 2032 proposed funding level represents an increase of close to +$30 billion or +442 percent.

In addition, our FY 2023 budget submission maintains focus on the IHS mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level and support for three main goals that are outlined in our strategic plan:

Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.

Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization.

Goal 3: To strengthen IHS program management and operations.

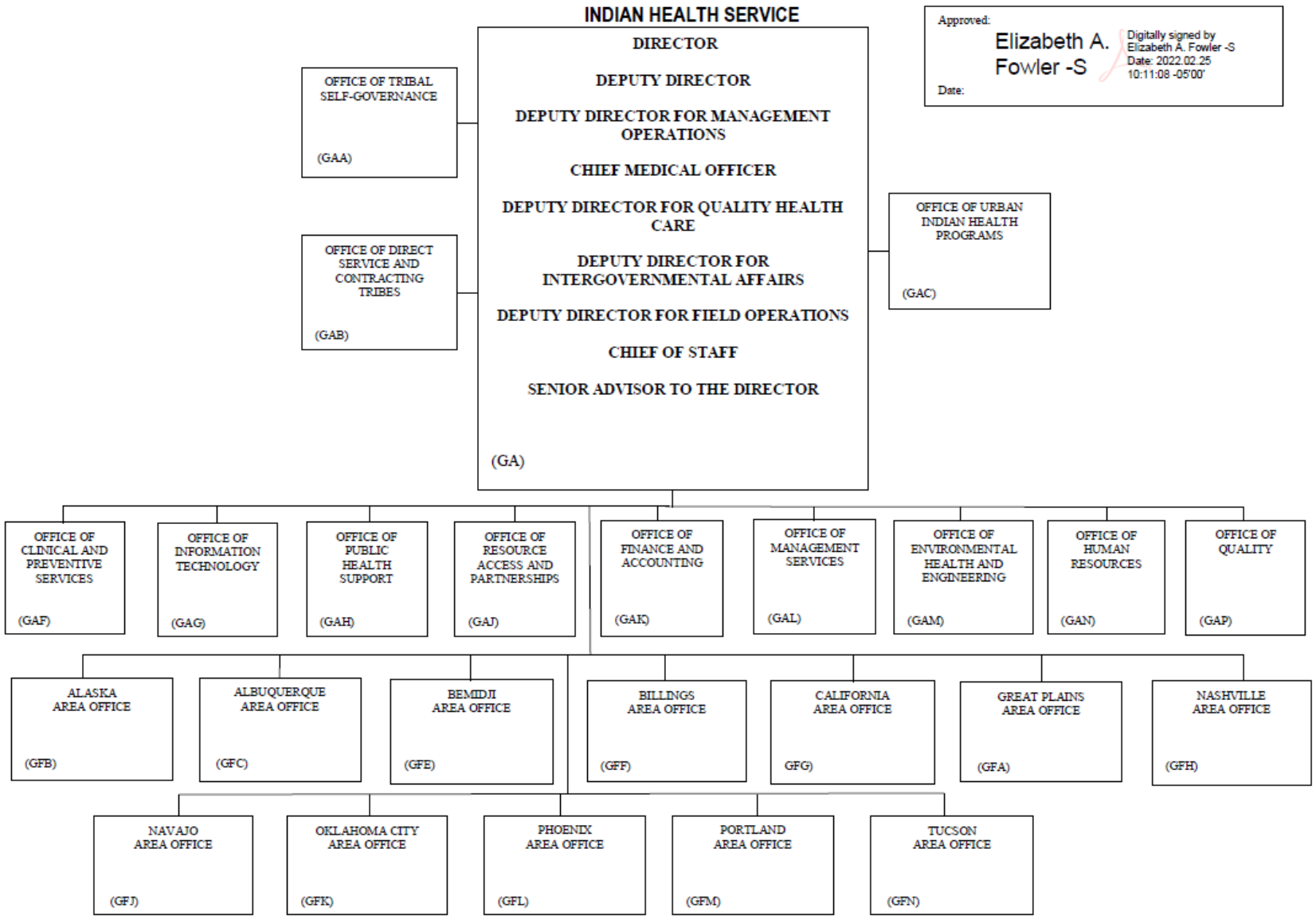
The Indian health system faces challenges related to access, quality, management, and operations. This budget, which is aligned with our strategic plan, aims to address these challenges and builds on the progress that we have already made to date. I am excited about what we will achieve together to improve the health and well-being of American Indians and Alaska Natives.

The bold action in the FY 2023 President's Budget demonstrates the Administration's continued commitment to work to raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level and strengthen the Nation-to-Nation relationship.

Elizabeth A. Fowler

Elizabeth A. Fowler
Acting Director

Organizational Chart



Information about IHS Key Leaders is available on the IHS Website at https://www.ihs.gov/aboutihs/keyleaders/.
NOTE: THE STANDARD ADMINISTRATIVE CODE IS LOCATED IN THE LOWER LEFT HAND CORNER OF EACH BOX.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2023 Performance Budget Submission to Congress

TABLE OF CONTENTS

Significant Items in Committee Reports

Operating Division-Specific Requirements

Self Determination

Non-Recurring Expense Fund

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2023 Performance Budget Submission to Congress

TABLE OF CONTENTS

Executive Summary

INTRODUCTION AND MISSION
Indian Health Service

The Indian Health Service (IHS), an Agency of the U.S. Department of Health and Human Services, is the principal Federal Agency charged with the mission of raising the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

The IHS provides comprehensive primary health care and disease prevention services to approximately 2.7 million American Indians and Alaska Natives through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations. Facilities are predominantly located in rural primary care settings and are managed by IHS, Tribal, and urban Indian health programs.

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.

Indian Health Service and Its Partnership with Tribes

In the 1970s, federal Indian policy was re-evaluated leading to adoption of 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. IHS partners with Tribes on health care delivery in the context of regular Tribal consultation.

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, provided new opportunities for the IHS and Tribes to deliver quality and accessible health care.

The IHCIA includes specific authorizations such as improvements for urban Indian health programs, Indian health professions programs, and the authority to collect from Medicare and Medicaid and other third-party insurers for services rendered at IHS or Tribal facilities. Under the ISDEAA, many Tribes have assumed the administrative and programmatic roles previously carried out by the Federal Government. Tribes currently administer over half of IHS resources through ISDEAA contracts and compacts. The IHS directly administers the remaining resources and manages programs where Tribes have chosen not to contract or compact health programs.

Overview of Budget

The fiscal year (FY) 2023 Indian Health Service (IHS) budget encompasses the overall goals of: 1) ensuring comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian/Alaska Native (AI/AN) people; 2) promoting excellence and quality through innovation of the Indian health system into an optimally performing organization; and 3) strengthening IHS program management and operations in carrying out the agency mission to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. The budget conveys the President's commitment to provide high-quality health care services for AI/ANs. The budget reflects the importance of providing health care, consistent with statutory authorities, to AI/ANs. This budget also fully supports the IHS Strategic Plan 2019 – 2023. In addition, the budget supports the HHS Secretary's priorities to advance health equity and address pressing public health issues such as HIV/Hepatitis C, the opioid epidemic, and maternal mortality.

The IHS provides a wide range of clinical, public health, community, and facilities infrastructure services to approximately 2.7 million AI/ANs who are members of 574 federally recognized tribes in 37 states. Comprehensive primary health care and disease prevention services are provided through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations. These facilities are predominately primary care settings and are managed by IHS, tribal, and urban (I/T/U) Indian health programs.

The IHS meets the annual statutory requirement to consult with and solicit the participation of Tribes and tribal organizations in the development of the budget for IHS. Likewise, IHS confers with urban Indian organizations. The consultation and confer input informs the IHS budget formulation process. The core of the agency's formulation process consists of the priorities and recommendations developed in consultation with Tribes through this independent annual budget process led by the National Tribal Budget Formulation Workgroup. IHS is strongly committed to this process and it ensures that the IHS budget is relevant to the health needs and priorities of AI/ANs. The tribal priorities identified in the consultation process are also instrumental to inform senior officials of other U.S. Department of Health and Human Services (HHS) agencies of the health needs of the AI/AN population, so that they have the opportunity to reflect those priorities in the Department's budget requests. The tribal budget consultation process is a key component of the IHS strategic objectives to build, strengthen, and sustain collaborative relationships (Objective 1.2); improve communication within the organization, with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public (Objective 3.1); and secure and effectively manage the assets and resources (Objective 3.2); objectives that advance the IHS mission.

Summary of Budget Submission

In line with the long-standing recommendations of Tribal leaders, the FY 2023 President's Budget proposes the first-ever full mandatory budget for the IHS. The FY 2023 budget is a historic step forward towards the goal of securing stable and predictable funding to improve the overall health status of AI/ANs, and ensuring that the disproportionate impacts experienced by tribal communities during the COVID-19 pandemic are never repeated.

The bold action taken in the FY 2023 President's Budget demonstrates the Administration's continued commitment to honor the United States' treaty responsibility to tribal nations and strengthen the nation-to-nation relationship. The budget significantly increases IHS's funding over 10 years, makes all funding mandatory, and exempts all proposed law funding from sequestration.

The Indian health system is chronically underfunded compared to other healthcare systems in the U.S. Despite substantial growth in the IHS discretionary budget over the last decade, by 57 percent from FY 2012 to the current FY 2022 Enacted level, the growth has not been sufficient to address the well documented funding gaps in Indian Country. Growth beyond what can be accomplished through discretionary spending is necessary to address funding gaps and remediate health disparities. Mandatory spending is a more appropriate avenue to provide high-quality health care that is reliable and widely available to AI/ANs, addressing health disparities.

Historical trauma and chronic underinvestment significantly contributed to the perpetuation of health disparities in Indian Country. AI/ANs born today have a life expectancy that is 5.5 years fewer than the U.S. all-races population, with some tribes experiencing life expectancy as much as 12 years fewer than the general population. AI/ANs also experience disproportionate rates of mortality from most major health issues, including chronic liver disease and cirrhosis, diabetes, unintentional injuries, assault and homicide, and suicide.

The COVID-19 pandemic compounded the impact of these disparities in tribal communities, with AI/ANs experiencing disproportionate rates of COVID-19 infection, hospitalization, and death. Underfunding of direct health care services in tribal communities, aging infrastructure, high vacancy rates, and other systemic issues significantly contributed to these stark inequities. The COVID-19 experience in Indian Country illustrates the urgent need for large-scale investments to improve the overall health status of AI/ANs, and ensure that the disproportionate impacts experienced during the pandemic are never repeated.

Mandatory funding provides a long-term solution for adequate, stable, and predictable funding for the Indian health system. The challenges of an annual discretionary budget are well documented by the Government Accountability Office in their report GAO-18-652, Indian Health Service: Considerations Related to Providing Advance Appropriation Authority. While providing advance appropriations for IHS would resolve some of the challenges presented by annual discretionary funding like the instability caused by continuing resolutions and lapses in appropriations, it would not address issues of adequacy or predictability in funding. Adequacy and predictability in funding would support enhanced recruitment and retention of health professionals and would enable health programs to more effectively complete longer-term planning activities over multiple years. These changes will have a direct positive impact on the availability and delivery of quality health care.

Mandatory funding for the IHS provides the opportunity for significant funding increases that could not be achieved under discretionary funding caps. Further, this mandatory and legislative funding proposal would authorize and appropriate funding over 10 years, through FY 2032, ensuring predictability that would allow IHS, Tribal, and urban Indian health programs the opportunity for long-term and strategic planning.

The budget also exempts IHS from proposed law sequestration, which is the legislatively mandated process of budget control consisting of automatic, across-the-board spending reductions to enforce budget targets to limit federal spending. Exempting the IHS budget from sequestration ensures funding for direct health care services to AI/ANs is not reduced, consistent with the treatment of other critical programs such as veterans' benefits and nutrition assistance programs. The budget also includes inflation factors to

address the growing cost of providing direct health care services, including pay costs, medical and non-medical inflation, and population growth.

While this is a historic first step, the IHS recognizes that we must continue to work in consultation with Tribes and confer with Urban Indian Organizations, and with our partners in Congress, to ensure the budget is structured and implemented correctly with the resources identified over the next 10 years.

FY 2023 President's Budget

For the first year of the proposal, the budget includes $9.3 billion in mandatory funding, which includes $9.1 billion in proposed law funding and $147 million in current law funding for the Special Diabetes Program for Indians. This is an increase of $2.5 billion above the FY 2022 Enacted level.

Crosscutting changes from the FY 2022 Enacted level include:

- Current Services: +$207 million to offset the rising cost of providing direct health care services, including tribal and federal pay costs ($96 million), medical and non-medical inflation ($24 million), and population growth ($87 million). These resources will help the IHS to maintain services at the FY 2022 levels by shoring up base operating budgets of IHS, Tribal, and urban Indian health programs in the face of increasing costs.

- Staffing and Operating Costs for Newly-Constructed Health Care Facilities: +$102 million for staffing of eight newly-constructed health care facilities. These funds support the staffing packages for new or expanded facilities, which will expand the availability of direct health care services in areas where existing health care capacity is overextended.

Indian Health Services account changes from the FY 2022 Enacted level include:

- Indian Health Care Improvement Fund: +$243 million to provide additional health services and address resource disparities across the Indian health system. The budget also proposes to realign funding for the Indian Health Care Improvement fund into the Hospitals and Health Clinics funding line, consistent with how this program was historically funded. This shift reduces administrative burden.

- Partially Sustain American Rescue Plan Act (ARPA) Investments: +$220 million to partially sustain the ARPA investments that were provided to expand access to mental health and substance abuse prevention and treatment services, and to expand the public health workforce in Indian Country. ARPA funds were provided on a one-time basis. The additional resources included in the budget prevent a sharp reduction in services as one-time ARP funds are exhausted.

- Hospitals and Health Clinics General Increase: +$215 million to expand access to direct health care services by providing an estimated 41 thousand inpatient admissions and almost 16 million outpatient visits at IHS and Tribal facilities. These resources will support efforts to reduce health disparities and improve the overall health status for AI/ANs by increasing the availability of health care services in Indian Country.

- Purchased and Referred Care: +$206 million to support additional contract health care services that are not available in IHS or Tribal health facilities, providing an estimated 7,333 additional inpatient admissions; 182,319 additional outpatient visits; and 8,006 additional patient travel

trips. These funds would also support establishment of a statewide Purchased/Referred Care Designation Area (PRCDA) for the state of Arizona and will support the feasibility studies for the statewide PRCDA expansion in North and South Dakota, as directed in the Indian Health Care Improvement Act.

- Electronic Health Record: +$140 million to improve the quality of health care in Indian Country and health status of AI/ANs by modernizing the IHS Electronic Health Record (EHR) system. These resources will support efforts to stabilize the aging IHS EHR while modernization is underway, and support the initial build activities for the EHR environment, as well as initial site transition planning.

- Addressing Targeted Public Health Challenges: +$60 million to make targeted investments in IHS as part of HHS initiatives to address our Nation's most pressing public health challenges, which disproportionately impact American Indian and Alaska Native communities. This includes HIV and Hepatitis C (+$47 million), improving maternal health (+$4 million), and addressing opioid use (+$9 million).

- Dental Health: +$48 million to expand access to dental health services in American Indian and Alaska Native communities by supporting an estimated 1 million dental visits in FY 2023.

- Assessments: +$27 million to offset the increasing costs of central assessments charged to the IHS by HHS since FY 2014. To address the growing costs of shared services at HHS, the IHS has delayed hiring and investments in critical systems, working to shield direct health care services to the maximum extent possible. However, the IHS is at a point where it can no longer sacrifice oversight and management of national health programs to absorb these rising costs.

- Urban Indian Health: +$27 million to increase funding for urban Indian health programs to provide additional culturally competent direct health care services for AI/ANs living in urban areas. This investment will provide an estimated 1.1 million health care, outreach, and referral services to urban Indian users in FY 2023. The budget also proposes to realign funding for former National Institute on Alcohol Abuse and Alcoholism (NIAAA) programs from the Alcohol & Substance Abuse line into the Urban Health line. This shift reduces administrative burden.

- National Community Health Aide Program (CHAP): +$20 million to support the expansion of CHAP to the lower 48 states. These additional resources would support the training, certifying, and hiring of health aides, as well as national program management activities.

- Indian Health Professions: +$20 million to offer additional IHS Scholarship and Loan Repayment awards, bolstering recruitment and retention efforts through these two high demand programs, and through other strategies.

- Emergency Medical Services: +$20 million to address critical needs for Emergency Medical Services in Indian Country, where stagnating funding creates difficulties in maintaining equipment, retaining staff, and other challenges.

- Direct Operations: +$18 million to support the efficient and effective administration and oversight of national and Area-level functions like financial management, human resources,

grants management, acquisitions, Indian Self-Determination and Education Assistance Act contracting and compacting administration, contract support costs and tribal lease payments administration, performance management, compliance, and other administrative supports and systems.

- Emergency Preparedness: +$10 million for emergency preparedness activities at IHS Headquarters and Area offices to establish a dedicated emergency preparedness workforce at IHS and support relevant training and capacity building efforts.

- Division of Telehealth: +$10 million to appropriately manage and oversee a comprehensive telehealth program at the IHS that would expand telehealth services, develop governance structures, provide training to users, and integrate with clinical services.

- Office of Quality: +$10 million to support activities that ensure high quality service provision and that CMS accreditation standards are met including a mock survey program, gap analyses for at-risk facilities, quality measures and reporting enhancements, training on medical quality issues, and expanded risk management activities.

- Office of Health Information Technology: +$9 million to support new FTE and existing salary costs. Funding for the Office of Information Technology has remained stagnant for the last 10 years, and pay costs and tribal shares have impacted the ability of this critical program to support its full salary cost and hire the staff necessary to ensure appropriate operations at the Agency.

- Cancer Initiative: +$8 million to develop a coordinated public health and clinical cancer prevention initiative to implement best practices and prevention strategies to address incidence of cancer and mortality among AI/ANs.

- Division of Graduate Medical Education: +$4 million to expand and support Graduate Medical Education programs to create a pipeline for future physicians to address longstanding vacancy issues at IHS.

- National Business Improvement Center: +$3 million to establish a new program to ensure proper monitoring and management of the revenue cycle and purchase of care, ensure compliance with internal controls to maximize revenue at the national level, and quickly identify threats to the revenue cycle and proactively assist Areas/facilities to mitigate adverse outcomes.

- Community Health Representatives Program Evaluation: +$3 million for a national evaluation of the Community Health Representatives program.

- Tribal Management Grants: +$2 million for an additional 15-20 awards to Tribes to access their capacity to directly operate health care services currently provided by the IHS.

- Nurse Preceptorship: +$1 million to create a new program to provide training, development, mentoring, and other on-the-job supports to improve placement rates of first year nurses in IHS and Tribal Health Programs.

- New Tribes: +$1 million to support new federally recognized Tribes.

- Self-Governance: +$140,000 for a general program increase to expand Self-Governance programs.

- Immunization Alaska: +$2,600 for a general program increase to expand the Immunizations in Alaska program.

Indian Health Facilities account changes from the FY 2022 Enacted level include:

- Health Care Facilities Construction: +$286 million to support the remaining projects on the 1993 IHS Health Care Facilities Construction Priority List, and to construct additional staff quarters, small ambulatory facilities, and new demonstration projects to fund mid-sized ambulatory health care facilities projects.

- Maintenance and Improvement: +$172 million for major projects to reduce the Backlog of Essential Maintenance. Alteration, and Repair (BEMAR), as well as routine maintenance and repair to sustain the condition of federal and Tribal healthcare facilities, and environmental compliance projects to meet changing healthcare delivery needs.

- Equipment: +$71 million for maintenance and upgrades to existing medical equipment, and procurement of new medical equipment to replace units that are at the end of their useable lifecycle at IHS and Tribal healthcare facilities.

- Facilities and Environmental Health Support: +$67 million for Facilities and Environment Health Support, including 1) +$49 million for additional Infrastructure Investment and Jobs Act program support activities and 2) +$18 million for a new program to recruit and retain new public health engineers by partnering with colleges and universities to implement a scholarship program with service requirements in support of Sanitation Facilities Construction projects across Indian Country.

FY 2023 Contract Support Costs and Section 105*(l)* Lease Agreements: The budget includes a mandatory indefinite appropriation for Contract Support Costs and Section 105*(l)* lease agreements with estimated funding levels of $1.1 billion for Contract Support Costs (+$262 million above the FY 2022 Enacted level) and $150 million for Section 105*(l)* Lease Agreements (same as the FY 2022 Enacted level).

Special Diabetes Program for Indians: The budget includes $147 million for the Special Diabetes Program for Indians (SDPI), which reflects current law (P.L. 116-260) and includes a mandatory sequester of 2 percent.

FY 2024 - FY 2032 President's Budget

This mandatory budget proposal culminates in a total funding level of approximately $36.7 billion in FY 2032. When compared with the FY 2022 Enacted level of $6.8 billion, the FY 2032 proposed funding level represents an increase of nearly +$30 billion or +442 percent. In total, the 10-year budget includes over $248 billion for the IHS. Targeted investments include the following:

- Inflation Factors: After the first year, IHS funding would automatically grow to keep pace with healthcare costs and population growth. Specifically, the budget grows by inflationary factors, such as Employment Cost Index (ECI), Consumer Price Index for All Urban Consumers (CPI-U), and CPI-U Medical, as assumed in the 2023 OMB economic assumptions during the 10-year budget window. Funding also grows by the IHS service population growth factor (1.8 percent) during the 10-year budget window. Including automatic inflationary increases in the budget ensures that funding for direct health care services is not eroded by the impacts of inflation, pay cost increases, and population growth.

- 2018 Indian Health Care Improvement Fund (IHCIF) Level of Need Funded Gap: Over five years, from FY 2024 to FY 2028, the budget addresses the funding gap for direct healthcare services documented in the FY 2018 level of need funded analysis. The level of need gap analysis calculated $11.2 billion as the point in time estimated funding shortfall identified for a baseline of health services in FY 2018. At that time, the overall funds needed were determined to be $16.203 billion. In FY 2018, the IHS received $4.9 billion in resources for direct health care services, which leaves a funding deficiency of $11.2 billion. Over five years, these funding increases would be distributed proportionally across the IHS funding lines that provide direct healthcare services, including: Hospitals and Health Clinics, Purchased/Referred Care, Dental Health, Mental Health, Alcohol and Substance Abuse, IHCIF, Public Health Nursing, Health Education, Community Health Representatives, and Urban Indian Health. This approach ensures a broad benefit of this increased funding for all Tribes, while also seeking to address funding disparities within the Indian health system.

- Electronic Health Records (EHR) Modernization: Provides +$6 billion over five years, from FY 2024 to FY 2028, to replace IHS's EHR with a modernized system. The current IHS EHR is over 50 years old, and the GAO identifies it as one of the 10 most critical federal legacy systems in need of modernization. The IHS relies on its EHR for all aspects of patient care, including the patient record, prescriptions, care referrals, and billing public and private insurance for over $1 billion reimbursable health care services annually. The EHR holds an extremely high degree of mission criticality given the ability to provide much-anticipated clinical and administrative capabilities used in modern systems for the delivery of timely and impactful healthcare. Expected benefits from adopting and implementing a modernized system include, but are not limited to, improved patient safety, improved patient outcomes, better disease management, enhanced population health, improved clinical quality measures, opioid tracking, patient data exchange, third party revenue generation, agency performance reporting, etc. Additionally, the new system will obtain interoperability with the Department of Veterans Affairs (VA), Department of Defense, tribal and urban Indian health programs, academic affiliates, and community partners, many of whom are on different health information technology (HIT) platforms.

- Medical Equipment: The budget includes +$454 million over five years, from FY 2024 to FY 2028, to ensure IHS can replace medical and laboratory equipment at the end of its six to eight-year life cycle. Many IHS hospital administrators reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance with the Medicare Hospital Conditions of Participation. Further, the administrators reported that aging buildings and equipment is a major challenge impacting recruitment and retention of clinicians.

- Health Care Facilities Construction 1993 Priority List: Funds the remaining projects on the IHS 1993 Health Care Facilities Construction Priority List over five years, from FY 2024 to FY 2028,

which include Phoenix Indian Medical Center, Phoenix, AZ; Whiteriver Hospital, Whiteriver, AZ; Gallup Indian Medical Center, Gallup, NM; Albuquerque West Health Center, Albuquerque, NM; Albuquerque Central Health Center, Albuquerque, NM; and Sells Health Center, Sells, AZ.

Overview of Agency Performance

The FY 2023 budget request provides critical support in assuring the availability and expansion of healthcare services, assuring the quality of services, and in providing operational support for the Indian health care system. The IHS budget supports monitoring of clinical measures, including childhood and adult immunizations; breastfeeding rates; critical health screenings; access to dental services and preventive procedures such as, dental sealants and topical fluorides; and several diabetes care measures. Included below is an overview of the IHS performance reporting process to monitor budget measures and performance management process to monitor agency progress. A brief summary of the COVID-19 impact on the health care system and performance reporting is also included below.

Performance Reporting

The IHS budget measures support the agency's strategic goals and objectives and are focused on monitoring population health (clinical measures) and strategies to assess program trends and management (non-clinical measures). In the FY 2022 President's Budget, IHS previously reported "interim" clinical measure results. The FY 2023 IHS outcomes and outputs table includes a list of all budget measures and final clinical measure results for FY 2021 and FY 2020.

IHS reports valid and reliable aggregated clinical measures using a centralized reporting system to meet the Government Performance and Results Act (GPRA) and GPRA Modernization Act (GPRAMA) requirements. IHS annually reports GPRA/GPRAMA clinical measure results. Tribes administer over 63.2 percent of IHS resources through ISDEAA contracts and compacts and may choose to participate in IHS GPRA/GPRAMA performance reporting. Many Tribal programs operate EHR systems that differ from the IHS EHR, Resource and Patient Management System (RPMS).

Since 2002, IHS has reported electronic population level results for GPRA/GPRAMA clinical measures. Over time, as more Tribes assumed responsibility of providing health care for their members and adopted non-RPMS EHR systems, the agency's clinical performance measure results primarily reflected IHS programs. Prior to FY 2018, IHS clinical measure results reflected only RPMS data as non-RPMS data could not be verified or validated for budget-related performance reporting. Beginning in FY 2018, the IHS clinical results were reported from a new system, the Integrated Data Collection System Data Mart (IDCS DM). [1] The IDCS DM provides those Tribes using non-RPMS EHRs the opportunity to report data for GPRA/GPRAMA purposes; reporting is optional for Tribes. The IDCS DM calculates measure results using any data (RPMS, non-RPMS or Fiscal Intermediary) submitted to the IHS National Data Warehouse (NDW) and assures reporting of valid and reliable clinical measure results. The IHS clinical GPRA/GPRAMA measure results are reported from the IDCS DM and reflect aggregated Federal, Tribal, and urban (I/T/U) results. Tribal programs have the option to participate in IDCS DM reporting and aggregated results include participating Tribal programs.

[1] The IDCS DM uses all data exported to the NDW, including non-RPMS tribal and urban data. Budget measures previously reported from RPMS cannot be compared to IDCS DM results because: IDCS DM standardizes the use of user population estimates as the denominator for clinical GPRA/GPRAMA measures, and the reporting year changes from July 1-June 30 (GPRA/GPRAMA year) to October 1-September 30 (to match the user population estimate report year).

COVID-19 Impact

During FYs 2020-2021, the Indian health care system has experienced fewer in-person visits as many patients postponed prevention and health maintenance appointments to reduce coronavirus (COVID-19) exposure risk. Several sites also transitioned from in-person primary care to virtual care or reduced services to minimize the risk of COVID-19 transmission, and prioritize COVID-19 testing and response. While patients with acute illnesses or the need for emergency care are still seen at IHS facilities, many patients may be unable or unwilling to have in-person visits during the COVID-19 pandemic due to limited services available or to reduce personal risk. The changes in health care delivery may impact clinical GPRA measures results. During FY 2021, the IHS modified its delivery system and may have shifted priorities to address the COVID-19 response, examples include: focusing on COVID-19 vaccine distribution and administration; ensuring access to COVID-19 testing; distribution of COVID-19 resources to support Tribal communities; ongoing expansion or enhancement of telehealth services; and addressing infrastructure challenges to increase access to water.

Performance Management

IHS cascades performance goals and objectives and performance-related metrics agency-wide, and aligns them with the agency's strategic plan (see diagram below). Specific measures cascade from senior executive performance plans to those of subordinate managers and supervisors. From there, they cascade into employee performance plans, which ensures that performance of all employees relates to key agency performance objectives. Agency leadership periodically reviews progress in meeting these agency performance objectives, holding regular discussions with senior executives to identify challenges to success and determine feasible solutions. Agency leadership then implements those solutions, making specific adjustments or taking corrective actions that eliminate or minimize obstacles preventing the achievement of desired results. The connection between performance objectives, performance measures, and employee accountability enables agency leadership to direct the efforts of the workforce more accurately, and to make more informed and effective decisions. The impact is greater success in meeting the full array of agency mission requirements.

IHS Strategic Plan FY 2019-2023 Goals and Objectives

All Purpose Table
Indian Health Service
(Dollars in Thousands)

Program	FY 2021 Final /1 /2	FY 2021 COVID-19 Supplemental /6	FY 2022 Enacted /2 /3	FY 2022 IIJA /6	FY 2023 President's Budget /4	FY 2023 FY 2022 +/- FY 2021 President's Budget
SERVICES						
Clinical Services	**3,901,522**	**0**	**4,219,290**	**0**	**5,721,251**	**1,501,961**
Hospitals & Health Clinics	2,237,633	0	2,399,169	0	3,365,792	966,623
Electronic Health Record System	34,500	0	145,019	0	284,500	139,481
Dental Services	214,687	0	235,788	0	309,193	73,405
Mental Health	115,206	0	121,946	0	199,088	77,142
Alcohol & Substance Abuse	251,360	0	258,343	0	344,620	86,277
Purchased/Referred Care	975,856	0	984,887	0	1,218,059	233,172
Indian Health Care Improvement Fund	72,280	0	74,138	0	0	-74,138
Preventive Health	**179,144**	**0**	**191,543**	**0**	**208,310**	**16,767**
Public Health Nursing	92,736	0	102,466	0	112,570	10,104
Health Education	21,389	0	23,250	0	24,675	1,425
Community Health Representatives[1]	62,892	0	63,679	0	68,844	5,165
Immunization AK	2,127	0	2,148	0	2,221	73
Other Services	**220,725**	**0**	**249,825**	**0**	**332,119**	**82,294**
Urban Health	62,684	0	73,424	0	112,513	39,089
Indian Health Professions	67,314	0	73,039	0	93,568	20,529
Tribal Management Grants	2,465	0	2,466	0	4,486	2,020
Direct Operations	82,456	0	95,046	0	115,378	20,332
Self-Governance	5,806	0	5,850	0	6,174	324
TOTAL, SERVICES	**4,301,391**	**0**	**4,660,658**	**0**	**6,261,680**	**1,601,022**
FACILITIES	**917,888**	**0**	**940,328**	**0**	**1,567,343**	**627,015**
Maintenance & Improvement	168,952	0	169,664	0	345,565	175,901
Sanitation Facilities Construction	196,577	0	197,783	0	202,651	4,868
Health Care Facilities Construction	259,290	0	259,293	0	545,784	286,491
Facilities & Environ Health Support	263,982	0	283,124	0	371,326	88,202
Equipment	29,087	0	30,464	0	102,017	71,553
TOTAL, SERVICES & FACILITIES	**5,219,279**	**0**	**5,600,986**	**0**	**7,829,023**	**2,228,037**
CONTRACT SUPPORT COSTS /7						
Total, Contract Support Costs	**916,000**	**0**	**880,000**	**0**	**1,142,000**	**262,000**
SECTION 105(*l*) LEASES /7						
Total Section 105(*l*) Leases	**101,000**	**0**	**150,000**	**0**	**150,000**	**0**
SPECIAL DIABETES PROGRAM FOR INDIANS (SDPI) /5						
Total, Special Diabetes Program for Indians	**150,000**	**0**	**147,000**	**0**	**147,000**	**0**
Coronavirus Response and Relief Act 2021	**0**	**1,000,000**	**0**	**0**	**0**	**0**
American Rescue Plan Act 2021	**0**	**6,094,000**	**0**	**0**	**0**	**0**
Infrastructure Investment and Jobs Act	**0**	**0**	**0**	**700,000**	**0**	**0**
TOTAL, Budget Authority	**6,386,279**	**7,094,000**	**6,777,986**	**700,000**	**9,268,023**	**2,490,037**
NEF /8	**193,700**	**0**	**80,210**	**0**	**38,000**	

1/ The FY 2021 column reflects final regular appropriation levels, including required and permissive transfers. Supplemental resources associated with COVID-19 are reflected separately.

2/ Includes discretionary budget authority and mandatory funding for the Special Diabetes Program for Indians.

3/ The FY 2022 column reflects enacted regular appropriation levels, including required transfers. Supplemental resources from the Infrastructure Investment and Jobs Act are reflected separately

4/ The FY 2023 budget proposes all IHS funding as mandatory.

5/ The FY 2021 Consolidated Appropriations Act (P.L. 116-260) extended the Special Diabetes Program for Indians through FY 2023 at $150 million per year. FY 2022 and FY 2023 levels reflect current law, which includes a mandatory sequester of 2%.

6/ Only includes direct appropriations and directed transfers. Displays supplemental funds post-transfer. The IIJA appropriated a total $3.5 billion over 5 years, from FY 2022-FY 2026.

7/ Maintains indefinite authority for Contract Support Costs and Section 105(l) Lease Agreements. The FY 2023 budget proposes mandatory indefinite appropriations for these accounts.

8/ FY 2022 and FY 2023 NEF amounts are planned estimates and subject to change.

Detail of Changes

(Dollars in Thousands)

Sub IHS Activity	FY 2022 Omnibus	FY 2023 Changes (1 of 2)																	
		Current Services	Staffing of Newly Constructed Facilities	Indian Health Care Improvement Fund /1	Partially Sustain ARPA Investments	Hospitals and Health Clinics General Increase	Purchased and Referred Care	Electronic Health Record	Hepatitis C & HIV	Opioids Grants	Maternal Health	Dental Health	Assessments	Urban Indian Health	National Community Health Aide Program	Indian Health Professions	Emergency Medical Services	Direct Operations	Emergency Preparedness	Division of Telehealth
SERVICES																			
Hospitals & Health Clinics	2,399,169	117,585	68,007	316,638	76,667	214,726	0	0	47,000	0	4,000	0	27,000	0	20,000	0	20,000	0	10,000	10,000
Electronic Health Record System	145,019	0	0	0	0	0	0	139,481	0	0	0	0	0	0	0	0	0	0	0	0
Dental Services	235,788	11,076	14,329	0	0	0	0	0	0	0	0	48,000	0	0	0	0	0	0	0	0
Mental Health	121,946	4,941	5,034	0	67,167	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Alcohol & Substance Abuse	258,343	9,286	855	0	67,167	0	0	0	0	9,000	0	0	0	0	0	0	0	0	0	0
Purchased/Referred Care	984,887	26,235	0	0	0	0	205,937	0	0	0	0	0	0	0	0	0	0	0	0	0
Indian Health Care Improvement Fund	74,138	0	0	(74,138)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total, Clinical Services	4,219,290	169,123	88,225	242,500	211,000	214,726	205,937	139,481	47,000	9,000	4,000	48,000	27,000	0	20,000	0	20,000	0	10,000	10,000
Public Health Nursing	102,466	4,649	5,455	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Education	23,250	1,022	403	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Health Representatives	63,679	2,665	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Immunization AK	2,148	47	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total, Preventive Health	191,543	8,383	5,858	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Urban Health	73,424	3,002	0	0	9,000	0	0	0	0	0	0	0	0	27,056	0	0	0	0	0	0
Indian Health Professions	73,039	529	0	0	0	0	0	0	0	0	0	0	0	0	0	20,000	0	0	0	0
Tribal Management	2,466	20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Direct Operations	95,046	2,759	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17,573	0	0
Self-Governance	5,850	184	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total, Other Services	249,825	6,494	0	0	9,000	0	0	0	0	0	0	0	0	27,056	0	20,000	0	17,573	0	0
Total, Services	**4,660,658**	**184,000**	**94,083**	**242,500**	**220,000**	**214,726**	**205,937**	**139,481**	**47,000**	**9,000**	**4,000**	**48,000**	**27,000**	**27,056**	**20,000**	**20,000**	**20,000**	**17,573**	**10,000**	**10,000**
FACILITIES																			
Maintenance & Improvement	169,664	3,972	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sanitation Facilities Construction	197,783	4,868	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Health Care Facility Construction (HCFC)	259,293	603	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Facility & Environmental Health Support	283,124	12,988	8,414	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Equipment	30,464	640	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total, Facilities	940,328	23,071	8,414	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total, Services & Facilities	**5,600,986**	**207,071**	**102,497**	**242,500**	**220,000**	**214,726**	**205,937**	**139,481**	**47,000**	**9,000**	**4,000**	**48,000**	**27,000**	**27,056**	**20,000**	**20,000**	**20,000**	**17,573**	**10,000**	**10,000**
CONTRACT SUPPORT COSTS																			
Total, Contract Support Costs	**880,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
SECTION 105(l) LEASES																			
Total Section 105(l) Leases	**150,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
SPECIAL DIABETES PROGRAM FOR INDIANS																			
Total, Special Diabetes Program for Indians	**147,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL, IHS MANDATORY BUDGET AUTHORITY	**6,777,986**	**207,071**	**102,497**	**242,500**	**220,000**	**214,726**	**205,937**	**139,481**	**47,000**	**9,000**	**4,000**	**48,000**	**27,000**	**27,056**	**20,000**	**20,000**	**20,000**	**17,573**	**10,000**	**10,000**

1/ The budget proposes to realign funding for the Indian Health Care Improvement fund into the Hospitals and Health Clinics funding line.

Detail of Changes

(Dollars in Thousands)

Sub IHS Activity	FY 2022 Omnibus	FY 2023 Changes Continued (2 of 2)																			FY 2023 Total
		Office of Quality	Office of Health Information Technology	Cancer Initiative	Division of GME	National Business Improvement Center	CHR Program Evaluation	Tribal Management Grants	Nurse Preceptorship	New Tribes	Self-Governance General Increase	Immunization Alaska General Increase	Former NIAAA Reallocation to Urban /3	Health Care Facilities Construction	Mid-Size Demonstration Projects	Maintenance and Improvement	Equipment	Facilities and Environ. Health Support	Public Health Engineering	Contract Support Costs	Subtotal of Changes	
SERVICES																					
Hospitals & Health Clinics	2,399,169	10,000	9,000	8,000	4,000	3,000	0	0	1,000	0	0	0	0	0	0	0	0	0	0	0	966,623	3,365,792
Electronic Health Record System	145,019	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	139,481	284,500
Dental Services	235,788	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	73,405	309,193
Mental Health	121,946	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	77,142	199,088
Alcohol & Substance Abuse	258,343	0	0	0	0	0	0	0	0	0	0	0	(31)	0	0	0	0	0	0	0	86,277	344,620
Purchased/Referred Care	984,887	0	0	0	0	0	0	0	0	1,000	0	0	0	0	0	0	0	0	0	0	233,172	1,218,059
Indian Health Care Improvement Fund	74,138	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(74,138)	0
Total, Clinical Services	4,219,290	10,000	9,000	8,000	4,000	3,000	0	0	1,000	1,000	0	0	0	0	0	0	0	0	0	0	1,501,681	5,720,971
Public Health Nursing	102,466	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10,104	112,570
Health Education	23,250	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,425	24,675
Community Health Representatives	63,679	0	0	0	0	0	2,500	0	0	0	0	0	0	0	0	0	0	0	0	0	5,165	68,844
Immunization AK	2,148	0	0	0	0	0	0	0	0	0	0	26	0	0	0	0	0	0	0	0	73	2,221
Total, Preventive Health	191,543	0	0	0	0	0	2,500	0	0	0	0	26	0	0	0	0	0	0	0	0	16,767	208,310
Urban Health	73,424	0	0	0	0	0	0	0	0	0	0	0	31	0	0	0	0	0	0	0	39,089	112,513
Indian Health Professions	73,039	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	20,529	93,568
Tribal Management	2,466	0	0	0	0	0	0	2,000	0	0	0	0	0	0	0	0	0	0	0	0	2,020	4,486
Direct Operations	95,046	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	20,332	115,378
Self-Governance	5,850	0	0	0	0	0	0	0	0	0	140	0	0	0	0	0	0	0	0	0	324	6,174
Total, Other Services	249,825	0	0	0	0	0	0	2,000	0	0	140	0	31	0	0	0	0	0	0	0	82,294	332,119
Total, Services	**4,660,658**	**10,000**	**9,000**	**8,000**	**4,000**	**3,000**	**2,500**	**2,000**	**1,000**	**1,000**	**140**	**26**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,601,022**	**6,261,680**
FACILITIES																					
Maintenance & Improvement	169,664	0	0	0	0	0	0	0	0	0	0	0	0	0	0	171,929	0	0	0	0	175,901	345,565
Sanitation Facilities Construction	197,783	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,868	202,651
Health Care Facility Construction (HCFC)	259,293	0	0	0	0	0	0	0	0	0	0	0	0	275,888	10,000	0	0	0	0	0	286,491	545,784
Facility & Environmental Health Support	283,124	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	49,000	17,800	0	88,202	371,326
Equipment	30,464	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	70,913	0	0	0	71,553	102,017
Total, Facilities	940,328	0	0	0	0	0	0	0	0	0	0	0	0	275,888	10,000	171,929	70,913	49,000	17,800	0	627,015	1,567,343
Total, Services & Facilities	**5,600,986**	**10,000**	**9,000**	**8,000**	**4,000**	**3,000**	**2,500**	**2,000**	**1,000**	**1,000**	**140**	**26**	**0**	**275,888**	**10,000**	**171,929**	**70,913**	**49,000**	**17,800**	**0**	**2,228,037**	**7,829,023**
CONTRACT SUPPORT COSTS																					
Total, Contract Support Costs	**880,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**262,000**	**262,000**	**1,142,000**
SECTION 105(l) LEASES																					
Total Section 105(l) Leases	**150,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**150,000**
SPECIAL DIABETES PROGRAM FOR INDIANS																					
Total, Special Diabetes Program for Indians	**147,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**147,000**
TOTAL, IHS MANDATORY BUDGET AUTHORITY	**6,777,986**	**10,000**	**9,000**	**8,000**	**4,000**	**3,000**	**2,500**	**2,000**	**1,000**	**1,000**	**140**	**26**	**0**	**275,888**	**10,000**	**171,929**	**70,913**	**49,000**	**17,800**	**262,000**	**2,490,037**	**9,268,023**

2/ Funding for New Tribes is currently reflected in Purchased/Referred Care. However, final funding will need to be reflected in the appropriate Program, Project, or Activity (PPA or budget line) when these numbers are identified.

3/ The budget proposes to realign funding for former National Institute on Alcohol Abuse and Alcoholism (NIAAA) programs from the Alcohol & Substance Abuse line into the Urban Health line.

Indian Health Service

Mandatory Budget: Ten-Year Table

(dollars in millions)

	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031	FY 2032	FY 23-27 Total	FY 23-32 Total
Mandatory Request	9,121	12,731	16,535	20,545	24,777	29,246	30,956	32,771	34,697	36,741	83,709	248,121
Estimated Baseline /2	(9,121)	(9,330)	(9,545)	(9,765)	(9,990)	(10,220)	(10,454)	(10,694)	(10,940)	(11,191)	(47,751)	(101,250)
Net Total, Proposal Costs	0	3,401	6,990	10,780	14,787	19,026	20,502	22,077	23,757	25,550	35,958	146,871

1/ This table reflects only proposed-law funding and excludes current law funding for the Special Diabetes Program for Indians.

2/ Reflects estimated baseline discretionary spending if IHS were to remain discretionary. This figure is used to calculate the net-cost of the mandatory funding proposal, and does not represent a reduction in funding for the IHS budget.

INDIAN HEALTH SERVICE

STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES

FY 2023 Budget -- Estimates

(Dollars in Thousands)

	Naytahwaush, MN Naytahwaush Health Center (JV)		Scottsdale, AZ NEACC (Salt River) Health Center		Phoenix, AZ Phoenix Indian Medical Center Central		El Paso, TX Ysleta Del Sur Health Center (JV)		Dilkon, AZ Alternative Rural Health Center		New Town, ND Elbowoods Memorial Health Center (JV) /2		Seward, AK North Star Health Clinic (JV) /2		Rapid City, SD Rapid City Health Center				
Opening Date	September 2022		January 2022		January 2022		April 2022		March 2022		July 2022		April 2022		December 2022		**TOTAL**		
Sub Sub Activity	Pos	Amount	FTE	Amount	FTE	Amount	Pos	Amount	FTE	Amount	Pos	Amount	Pos	Amount	FTE	Amount	**FTE**	**Pos**	**AMOUNT**
Hospitals & Health Clinics	70	$9,101	84	$10,900	9	$676	23	$2,673	92	$12,181	10	$3,064	20	$3,500	232	$25,912	417	123	$68,007
Dental Health	10	$1,409	14	$2,213	0	$0	2	$285	10	$1,333	20	$3,112	0	$0	57	$5,977	81	32	$14,329
Mental Health	5	$507	6	$709	0	$0	1	$172	4	$482	0	$0	0	$0	32	$3,164	42	6	$5,034
Alcohol & Substance Abuse	2	$256	2	$352	0	$0	0	$67	1	$180	0	$0	0	$0	0	$0	3	2	$855
Purchased/Referred Care	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Clinical Services	87	$11,273	106	$14,174	9	$676	26	$3,197	107	$14,176	30	$6,176	20	$3,500	321	$35,053	543	163	$88,225
Public Health Nursing	5	$845	7	$1,099	0	$0	2	$302	3	$391	0	$0	0	$0	22	$2,818	32	7	$5,455
Health Education /1	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	4	$403	4	0	$403
Community Health Representatives	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	0	$0
Total, Preventive Health	5	$845	7	$1,099	0	$0	2	$302	3	$391	0	$0	0	$0	26	$3,221	36	7	$5,858
Total, Services	92	$12,118	112	$15,273	9	$676	28	$3,499	110	$14,567	30	$6,176	20	$3,500	347	$38,274	578	170	$94,083
Facilities Support	2	$925	4	$1,208	0	$0	1	$338	5	$1,310	1	$409	0	$0	13	$3,239	22	4	$7,429
Environmental Health Support	1	$116	1	$63	0	$0	0	$75	2	$288	1	$93	0	$0	2	$350	5	2	$985
Total, FEHS	3	$1,041	4	$1,271	0	$0	1	$413	7	$1,598	2	$502	0	$0	15	$3,589	26	6	$8,414
Total, Facilities	3	$1,041	4	$1,271	0	$0	1	$413	7	$1,598	2	$502	0	$0	15	$3,589	26	6	$8,414
Grand Total /2	**95**	**$13,159**	**116**	**$16,544**	**9**	**$676**	**29**	**$3,912**	**117**	**$16,165**	**32**	**$6,678**	**20**	**$3,500**	**362**	**$41,863**	**604**	**176**	**$102,497**

1/ Includes Utilities

2/ As a result of JVCPs entering their planning phases and detailed budgets not yet available, preliminary estimates are included for budget planning purposes.

NEACC = Northeast Ambulatory Care Center

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2023 Performance Budget Submission to Congress

TABLE OF CONTENTS

Appropriation Accounts

INDIAN HEALTH
SERVICE
Appropriations Language Exhibit

Language Provision	Explanation
Discretionary language is removed as the FY 2023 President's Budget proposes to make IHS mandatory.	The administration will work with Congress to develop legislative language to enact the FY 2023 budget for IHS.

INDIAN HEALTH SERVICE
Amounts Available for Obligations

SERVICES

	FY 2021	FY 2022	FY 2023
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$4,301,391,000	$4,660,677,000	$0
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$4,301,391,000	$4,660,677,000	$0
Mandatory Appropriation:			
Appropriation[1]	$150,000,000	$147,000,000	$6,408,680,000
Offsetting Collections:			
Federal sources	($259,000)	($299,000)	($436,000)
Non-federal sources	($1,627,000,000)	($1,268,000,000)	($1,432,000,000)
Subtotal, Offsetting Collections	($1,627,259,000)	($1,268,299,000)	($1,432,436,000)
Unobligated Balances:			
Discretionary, Start of Year	$2,109,000,000	$47,536,000,000	$2,126,000,000
Mandatory, Start of Year	$2,644,000,000	($45,410,000,000)	($410,000,000)
End of Year	$4,753,000,000	$2,126,000,000	$1,716,000,000
Total Obligations, Services	$2,824,132,000	$3,539,378,000	$5,386,244,000

[1]In FY 2022, this reflects the 2% sequester amount for the Special Diabetes Program for Indians.

INDIAN HEALTH SERVICE
Amounts Available for Obligations

FACILITIES

	FY 2021	FY 2022	FY 2023
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$917,888,000	$940,328,000	$1,567,343,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$917,888,000	$940,328,000	$1,567,343,000
Mandatory Appropriation:			
Appropriation	$0	$0	$1,567,343,000
Offsetting Collections:			
Federal sources	(92,000,000)	($59,000,000)	(59,000,000)
Subtotal, Offsetting Collections	(92,000,000)	($59,000,000)	(59,000,000)
Unobligated Balances:			
Discretionary, Start of Year	$944,000,000	$1,620,000,000	$2,481,000,000
End of Year	$1,620,000,000	$2,481,000,000	$3,986,000,000
Total Obligations, Facilities	$149,888,000	$20,328,000	$3,343,000

INDIAN HEALTH SERVICE
Amounts Available for Obligations

CONTRACT SUPPORT COSTS

	FY 2021	FY 2022	FY 2023
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$916,000,000	$880,000,000	$0
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$916,000,000	$880,000,000	$0
Mandatory Appropriation:			
Appropriation	$0	$0	$1,142,000,000
Total Obligations, CSC	$916,000,000	$880,000,000	$1,142,000,000

INDIAN HEALTH SERVICE
Amounts Available for Obligations

PAYMENTS FOR TRIBAL LEASES

	FY 2021	FY 2022	FY 2023
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$101,000,000	$150,000,000	$0
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$101,000,000	$150,000,000	$0
Mandatory Appropriation:			
Appropriation	$0	$0	$150,000,000
Total Obligations, Payments for Tribal Leases	$101,000,000	$150,000,000	$150,000,000

Indian Health Service - Combined
Summary of Changes
(Dollars in millions)

FY 2022 Enacted	
Total estimated budget authority	$6,630,986.000
(Obligations)	$6,630,986.000
FY 2023 President's Budget	
Total estimated budget authority	$9,268,023.000
(Obligations)	$9,268,023.000
Net Change	$2,637,037.000

	FY 2022 Enacted		FY 2023 President's Budget		FY 2023 +/- FY 2022	
	FTE	BA	FTE	BA	FTE	BA
Increases:						
A. Built-in:						
1. Annualization of 2022 CO pay increase (3 months)	--	--	--	$611.254	--	+$611.254
2. FY 2023 Pay Raise CO (9 months)	--	--	--	$1,069.514	--	+$1,069.514
3. Annualization of 2022 CS Pay Raise (3 months)	--	--	--	$4,130.961	--	+$4,130.961
4. FY 2023 Pay Riase CS (9 months)	--	--	--	$7,227.957	--	+$7,227.957
Subtotal, Built-in Increases	**--**	**--**	**--**	**$13,039.685**	**--**	**+$13,039.685**
B. Program Adjustments:						
1. Tribal Pay	--	$49,288.000	--	$61,720.000	--	+$12,432.000
2. Cost of Medical Inflation		$29,374.000	--	$18,203.000	--	-$11,171.000
3. Cost of Non-Medical Inflation		$6,057.000	--	$5,987.000	--	-$70.000
4. 105(l) Tribal Leases	--	$49,000.000	--	--	--	-$49,000.000
5. Contract Support Costs	--	--	--	$262,000.000	--	+$262,000.000
6. Special Diabetes Program for Indians - Include	--	--	--	$147,000.000	--	+$147,000.000
7. Population Growth	--	--	--	$86,665.000	--	+$86,665.000
Subtotal, Program Increases	**--**	**$133,719.000**	**--**	**$581,575.000**	**--**	**+$447,856.000**
C. Phasing -In of Staff & Operating Cost of New Facilities	538	$98,897.000	604	$102,497.000	+66	+$3,600.000
D. New Tribes	--	--	--	$1,000.000	--	+$1,000.000
E. Assessments	--	--	--	$27,000.000	--	+$27,000.000
F. Program Increases	207	$203,171.000	122	$1,890,469.000	-85	+$1,687,298.000
Subtotal, Program Increases	**745**	**$302,068.000**	**726**	**$2,020,966.000**	**-19**	**+$1,718,898.000**
Total Increases	**1,283**	**$534,684.000**	**1,330**	**$2,746,077.685**	**+47**	**+$2,211,393.685**
Decreases:						
A. Built-in:						
1. Decrease in the number of compensable days	--	--	--	$2,408.115	--	+$2,408.115
2. Absorption of FY21 CO Pay Increase (3 months)	--	$688.227	--	--	--	-$86,665.000
3. Absorption of FY21 CS Pay Increase (3 months)	--	$1,529.985	--	--	--	-$1,529.985
4. Absorption of FY22 CO Pay Increase (9 months)	--	$1,833.762	--	--	--	-$1,833.762
5. Absorption of FY22 CS Pay Increase (9 months)	--	$12,392.882	--	--	--	-$12,392.882
4. Absorption of Unfunded Medical Inflationary Costs	--	$19,384,138.305	--	$39,524,258.005	--	+$20,140,119.699
5. Absorption of Unfunded Non-Medical Inflationary Costs	--	$5,856,128.325	--	$11,829,379.216	--	+$5,973,250.891
6. Absorbtion of Population Growth	--	$100,817.748	--	$14,152.748	--	-$86,665.000
Subtotal, Built-in Decreases	**--**	**25,357,529**	**--**	**51,370,198**	**## ###**	**25,926,692**
B. Program Decrease						
1. Absorption of Sanitation Facilities Congressional Priorities	--	$40,171.000	--	--	--	-$40,171.000
2. Contract Support Costs Estimate Decrease	--	$36,000.000	--	--	--	-$36,000.000
Subtotal, Program Decreases	**--**	**$76,171.000**	**--**	**--**	**--**	**-$76,171.000**
Total Decreases	**--**	**$25,433,700.235**	**--**	**$51,370,198.084**	**--**	**+$25,850,521.076**

INDIAN HEALTH SERVICE
Budget Authority by Activity

(Dollars in Thousands)

	2021 Final /3		2022 Enacted		2023 President's Budget	
	FTE 1/	Amount	FTE 1/	Amount	FTE 1/	Amount
SERVICES						
Hospitals & Health Clinics	5,912	$2,237,633	6,320	$2,399,169	6,876	$3,365,792
Electronic Health Record System	6	$34,500	106	$145,019	178	$284,500
Dental Health	530	214,687	585	235,788	681	309,193
Mental Health	175	115,206	198	121,946	240	199,088
Alcohol & Substance Abuse	232	251,360	241	258,343	244	344,651
Purchased/Referred Care	89	975,856	89	984,887	89	1,218,059
Indian Health Care Improvement Fund	48	72,280	48	74,138	0	0
Total, Clinical Services	6,992	3,901,522	7,587	4,219,290	8,308	5,721,282
Public Health Nursing	197	92,736	221	102,466	253	112,570
Health Education	15	21,389	15	23,250	19	24,675
Comm. Health Reps.	5	62,892	5	63,679	6	68,844
Immunization AK	0	2,127	0	2,148	0	2,221
Total, Preventive Health	217	179,144	241	191,543	278	208,310
Urban Health	8	62,684	8	73,424	8	112,482
Indian Health Professions	14	67,314	16	73,039	16	93,568
Tribal Management	0	2,465	0	2,466	0	4,486
Direct Operations	264	82,456	279	95,046	294	115,378
Self-Governance	12	5,806	12	5,850	12	6,174
Total, Other services	298	220,725	315	249,825	330	332,088
Total, Services	7,507	4,301,391	8,143	4,660,658	8,916	6,261,680
CONTRACT SUPPORT COSTS	0	916,000	0	880,000	0	1,142,000
PAYMENTS FOR TRIBAL LEASES 4/	0	101,000	0	150,000	0	150,000
FACILITIES						
Maintenance & Improvement	0	168,952	0	169,664	0	345,565
Sanitation Facilities Constr.	119	196,577	119	197,783	119	202,651
Health Care Facs. Constr.	0	259,290	0	259,293	0	545,784
Facil. & Envir. Health Supp.	1,044	263,982	1,066	283,124	1,092	371,326
Equipment	0	29,087	0	30,464	0	102,017
Total, Facilities	1,163	917,888	1,185	940,328	1,211	1,567,343
SPECIAL DIABETES PROGRAM FOR INDIANS						
SDPI/2	111	150,000	111	147,000	111	147,000
Total, SDPI	111	150,000	111	147,000	111	147,000
Total IHS	15,545	$6,386,279	16,203	$6,777,986	17,002	$9,268,023

1/ FTE estimates exclude FTEs funded by reimbursements such as Medicaid and Medicare collections.

2/ The FY 2021 Consolidated Appropriations Act (P.L. 116-260) extended the Special Diabetes Program for Indians through FY 2023 at $150 million per year. FY 2022 and FY 2023 levels reflect current law, which includes a mandatory sequester of 2%.

INDIAN HEALTH SERVICE
Appropriation History Table
Services

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2005	$2,612,824,000	$2,627,918,000	$2,633,624,000	$2,632,667,000
Rescission (PL 108-447, Sec. 501)				($15,638,000)
Rescission (PL 108-447, Sec. 122)				($20,936,000)
2006	$2,732,298,000	$2,732,298,000	$2,732,323,000	$2,732,298,000
Rescission (PL 109-54)				($13,006,000)
Rescission (PL 109-148)				($27,192,000)
2007	$2,822,449,000	$2,830,085,000	$2,835,493,000	$2,818,871,000
2008	$2,931,530,000	$3,023,532,000	$2,991,924,000	$3,018,624,000
Rescission (PL 110-161)				($47,091,000)
2009 Omnibus	$2,971,533,000	-	-	$3,190,956,000
2009 ARRA (PL 111-5)	-	-	-	$85,000,000
2010	$3,639,868,000	$3,657,618,000	$3,639,868,000	$3,657,618,000
2011	$3,657,618,000	-	-	$3,672,618,000
Rescission (PL 112-10)				($7,345,000)
2012	$4,166,139,000	$4,034,322,000	-	$3,872,377,000
Rescission (PL 112-74)				($6,195,804)
2013	$3,978,974,000	-	$ 3,914,599,000	$3,914,599,000
Sequestration				($194,492,111)
Rescission				($7,829,198)
2014 Omnibus (PL 113-64)	$3,982,498,000	-	-	$3,982,842,000
2015 Omnibus (PL 113-235)	$4,172,182,000	$4,180,557,000	-	$4,182,147,000
2016 Omnibus (PL 114-39)	$3,745,290,000	$3,603,569,000	$3,539,523,000	$3,566,387,000
2017 Omnibus (PL 115-31)	$3,815,109,000	$3,720,690,000	$3,650,171,000	$3,694,462,000
2018 Congressional Justification	$3,574,365,000	$3,867,260,000	$3,759,258,000	$3,952,290,000
2019 Congressional Justification	$3,945,975,000	$4,202,639,000	$4,072,385,000	$3,965,711,000
2020 Congressional Justification	$4,286,542,000	$4,556,870,000	$4,318,884,000	$4,315,205,000
2021 Congressional Justification	$4,507,113,000	$4,534,670,000	$4,266,085,000	$4,301,391,000
2022 Congressional Justification	$5,678,336,000	$5,799,102,000	$5,414,143,000	$5,600,985,000
2023 Congressional Justification 1/	$6,261,680,000			

1/ FY 2023 Congressional Justification proposes to make the FY 2023 Budget mandatory.

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2009 Omnibus	$353,329,000	-	-	$390,168,000
2009 ARRA (PL 111-5)	-	-	-	$415,000,000
2010	$394,757,000	$394,757,000	$394,757,000	$394,757,000
2011	$394,757,000	-	-	$404,757,000
Rescission (PL 112-10)				($810,000)
2012	$457,669,000	$427,259,000	-	$441,052,000
Rescission (PL 112-74)				($705,683)
2013	$443,502,000	-	$ 441,605,000	$441,605,000
Sequestration				($22,152,062)
Rescission				($883,210)
2014 Omnibus (PL 113-64)	$448,139,000	-	-	$451,673,000
2015 Omnibus (PL 113-235)	$461,995,000	$461,995,000	-	$460,234,000
2016 Omnibus (PL 114-39)	$639,725,000	$466,329,000	$521,818,000	$523,232,000
2017 Omnibus (PL 115-31)	$569,906,000	$557,946,000	$543,607,000	$545,424,000
2018 Congressional Justification	$346,956,000	$551,643,000	$563,658,000	$867,504,000
2019 Congressional Justification	$505,821,000	$882,748,000	$877,504,000	$868,704,000
2020 Congressional Justification	$803,026,000	$964,121,000	$902,878,000	$911,889,000
2021 Congressional Justification	$769,455,000	$934,863,000	$927,113,000	$917,888,000
2022 Congressional Justification	$1,500,943,000	$1,285,064,000	$1,172,107,000	$940,328,000
2023 Congressional Justification 1/	$1,567,343,000			

1/ FY 2023 Congressional Justification proposes to make the FY 2023 Budget mandatory.

INDIAN HEALTH SERVICE
Appropriation History Table
Contract Support Costs

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2016 Omnibus (PL 114-39)	$717,970,000	$717,970,000	$717,970,000	$717,970,000
2017 Omnibus (PL 115-31)	$800,000,000	$800,000,000	$800,000,000	$800,000,000
2018 Congressional Justification	$717,970,000	$717,970,000	$717,970,000	$717,970,000
2019 Congressional Justification	$822,227,000	$822,227,000	$822,227,000	$717,970,000
2020 Congressional Justification	$855,000,000	$820,000,000	$820,000,000	$855,000,000
2021 Congressional Justification	$855,000,000	$916,000,000	$916,000,000	$916,000,000
2022 Congressional Justification	$1,142,000,000	$880,000,000	$880,000,000	$880,000,000
2023 Congressional Justification 1/	$1,142,000,000			

1/ FY 2023 Congressional Justification proposes to make the FY 2023 Budget mandatory.

INDIAN HEALTH SERVICE
Appropriation History Table
ISDEAA 105*(l)* Leases

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2019 Congressional Justification	$0	$0	$0	$0
2020 Congressional Justification	$0	$0	$0	$0
2021 Congressional Justification	$101,000,000	$101,000,000	$101,000,000	$101,000,000
2022 Congressional Justification	$150,000,000	$150,000,000	$150,000,000	$150,000,000
2023 Congressional Justification 1/	$150,000,000			

1/ FY 2023 Congressional Justification proposes to make the FY 2023 Budget mandatory.

Indian Health Service

Authorizing Legislation /1

(Dollars in Thousands)

	FY 2022	
	Amount Authorized	President's Budget
1. Services Appropriation:	4,660,658	5,678,336
Snyder Act, 25 U.S.C. 13.		
Transfer Act (P.L. 83-568), 42 U.S.C. 2001.		
Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (most recently amended by the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), § 10221, 124 Stat. 119, 935 (2010)), 25 U.S.C. 1601 *et seq.*		
Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.*		
Public Health Service Act, titles II & III, as amended, 25 U.S.C. 201-280m.		
2. Contract Support Costs Appropriation:	880,000	1,142,000
Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.*		
3. Facilities Appropriation:	940,328	1,500,943
Indian Sanitation Facilities Act (P.L. 86-121), as amended, 42 U.S.C. 2004a.		
IHCIA, title III, as amended, 25 U.S.C. 1631-1638g.		
ISDEAA, sec. 102 & 509, as amended, 25 U.S.C. 450f & 458aaa-8.		
5 U.S.C. 5911 note (Quarters Rent Funds).	11,500	11,500
4. Public and Private Collections:	1,126,702	1,126,702
IHCIA sec. 206, 25 U.S.C. 1621e.		
Social Security Act, sec. 1880 & 1911, 42 U.S.C. 1395qq & 1396j.		
5. Special Diabetes Program for Indians /2:	147,000	147,000
42 U.S.C. 245c-3.		
6. Section 105(*l*) Leases	150,000	150,000
Sec. 900.69		
Unfunded authorizations:	-	-
Total appropriations:	7,916,188	9,756,481
Total appropriations against Definite authorizations:	7,916,188	9,756,481

1/ FY 2023 Congressional Justification proposes to make the FY 2023 Budget mandatory. Account level data is not available.

2/ Reflect the 2% sequester amount for the Special Diabetes Program for Indians.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2023 Performance Budget Submission to Congress

TABLE OF CONTENTS

Services

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

(dollars in thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$3,901,877	$4,219,290	$5,721,251	+$1,501,961
FTE*	6,692	7,587	8,308	+721

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.

SUMMARY OF THE BUDGET REQUEST

The FY 2023 Indian Health Service (IHS) Budget submission for Clinical Services is $5.7 million, which is +$1.5 billion above the FY 2022 Enacted level. This funding level includes additional resources for:

- Current Services (+$169 million),
- Staffing of New Facilities (+$88 million),
- Electronic Health Record (+$140 million),
- Hospitals and Health Clinics General Program Increase (+$215 million),
- National Community Health Aide Program (+$20 million),
- Assessments (+$27 million),
- Dental Health (+$48 million),
- Purchased and Referred Care (+$206 million),
- Indian Health Care Improvement Fund (IHCIF) (+$243 million)
- Ending HIV/Hepatitis C Initiative (+$47 million),
- Opioids Grants (+$9 million),
- Maternal Health (+$4 million),
- New Tribes (+$1 million),
- Partially Sustain American Rescue Plan Act Investments (+$211 million),
- Nurse Preceptorship Program (+$1 million),
- Emergency Preparedness (+$10 million),
- Emergency Medical Services (+$20 million),
- Division of Graduate Medical Education (+$4 million),
- Division of Telehealth (+$10 million),
- Cancer Initiative (+$8 million),
- Office of Quality (+$10 million),
- Office of Information Technology (+$9 million),
- National Business Improvement Center (+$3 million), and
- Realign Funding for Former National Institute on Alcohol Abuse and Alcoholism (NIAAA) funds from Alcohol and Substance Abuse to Urban (-$31,061)

In addition, the Budget Submission for Clinical Services proposes to consolidate funding for the Indian Health Care Improvement Fund into the Hospitals and Health Clinics funding line.

The budget narratives that follow this summary include detailed explanations of the request.

- **Hospitals and Health Clinics**, supports essential personal health services and community based disease prevention and health promotion services. Health services include: inpatient care, routine and emergency ambulatory care; and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, and other services. Specialized programs are conducted to address: diabetes; maternal and child health; youth services; communicable diseases including human immunodeficiency virus (HIV)/acquired immune deficiency syndrome, tuberculosis, and hepatitis; women's and men's health; geriatric health; disease surveillance; and healthcare quality improvement.

- **Electronic Health Record (EHR)**, holds an extremely high degree of mission criticality given the ability to provide much-anticipated clinical and administrative capabilities used in modern systems for the delivery of timely and impactful healthcare. Expected benefits from adopting and implementing a modernized or new system include but are not limited to improved patient safety, improved patient outcomes, better disease management, enhanced population health, improved clinical quality measures, opioid tracking, patient data exchange, third party revenue generation, agency performance reporting, etc. By identifying and properly selecting the best match for proposed system capabilities, the system will support the IHS mission. Additionally, the IHS will obtain interoperability with the Department of Veterans Affairs, Department of Defense, tribal and urban Indian health programs, academic affiliates, and community partners, many of whom are on different Health Information Technology platforms. The IHS must consider an integrated EHR system solution that will allow for a meaningful integration to create a system that serves IHS/Tribal/Urban beneficiaries in the best possible way.

- **Dental Health**, supports preventive care, basic care, and emergency care, with approximately 90 percent of services covering basic and emergency care. Basic services are prioritized over more complex rehabilitative care such as root canals, crowns and bridges, dentures, and surgical extractions. The demand for dental treatment remains high due to a high dental caries rate in American Indian and Alaska Native (AI/AN) children; however, a continuing emphasis on community oral health promotion and disease prevention is essential to impact long-term improvement of the oral health of AI/AN people.

- **Mental Health**, supports a community-oriented clinical and preventive mental health service program that provides outpatient mental health and related services, crisis triage, case management, prevention programming, and outreach services.

- **Alcohol and Substance Abuse**, supports an integrated behavioral health approach to collaboratively reduce the incidence of alcoholism and other drug dependencies in AI/AN communities.

- **Purchased/Referred Care (PRC)**, supports the purchase of essential health care services not available in IHS and Tribal healthcare facilities including inpatient and outpatient care, routine emergency ambulatory care, transportation, specialty care services (mammograms, colonoscopies, etc.), and medical support services (e.g., laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, etc.). The demand for PRC remains high as the cost of medical care increases. The PRC program continues to emphasize adherence to medical priorities, enrolling patients in alternate resources available to them (such as Medicare, Medicaid and private insurance), negotiating discounted rates with medical providers, and implementing improvements recommended by Tribes and oversight authorities.

The majority of clinical services funds are provided to 12 Area (regional) Offices that distribute resources, monitor and evaluate activities, and provide administrative and technical support to approximately 2.6 million AI/ANs through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations in service areas that are rural, isolated, and underserved.

Performance Summary Table

The following long-term performance measures are considered overarching because they are accomplished through a variety of programs and activities in the IHS Services budget.

OUTPUTS/OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
28 Unintentional Injury Rates: Age-Adjusted Unintentional injuries mortality rate in AI/AN population (Outcome)	FY 2012: 90.9 Target: Not Defined (Target Not In Place)	Not Defined	Not Defined	Maintain
71 Childhood Weight Control: Proportion of children, ages 2-5 years with a BMI at or above the 95th percentile. IHS-All (Outcome)	FY 2021: 25.1 % Target: 22.6 % (Target Not Met) FY 2020: 23.3% Target: 22.6 % (Target Not Met)	22.6%	Not Defined	N/A

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$2,237,633	$2,399,169	$3,365,792	+$966,623
FTE*	5,912	6,320	6,876	+556

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2023 Authorization.....Permanent

Allocation Method… .....Direct Federal, P.L. 93-638 contracts and compacts, Tribal shares, interagency agreements, commercial contracts, and grants

PROGRAM DESCRIPTION

Hospitals and Health Clinics (H&HC) funds essential, personal health services for approximately 2.6 million American Indians and Alaska Natives (AI/AN). The Indian Health Service (IHS) provides medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, and physical therapy. The IHS direct health care services supports the IHS Strategic Plan FY 2019-2023 and integrates the Department's Strategic Goal to protect the health of Americans *(HHS Strategic Plan FY 2022-2026, Goal 2 Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.1.Improve capabilities to predict, prepare for, and respond to public health emergencies and threats in the nation and across the globe; Objective 2.2.Protect individuals, families, and communities against communicable, and infectious disease through effective, innovative, readily available and equitable delivery of treatments, therapeutics, medical devices, and vaccines; & Objective 2.3. Enhance promotion of healthy lifestyle choices to reduce occurrence and disparities in preventable injury, illness, and death)*. The IHS and tribes primarily serve small, rural populations with primary medical care and community health services, relying on the private sector for much of the secondary and most of the tertiary medical care needs. Some IHS and tribal hospitals provide secondary medical services such as ophthalmology, orthopedics, infectious disease, emergency medicine, radiology, general and gynecological surgery, and anesthesia.

The IHS system of care is unique in that personal health care services are integrated with community health services. The program includes public/community health programs targeting health conditions disproportionately affecting AI/AN populations such as diabetes, maternal and child health, and communicable diseases including influenza, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), and viral hepatitis. The health status of AI/AN people has improved significantly in the past 60 years since IHS's inception. However,

AI/AN people born today have a life expectancy that is 5.5 years less than the U.S. all races population, 73.0 years to 78.5 years, respectively.[1]

More than 60 percent of the H&HC budget is transferred under P.L. 93-638 contracts or compacts to tribal governments or tribal organizations that design and manage the delivery of individual and community health services through 22 hospitals, 319 health centers, 79 health stations, 146 Alaska village clinics, and 12 school health centers. The remainder of the H&HC budget is managed by direct federal programs that provide health care at the service unit and community level. The federal system consists of 24 hospitals (23 hospitals have emergency departments), 51 health centers, 25 health stations, and 12 school health centers.

Collecting, analyzing, and interpreting health information is done through a network of tribally operated epidemiology centers in collaboration with a national IHS coordinating center leading to the identification of health conditions as well as promoting interventions. Information technology supports personal health services (including the Electronic Health Record and telemedicine) and public health initiatives (such as *Baby Friendly Hospitals* and *Improving Patient Care*) that are primarily funded through the H&HC budget.

The H&HC funds provide critical support for direct health care services, ensures comprehensive, culturally appropriate services, provides available and accessible personnel, promotes excellence and quality through implemented quality improvement strategies, and strengthens the IHS program management and operations to raise the health status of AI/AN populations to the highest level (*IHS Strategic Plan FY 2019–2023, Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people; Goal 2, To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; Goal 3, To strengthen IHS program management and operations; HHS Strategic Plan FY 2022-2026 Goal* 1*, Protect and Strengthen Equitable Access to High Quality and Affordable Health Care, Objective 1.3.Expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while recognizing social determinants of health & Objective 1.4. Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families).*

PROGRAM ACCOMPLISHMENTS

The following are examples of specific activities funded through H&HC that improve the quality of services throughout the IHS healthcare system:

Office of Quality – Established in FY 2019, the IHS Office of Quality (OQ) has made significant quality and patient safety improvements across the Agency. The OQ has three divisions: 1) Quality Assurance; 2) Patient Safety and Clinical Risk Management; and, 3) Innovation and Improvement that lead the work on oversight of policy and accreditation standards, implementation of quality improvement strategies, and monitoring accountability of federally-operated facilities.

Accomplishments FY 2021
In FY 2021 and FY 2022, the Office's activities and accomplishments include the following:

[1] Data comparing the AI/AN population to the U.S. general population are documented and updated annually by the IHS.

The ongoing Agency response to novel coronavirus disease (COVID-19) has continued to impact the IHS, forcing the Agency to rapidly redesign service delivery methods, increase vaccination acceptance and leverage local, tribal, state and federal resources and guidance to safely and efficiently meet the continuing challenges and health care needs of AI/AN people while maintaining its commitment to the mission of the IHS. The OQ led this redesign, provided staff to serve as the planning section for the IHS Incident Command Structure (ICS); developing and disseminating four Concept of Operations (CONOPS) for COVID-19 response, contact tracing, recovery, and vaccine administration; collected situation and resource status information, analyzed it, and synthesized it for use in developing the Agency's Action Plan. The planning section supported ICS operations and the distribution of guidance documents. The OQ continues to provide The Joint Commission (TJC), Accreditation Association for Ambulatory Health Care (AAAHC), and Centers for Medicare and Medicaid Services (CMS) accreditation updates on a monthly basis to provide awareness of changing standards and assist facilities to maintain compliance with updated and new standards and accreditation requirements during the pandemic. The continued work of the OQ to address COVID-19 meets the *IHS Strategic Plan Goal 2, To promote excellence and quality through innovation of the Indian health system into an optimally performing organization, the IHS Strategic Plan Goal 3 To Strengthen IHS program management and operations, and the HHS Strategic Plan Goal 2, Strategic Objective 2.1 Improve capabilities to predict, prevent, prepare for, respond to, and recover from emergencies, disasters, and threats across the nation and globe.*

Strategic Plan Implementation - The IHS Strategic Plan FY 2019-2023 provides the framework on how the IHS will achieve its mission (to raise the physical, mental, social, and spiritual health of AI/AN to the highest level) through three Goals, eight objectives, and 70 strategies. To monitor implementation of the framework, the Office created a site that allows for IHS Area and Headquarter (HQ) Offices reporting into a centralized location, the Strategic Plan Activity Repository (SPAR). Area and HQ Offices select high bar activities to include in the SPAR. These activities are updated quarterly (or more frequently as appropriate) and tied to a strategy. The IHS Strategic Plan has focused IHS programs and activities on improving quality, safety, and sustained compliance across the IHS healthcare system. As of December 2022, 342 total activities from Areas and HQ offices are currently tied to the IHS Strategic Plan, all 12 Areas and 12 HQ offices have contributed activities and updates. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal 5, Advance Strategic Management to Build Trust, Transparency, and Accountability.*

Quality Assurance - The Division of Quality Assurance focused intently on ensuring quality of care in IHS facilities through external accreditation and certification support. The OQ provides survey readiness support by making available tools, resources, and consultation for all IHS Area Offices and facilities. The OQ supported and provided assistance to IHS facilities in all 12 IHS Areas to achieve and maintain TJC and AAAHC accreditation standards and CMS regulations for IHS Hospitals, Health Centers, Behavioral Health facilities, and Critical Assess Hospitals (CAH). The IHS has also directed that all ambulatory care facilities attain Patient Centered Medical Home (PCMH) designation by the end of Calendar Year (CY) 2022. As of September 2021, 100 percent of all IHS hospitals and CAHs have achieved and maintained CMS conditions of participation, 21 of 24 hospitals and CAHs have TJC accreditation. All 29 eligible IHS health centers are accredited by TJC or the AAAHC, with 1 additional health center that is ineligible for accreditation because it does not provide the services required to obtain accreditation. 90 percent of the IHS health centers and 71 percent of IHS hospitals with ambulatory care services have attained PCMH designation. The remaining facilities without PCMH designation were affected

by the inability of accreditation organizations to conduct surveys due to the COVID-19 public health emergency. In the first quarter of FY 2022, there were 16 successful surveys by TJC (including TJC Lab surveys), AAAHC, and CMS completed at facilities. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.*

In August 2020, the Labor and Delivery Service at Phoenix Indian Medical Center (PIMC) was temporarily closed due to safety concerns arising from facility infrastructure, equipment, and challenges with staffing. PIMC contracted for an intensive Joint Commission Resources Review in September 2020 as well as an internal review by the IHS Chief Clinical Consultant for Obstetrics on September 17-18. Both reviews focused on facility deficiencies, equipment deficiencies, infection control, OB Triage, and interdisciplinary teamwork. To support addressing concerns identified in these reviews, IHS engaged a contractor to provide accreditation support and review care provided by the Obstetrics Department at PIMC. The contractor conducted a review of IHS operations at PIMC, provided a gap analysis, and then worked with IHS leadership and management to provide training and mentoring, providing training, sharing best practices and conducting a mock survey to test PIMC's readiness for an accreditation survey. In October 2021, TJC conducted an announced survey of PIMC, which resulted in reaccreditation. Without Accreditation Emergencies Funding, PIMC would have been forced to curtail some patient services to afford this level of support for their operations and could have lost tens of millions in Medicare and Medicaid reimbursements. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal 4, Strategic Objective 4.2 Invest in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, healthcare, public health, and human services resulting in more effective interventions, treatments, and programs.*

The IHS monitors the credentialing and privileging system and continuously optimizes its functions. In FY 2021, the OQ continues to improve the IHS credentialing and privileging process through the implementation of ASM Products credentialing and privileging software. All 11 eligible Areas use the software to facilitate the hiring and ongoing monitoring of qualified practitioners. The OQ provides technical assistance through training and support to Areas and facilities for ASM use and promotes the transition to 100 percent paperless. The OQ is also facilitating a quality improvement project for standardization. The system completes a monthly check on an average of 3,000 active medical staff provider credentials, flagging any negatively changed items and to date has processed nearly 2,459 initial appointment and reappointment applications. Phase I of the standardization project is at 96 percent implementation across all IHS areas. In FY 2021, standardization increased from 54 percent to 95 percent (over 40 percent increase), there were 858 initial applications, 2,791 reappointment applications, 141,445 total verifications, and 21,785 MD-Staff reports generated. As of December 2021, the system continues to process user Logins, virtual Committee Reviews, MD-App Initial Applications, and MD-App - Reappointment Applications. The improved credentialing and privileging process meets the *IHS Strategic Plan Goal 3, Objective 3.3 Modernize information technology and information systems to support data driven decisions and the HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.*

Patient Safety and Clinical Risk Management – The IHS Safety Tracking & Response (I-STAR), a system for reporting adverse events, is fully implemented across the Agency. The IHS monitors

the system and is continuously optimizing its functions. In FY 2021, events were reported in I-STAR from 172 facilities and 42 Tribal facilities. 20,668 events were entered with 7,637 medication good catch events entered. In FY 2021, the OQ began holding regular office hours and provided 37 Q&A sessions; modified I-STAR to allow for enhanced reporting and collection of data for sexual assault and worker COVID-19 vaccine ADRs; developed back-up forms for user use during I-STAR downtimes; developed an IHS Medication Safety Dashboard that includes 13 standard reports commonly used for reporting medication errors to Area Governing Boards; added three new facilities as I-STAR users; developed a new I-STAR profile to help Tribal I-STAR users to review and close events; developed and disseminated five I-STAR Updates to provide an overview of use and education tips to help users; developed and posted 13 new job aides to assist users; added 33 new drugs to the I-STAR formulary; and, migrated non-patient safety data from WebCident to I-STAR. In FY 2022, through December 2021, events were reported in I-STAR from 135 facilities and 32 Tribal facilities. These sites entered 5,172 events with 1,746 medication good catch events entered. A good catch event is an event or a potential safety hazard that is caught before it reaches a patient, worker, visitor, or facility. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.*

The Infection Prevention and Control program drafted the IHS Indian Health Manual Infection Control and Prevention (Chapter 33), the purpose of the chapter is to establish infection control and prevention program policies, procedures, and responsibilities required for ensuring a comprehensive Infection Control and Prevention (ICP) program exists in all IHS health care facilities and Service Units. An ICP program is required to meet and maintain readiness with applicable healthcare accreditation standards. The IHS manages the ICP listserv with 312 I/T/U users that regularly distributes infection prevention and control resources, updates and provides expert technical assistance across the health system. In FY 2021, the IHS concluded an Infection Control Assessment and Response (ICAR) project that provided 43 COVID-19 infection control assessments at IHS and Tribal facilities in partnership with the Centers for Disease Control and Prevention (CDC). To date in FY 2022, the ICP program has completed one ICAR at a Nashville Area Youth Regional Treatment Center. ICAR sites report increased understanding of CDC infection prevention and control guidelines, increased accreditation readiness, and leadership commitment to implementing changes to improve infection control and prevention practices. Following the ICAR assessments, the IHS-CDC ICAR team provides a written report that identifies strength and recommendations/resources for improvement opportunities. Facilities are advised to track improvements and implementation of best practices through local Governing Board Quality Management Programs. ICARs have been designated as "best practice" by multiple accreditation surveyors and of noted value in mitigating risk in reference to Occupational Health and Safety Administration (OSHA) investigations. The ICP coordinated with the Organization for Safety Asepsis and Prevention (OSAP) to secure tribal and Urban Indian Organization scholarships for the annual OSAP Dental Infection Control Bootcamp, which was held in January 2022. In total, 14 tribal scholarships were awarded and participants will be able to describe disease transmission and principles of infection prevention and control in a variety of oral health care settings; identify relevant infection control laws, regulations, guidelines, standards, and best practices; and, utilize tools to assist with quality assurance measures. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.*

Innovation and Improvement - The Division of Innovation and Improvement has increased quality improvement capacity within the Agency. A survey was developed to assess the experience and satisfaction with the care provided. This Patient Experience of Care Survey was established to develop a standardized survey instrument for use at all IHS health care facilities. These anonymous surveys are administered and the results analyzed individually by each IHS healthcare facility to determine what improvements, if any, are required to improve the patient experience. In FY 2021, the survey was made available Agency wide and received renewed OMB approval through February 2025. By directly gathering the opinions and experiences of our patients, the survey directly supports improved quality of care provided by the IHS. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.*

The OQ continues implementation of the accelerated model for improvement (Ami™) improvement science framework, and provides the Healthcare Improvement Professionals (HIP) training to support quality improvement initiatives throughout the IHS areas. There are 44 HIPs implementing various improvement projects and Ami™. The OQ tracks improvement projects, which change throughout the year. As of December 2021, 32 quality improvement projects were actively being implemented across the Agency, with 13 projects completed, and three change packages are available for Agency dissemination. The projects focus on improving both administrative and clinical processes, all project information is housed on a server that allows for sharing across the Agency resulting in increased transparency of new best practices. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.1 Create quality improvement capability at all levels of the organization, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities, and HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.*

The OQ manages the Innovations Projects, which started its 5th year on October 1, 2021. The purpose of the project is to develop and implement quality improvement innovation initiatives to that support the Patient Centered Medical Home and result in measurable improvement in care and outcomes. These projects increase the capability of IHS, Tribal and Urban Indian Health programs to provide comprehensive, patient-centered care that improves health outcomes for persons with complex needs and address social determinants of health. The funded 2021 Innovations Projects include: Ute Mountain Ute Health Center: *Outpatient clinic integration of a pharmacist provide increased access to and equitable distribution of quality health care*, Lawton SU: *PCMH Orientation Book*, Whiteriver SU: *Incorporation of a Dedicated Behavioral Health Pharmacist into the PCMH*, Western Oregon SU: *Addressing social determinants of health to decrease obesity rates at Chemawa Indian Health Center,* Yakama SU: *Screen and treat obesity, adopting materials from a proven curriculum called MOVE!*, Phoenix Area Office: *Co-development of quality measures to assess the patient journey*), and American Indian Health & Services (UIO): *Modernize Data Collection*. Funded project teams will use the Ami™ model to guide and implement their projects. Three projects completed participation at the end of September 2021. The Oklahoma City Indian Clinic redesigned prenatal services to decrease morbidity and mortality of women ages of 15-44 from pregnancy related complications. This project increased the number of patients enrolled for prenatal care from 43 to 94. Ft. Hall Service Unit redesigned collaborative management of patients with diabetes to decrease percent of high risk diabetic patients resulting in increased patient satisfaction and a decrease in average A1C from 9.5 to 8.9 and decreased cost of continuous glucose monitoring from $178 to $151. Wellpinit Service Unit collaborated with Bureau of Indian Affairs to redesign telehealth to

increase the number of inmate patient telehealth visits. This resulted in increased telehealth visits, decreased staff burden, and permanent adoption of the model. Information for all three projects is available for use by other facilities to encourage system spread. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.1 Create quality improvement capability at all levels of the organization, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities, and the HHS Strategic Plan Goal 3 Strengthen Social Well-Being, Equity, and Economic Resilience.*

Improving Patient Care (IPC) Program - The purpose of the IPC Program is to promote the development and application of the quality improvement processes and to promote the implementation of the PCMH model of care to improve the health and wellness of AI/AN people. The IPC program provides a model of collaborative learning to develop proficiency in quality improvement methodologies, data management and analysis are used to drive improvements. The IPC program supports the continued learning of IHS staff. As of December 2021, the IPC program provides 219 subscriptions to the Institute for Healthcare Improvement (IHI) Open School to support I/T/U facility staff in their quality improvement efforts. In 2021, the IHS continued support of the web based collaborative learning environment, the Quality Portal, to disseminate quality improvement and PCMH information. The portal includes subscription and notification settings, integration of a calendar invitation, the ability for the IHS staff to create "affinity groups" to manage quality improvement work, and the ability to upload resources when replying to a request in the Community Exchange. In 2021, subject matter experts provided responses to 110 questions and 460 documents were added in the Resources Section. The customer experience continued to improve through functionality enhancements such as the workgroups to expand the Community Exchange. As of December 2021, a total of 975 I/T/U members participate in this knowledge exchange. The IPC Program monitors areas for improvements though regular quality portal analytic reports. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.1 Create quality improvement capability at all levels of the organization, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities, and the HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.*

The IPC program supports I/T/U facilities in providing them with the tools and resources needed to determine when a change is an improvement and to monitor the spread and scale-up of change using PCMH measures. The IPC program continues to develop an ambulatory care measure set integrated in the health information system in collaboration with the IHS Office of Information Technology (OIT). There are currently 19 approved measures and in FY 2022, the majority of these measures were available in our population health management tool (iCare) for facilities to view, monitor, and use to guide quality improvement measures. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.1 Create quality improvement capability at all levels of the organization, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities, and the HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.*

Establishment of the National Compliance Program: In January 2020, the IHS initiated the development of a national compliance program (NCP). The NCP was established for many reasons, including to address the recommendations made by the HHS Office of Inspector General (https://oig.hhs.gov/oei/reports/oei-06-16-00390.asp. The NCP was a significant step forward in strengthening IHS HQ oversight responsibilities. The NCP itself is broadly overseen by a senior official, the Deputy Director for Quality Health Care, through the IHS Chief Compliance Officer assigned full time to lead the NCP. Seven key components of the OIG framework for compliance programs for health care providers have guided the IHS NCP activities. These include:

1. Designated compliance professionals;
2. Written policies and procedures;
3. Effective communication;
4. Effective training;
5. Enforcement of standards;
6. Internal auditing and monitoring; and
7. Prompt, responsive corrective action plans.

This activity meets the *IHS Strategic Plan Goal 3, Objective 3.2 Secure and effectively manage the assets and resources and the HHS Strategic Plan Goal 5, Strategic Objective 5.1 Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices.*

Enterprise Risk Management and Internal Audit under OMB Circular A123
In FY 2021, IHS re-competed a 5 year small business contract for OMB Circular A123 support services. As of September 30, 2021, the result of testing of controls in FY2021 led to the reduction of the IHS' only material weakness from the prior year. IHS developed an Enterprise Risk Management (ERM) Profile for FY 2022, to inform compliance activities throughout the year. This activity meets the *IHS Strategic Plan Goal 3, Objective 3.2 Secure and effectively manage the assets and resources, and the HHS Strategic Plan Goal 5, Strategic Objective 5.1, Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices and Strategic Objective 5.2, Sustain strong financial stewardship of HHS resources to foster prudent use of resources, accountability, and public trust.*

National HQ Oversight Reviews
One of the first major activities initiated by the NCP was to reinstate HQ Oversight Reviews on a bi-annual basis in 2020 as a component of that overall effort. Subjects included in the content of the 2020 HQ Oversight Reviews were chosen with the following considerations:

- High-Risk Areas identified in IHS Enterprise Risk Management discussions in 2018 and 2019.
- Un-remediated findings from prior year internal audits
- High frequency of findings by both GAO and OIG.

Review topics during 2020 and 2021 were based on assessing compliance with regulatory areas, agency-wide policies in the Indian Health Manual, CMS Conditions of Participation, and accreditation standards for IHS hospitals. Results from these reviews will continuously inform further work and priorities of the NCP. The HQ Oversight Review activity spanned 2 years, and a review of high risk subject areas of all 12 IHS Areas has been fully completed as of January 2022. The next 2-year cycle will be initiated in 2022, and the ERM program will inform the topics to be decided for review in the 2022-2024 review cycle. This activity meets the *IHS Strategic Plan Goal 3, Objective 3.2 Secure and effectively manage the assets and resources and the HHS Strategic Plan Goal 5, Strategic Objective 5.1 Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices.*

Quality Assurance/Risk Management
In FY 2020, IHS established the Quality Assurance Risk Management Committee (QARMC) to provide senior level oversight and management of complex, adverse patient safety events and administrative matters involving fraud, waste, abuse, and employee misconduct within IHS-

operated hospitals and clinics; and perform Agency-wide clinical and administrative risk management to identify systematic changes needed to improve the quality of health care services and IHS-operated hospitals and clinics. The QARMC is a component of the overall ERM governance structure and is intended to ensure enterprise-wide accountability and effectiveness of those internal and external reporting systems, necessary management responses, and swift and effective corrective action. To date, IHS has closed over 100 cases that have bene tracked and monitored by Area Directors, and the QARMC.

All IHS Area Directors have developed local processes to coordinate with the HQ QARMC and to ensure all reporting requirements within each IHS Area are understood and followed. Policies and procedures, and related staff training are under development to ensure clarity around new, streamlined reporting systems. Excellent collaboration between the IHS and OIG with joint training opportunities for compliance and overall improvements is making reporting more timely, efficient, and responsive. This activity meets the *IHS Strategic Plan Goal 3, Objective 3.2 Secure and effectively manage the assets and resources and the HHS Strategic Plan Goal 5, Strategic Objective 5.1 Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices.*

New IHS-OIG child/sexual abuse hotline
In January 2021, IHS established a key partnership with OIG Office of Investigations/OIG Hotline Manger to develop and implement a first of its kind, new child abuse/sexual abuse hotline. The new Hotline uses a mnemonic for the phone number: 1-855-SAFE-IHS. This required key collaborations with the OIG that was led by the NCP. This new special hotline was fully implemented in January, 2021. This activity meets the *IHS Strategic Plan Goal 3, Objective 3.2 Secure and effectively manage the assets and resources and the HHS Strategic Plan Goal 5, Strategic Objective 5.1, Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices and Strategic Objective 5.2, Sustain strong financial stewardship of HHS resources to foster prudent use of resources, accountability, and public trust.*

Nursing – Nursing represents the largest category of health care providers in the Indian health system and has a major impact on patient safety and health care outcomes. Nurses are actively engaged in the transformation of the health care system by placing more emphasis on prevention, wellness, and coordination of care.

Collaborations have been established with Tribal health care systems with the goal of providing safe and quality care for Native communities. A collaborative agreement was formed between IHS and the Chickasaw Nation Medical Center, Ada, Oklahoma, to enhance clinical competencies for IHS Emergency Department, Perioperative Room, and Labor and Delivery Registered Nurses (RNs). The agreement is designed to enhance IHS specialty nurses' clinical competency through preceptored clinical rotations offered at the Tribally-managed Chickasaw Medical Center, which maintains higher patient volume. Factors that impact IHS's capacity to assist RNs to maintain their level of clinical competency, beyond initial licensure, credentialing, and continuing education, are attributable to geographically isolated IHS hospitals that are further challenged with fluctuating patient volume. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goals 1, Strategic Objective 1.2, Expand safe, high quality Healthcare options, and encourage innovation and competition.*

The Division of Nursing Services (DNS) implemented the Rural Obstetrical Nurse Residency Program (RONR). The purpose of RONR is to facilitate a structured professional nursing

experience for new and inexperienced obstetrical nurses in an effort to alleviate critical shortages of practicing nurses within the Indian Health System. To sustain the RONR, DNS led a workgroup to develop and draft a RONR charter. The workgroup consisted of Area Nurse Consultants through the agency. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goals 1, Strategic Objective 1.2, Expand safe, high quality Healthcare options, and encourage innovation and competition.*

DNS made available 400 subscriptions to the Emergency Severity Index (ESI) web-based course. The web course was offered to Registered Nurses and Advanced Practice Nurses who care for patients in the emergency department, urgent care or other critical care settings, as well as nurses who provide additional coverage for these units. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska Native communities and the HHS Strategic Plan Goals 1, Strategic Objective 1.2, Expand safe, high quality Healthcare options, and encourage innovation and competition.*

HIV Program – According to CDC's HIV Surveillance Report using data reported through December 2020, in 2019, 36,801 people received an HIV diagnosis in the United States and dependent areas. Of those, approximately less than 1 percent (210) new HIV diagnosis were American Indian or Alaska Native. The overall HIV diagnosis trend shows 9 percent decrease from 2015. In the same CDC report, the rate of diagnoses of new HIV infection among AI/AN adults and adolescents increased by 18 percent. The HIV diagnosis rate is approximately 9 per 100,000 for AI/AN compared to 5 per 100,000 for Whites. From 2015-2019, the HIV diagnosis increased by 24 percent among AI/AN men with male-to-male (MSM) sexual contact as the HIV transmission. Among AI/AN women, the main transmission route was heterosexual contact, accounting for 60 percent of new diagnoses, followed by injection drug use at 40 percent of new diagnoses.[2]

In this same CDC report, the death rate among AI/AN people living with HIV in 2019 was 19 percent lower than in 2015.[3] While IHS cannot infer direct causation on a national scale, the largest HIV treatment programs like those at the Phoenix and Gallup Indian Medical Centers show outstanding HIV testing, linkage to care, and viral suppression outcomes among their HIV patients. These sites use intensive and specialized case management to initiate care, adherence, and support for co-morbidities and social barriers that are unique to their patients' social and cultural contexts. In IHS, HIV screening increases are plateauing at 50 percent to 60 percent of those who have used IHS clinics in the past three years, especially in large IHS hospitals. Some of IHS' primary care facilities reach screening rates over 90 percent, but not all IHS patients access primary care and therefore go unscreened for HIV. It is important to remember that while HIV screening programs in emergency departments, urgent care, and other non-primary care settings is crucial, these programs are difficult to start and sustain. (IHS Clinical Reporting System).

[2] Centers for Disease Control and Prevention. HIV Surveillance Report, 2019; vol. 32. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed August 10, 2021.
[3] Centers for Disease Control and Prevention. HIV Surveillance Report, 2019; vol. 32. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed August 10, 2021.

IHS data shows that from 2005-2014, there were 2,273 HIV diagnoses in IHS facilities.[4] CDC data ranks AI/AN people fourth in the nation for the estimated rate of new HIV diagnoses when compared with all other races and ethnicities. Diagnosing HIV quickly and linking people to treatment immediately are crucial to achieving further reduction in new HIV infections.

Although the United States is making significant progress in improving HIV outcomes, significant challenges remain. Gaps in the HIV care continuum are driving HIV transmission. By ensuring that everyone with HIV is aware of their status, receives the treatment they need, and achieves and maintains viral suppression—key steps in the HIV care continuum—we can preserve the health of people with HIV, improve the quality of their lives, and drive down new HIV infections[5].

Primary care providers are the front line for detecting and preventing the spread of HIV. People with HIV who are aware of their status should be prescribed antiretroviral therapy (ART) and, by achieving and maintaining an undetectable (<200 copies/mL) viral load, can remain healthy for many years.[6] ART is now recommended for all people with HIV, regardless of CD4 count.[7] Studies show that the sooner people start treatment after diagnosis, the more they benefit from ART. Early diagnosis followed by prompt ART initiation[8]:

- Reduces HIV-associated morbidity and mortality;
- Greatly decreases HIV transmission to others; and
- May reduce risk of serious non-AIDS–related diseases.

A new analysis from CDC shows the vast majority – or about 80 percent – of new HIV infections in the U.S. in 2016 were transmitted from the nearly 40 percent of people with HIV who either did not know they had HIV, or who had been diagnosed but were not receiving HIV care[9]. There is no reason to believe this statistic is different among American Indian and Alaska Native people. These data underscore the impact of undiagnosed and untreated HIV in the nation and also the critical need to expand HIV testing and treatment throughout Indian Country.

While IHS has done excellent screening in primary care, annual increases in screening are experiencing diminishing returns, and we are looking at ways to better screen patients who do not have — or use — a primary care provider, such as those individuals using only emergency departments and urgent care clinics.

[4] Reilley B, Haberling DL, Person M, Leston J, Iralu J, Haverkate R, Siddiqi AE. Assessing New Diagnoses of HIV Among American Indian/Alaska Natives Served by the Indian Health Service, 2005-2014. Public Health Reports. 2018 Mar;133(2):163-8. https://journals.sagepub.com/doi/full/10.1177/0033354917753118

[5] Source: https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/NHAS-2022-2025.pdf. Accessed 3/22/2022

[6] Bavinton B, Grinsztejn B, Phanuphak N, et al, for the Opposites Attract Study Group. HIV treatment prevents HIV transmission in male serodiscordant couples in Australia, Thailand and Brazilexternal icon. Presented at the 9th IAS Conference on HIV Science; July 25, 2017; Paris, France

[7] USDHHS. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. https://aidsinfo.nih.gov/guidelines/html/1/adultand-adolescent-treatment-guidelines/0/external icon. Accessed June 28, 2018

[8] Rodger AJ, Cambiano V, Bruun T, et al, for the PARTNER Study Group. Sexual activity without condoms and risk of HIV transmission in serodifferent couples when the HIV-positive partner is using suppressive antiretroviral therapy. *JAMA* 2016;316:171-181. PubMed abstractexternal icon.

[9] Source: https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview . Accessed 3/22/2022

According to the CDC, from 2010 to 2017, the annual number of HIV diagnoses increased 39 percent among AI/AN overall, but trends varied by age and gender. While HIV diagnoses for AI/AN women remained stable, CDC's most recent data shows a 54 percent increase for men. When looking at age grouping among AI/AN, CDC data shows a 67 percent increase in HIV diagnoses for those in the 25-34-year-old group. Most new diagnoses were among gay and bisexual men – a group that accounted for 77 percent of all AI/AN diagnoses. In the same report, the CDC also stated that when compared to other people overall with HIV, AI/AN people have lower viral suppression rates. For every 100 AI/AN with HIV, 60 received some HIV care, 46 were retained in care, and 49 were virally suppressed.[10]

AI/AN living in the U.S. Southwest have more than 50 percent of all HIV diagnoses in the IHS system. Over 500 IHS patients are currently in HIV treatment in the Southwest, with over 85 percent viral suppression. IHS programs supported by the Minority HIV/AIDS Fund in the Southwest include PIMC, GIMC, Chinle, and Northern Navajo Medical Center (Shiprock). Data from the Southwest show that viral suppression rates are above 85 percent and moving the needle positively on statewide AI/AN HIV statistics in those states.

The HIV Program goal is to prevent new HIV infections and ensure access to quality health services for AI/ANs living with HIV (*IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services; Goal 2, To promote excellence and quality through innovation of the Indian health system into an optimally performing organization, Objective 2.1 Create quality improvement capability at all levels of the organization & 2.2 Provide care to better meet the health care needs of American Indian and Alaska Native communities).* IHS increased overall prenatal HIV screening to 87 percent in FY 2016 – a 15 percent increase over FY 2006 data *(HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Health Care, Objective 1.3.Expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while recognizing social determinants of health*). To improve AI/AN access to healthcare in remote areas, the IHS HIV Program provides technical support to IHS, tribal, and urban Indian health sites on screening and treatment, and the use of telehealth.

In spring 2021, the IHS National HIV/HCV Program received $10.5 million from the HHS Minority HIV/AIDS Fund to expand partnerships between the IHS and Native communities to End the HIV epidemic in the U.S. National-level projects include the following:

1. National Continuum of Care ($750,000);
2. Project Red Talon ($1,248,483);
3. Enhancing Telehealth ($1,670,822);
4. Clinical Innovations ($1,771,770)
    a. Alaska Area Health Tech Case Management for HIV Care ($157,534);
    b. Chinle Health Tech Case Management for HIV Care ($55,382);
    c. Shiprock Health Tech Case Management for HIV Care ($55,382);
    d. GIMC: Health Tech Case Management for HIV Care, HIV Pharmacist, and HIV Case Manager ($442,848); and
    e. PIMC: HIV Pharmacist, HIV Case Manager, and HCV Pharmacist ($1,060,624)

[10] https://www.cdc.gov/hiv/group/racialethnic/aian/index.html

5. Empowering Healthier Tribal Communities ($2,925,000)
    a. IHS published and funded a $2.4 million limited competition notice of funding opportunity for the TECs to support tribal communities in reducing new HIV infections and relevant co-morbidities, specifically STD and HCV infections, improve HIV-, STI- and HCV-related health outcomes, and to reduce HIV-, STI- and HCV-related health disparities among AI/AN people. *(IHS Strategic Plan FY 2019-2023 Goal 1, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services; HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.2 Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health, & Objective 1.4 Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families)*. The TECs will provide resources to help Native communities address the four main pillars of the Ending the HIV Epidemic plan: Diagnose, Treat, Protect, and Respond (*HHS Strategic Plan FY 2022-2026 Goal 4, Restore Trust and Accelerate Advancements in Science and Research for All, Objective 4.2 Invest in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, healthcare, public health, and human services resulting in more effective interventions, treatments, and programs, Objective 4.3 Strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions, & Objective 4.4 Improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience*). Only current TEC grantees were eligible to apply for the competing supplemental funding under this announcement and had to demonstrate that they have complied with previous terms and conditions of the TEC program. There were two separate, but related notices in the Federal Register. The first was for those Tribal Epi Centers that do not provide services in the 48 counties or 7 southern states of the EHE Phase One Jurisdictions. These "Group A" applicants could apply for up to $100,000. The second announcement – for "Group B" applicants – was for those TECs whose constituency contains one or more of the 48 counties or seven southern states in the Phase One jurisdictions of the EHE. These "Group B" applicants could apply for up to $275,000.
    b. The National Native HIV Network operated by the Albuquerque Area Indian Health Board for boots-on-the-ground coordinating and program direction to IHS ($100,000);
    c. IHS Office of Public Health Support, Division of Epidemiology and Disease Prevention (OPHS/DEDP) for STD work ($200K); and
    d. The Southern Plains Tribal Health Board "HIV Self-Testing" and "Tele-PrEP" pilot projects ($225,000).
6. OURStory – a digital story telling of the history of HIV/AIDS in Native Communities ($100,000)

7. National Council of Urban Indian Health to End the HIV & HCV Epidemics among urban-based Natives ($527,974)
8. ETHIC (Ending the HIV/HCV/STI Epidemics in Indian Country) strategic plan – a Congressional IHS set-aside ($1.5 million)

In February 2021, the IHS National HIV/HCV program submitted a proposal to Office of Infectious Disease and HIV/AIDS Policy (OIDP) for $1.5 million as a Congressionally mandated Tribal set-aside within the Minority HIV/AIDS Fund. OIDP funded the proposal, which will allow AI/AN stakeholders to formulate their own response to HIV in their own communities by incorporating local leadership and knowledge with federal strategic plans and best practices. The planned outcome is an indigenized version of the National HIV/AIDS Strategy (2022-2025). This proposed strategic planning project will address national-level strategy planning to Ending the HIV Epidemic in the U.S. by using an environmental scan and community-based assessment framework, working across all Indian Health Service Areas and including Urban Indian Organizations.

In addition, the FY 2021 final appropriation includes $5 million in Ending the HIV Epidemic in the U.S. for the IHS HIV and Hepatitis C initiative, which is the same funding level and purpose as FY 2021. The IHS has conducted tribal consultation and urban confer to understand priorities of Tribal and Urban Indian Organization leaders. The IHS will use the EHE funds for tribes, tribal organizations, and urban Indian organizations to address diagnoses, and prevention, activities or and treatment activities associated with HIV, HCV and sexually transmitted infections (STIs). Funds will also support clinical training, including funding for an ECHO model for ongoing case-based training and technical assistance, and will support national infrastructure and a national media campaign for HIV, HCV, and STI diagnosis, prevention, and treatment.

In mid-January 2021, IHS released the HIV Primary Care Treatment Guidelines for Adults and Adolescents. The new guideline offers advice for the care of AI/AN persons with HIV and provides (1) guidance on HIV care specific to the AI/AN population, including tuberculosis prevention and diabetes screening; (2) recommendations for treatment utilizing drugs on the IHS Formulary; (3) specific advice on the care of transgender and gender non-binary persons in Indian Country; and (4) a single site resource that consolidates HIV, TB, STI, and primary care advice in one place for I/T/U care providers.

The National HIV/HCV Program continues to collaborate with OIDP to ensure IHS pharmacies and patients have the best possible access to PrEP drugs under the Ready Set PrEP (RSP) program. OIDP and IHS have a draft RSP fact sheet for potential AI/AN PrEP users and a draft algorithm for IHS and tribal prescribers to help them navigate the RSP protocols.

All of IHS' HIV projects and activities are supported by the Minority HIV/AIDS Fund, and that includes the $2.4 million in cooperative agreements to Tribal Epidemiology Centers. Following are some of their recent achievements:

- The Albuquerque Area Southwest Tribal Epidemiology Center developed an HIV/AIDS Resource Guide for the 27 tribal communities in New Mexico and southwestern Colorado. The guide contains data on HIV, Hepatitis C Virus, and other sexually transmitted infections in the geographic regions and highlights area resources in the communities that provide HIV testing and PrEP.

- The Alaska Native Epidemiology Center executed the Global Network of People Living with HIV Stigma Index survey in Alaska Native communities.

- The Urban Indian Health Institute's Trial Epi Center created a survey on HIV and PrEP knowledge, attitudes, and beliefs for staff at 41 urban Indian health organizations.

- The Oklahoma Area Tribal Epidemiology Center (OKTEC), in coordination with Northwest Portland Area Indian Health Board, launched a campaign to train providers and increase access to PrEP prescribers. The effort now counts more than 50 providers and represents 34 different tribes and tribal facilities.

- OKTEC and the Cherokee Nation are increasing HIV testing access through a text messaging system already in place and operational. This text messaging system will deliver HIV self-testing kits to doorsteps throughout Indian Country. OKTEC has a goal of a statewide reach by 2021; and a national reaching program by 2022.

- The Northwest Tribal Epi Center is using race-corrected HIV data from the Washington State Department of Health better to understand the HIV disease burden within NW tribal communities. Northwest Portland will use these data, along with virtual and in-person training on prevention, control, and outbreak investigation, to adopt HIV prevention and control methods on a local level that are de-stigmatizing and culturally appropriate.

- The IHS National HIV/HCV Program continually searches for ways to help the Area Offices and Service Units achieve their HIV and HCV goals. In the summer of 2020, the IHS National HIV/HCV Program created IHS Area-wide and Service Unit-specific report cards for nationally monitored HIV and HCV screening measures.

- In August, IHS, in partnership with the Northwest Portland Area Indian Health Board, released the fourth and final course in the learning module called "PrEP Navigator Training for Community and Public Health Staff." The learning module is available online. Go to www.ihs.gov and search "PrEP Navigator."

- The Northwest Portland Area Indian Health Board's Healthy Native Youth collaborative launched a Talking is Power campaign to help American Indian and Alaska Native parents and caring adults initiate difficult conversations about sexual health topics with their teens and young adults. Caring adults can text the word "EMPOWER" to 97779 to receive weekly text messages that include culturally appropriate tips and resources, covering sexual health, pregnancy, HIV/STDs, condoms, and consent.

- Northwest Portland recently began its second cohort of a six-month Trans & Gender-Affirming Care ECHO designed for IHS, tribal, and urban Indian health care providers.

- To assess the impact of COVID-19 on our HIV services, in May, August, and December IHS conducted a three-question survey of the clinical leads at our major anti-retroviral therapy programs – specifically those facilities receiving Minority HIV/AIDS Fund support. In total, we interviewed seven sites. The overall impression is that the impact of COVID has been moderate on the overall health of our patients with HIV as well as the impact on ART. However, many providers signaled that the quality of care is suffering and the effects will be manifest in time. A lack of in-person visits means some clinical indicators will go undetected. COVID is causing these HIV medical teams to work in

silos more than ever before, and at least one site has reported new HIV patients since COVID-19. Still, one facility noted that resources going towards COVID-19 had actually improved ART adherence, as a proportion of their HIV patient cohort were homeless, but emergency housing was made available as part of the COVID-19 response to stabilize their housing situation.

Hepatitis C Virus (HCV) infections can result in illness varying in severity from mild (lasting a few weeks), to serious (a lifelong illness ending in death by liver failure). The likelihood of liver damage is related to the duration and severity of untreated infection. In 2019, CDC reported 1,657 new diagnoses of chronic HCV infection among AI/AN, for a rate of 86.7 per 100,000 the highest of race/ethnicity, and more than double the next highest group (34 per 100,000 among Whites). In the same year, acute HCV infection among AI/AN at 3.6 per 100,000 was more than double the next highest group (1.4 per 100,000 among Whites).[11] The IHS National Patient Information Reporting System (NPIRS) data identifies 29,803 IHS patients from 2005-2015 with HCV, and estimates nearly 200 new cases each year; 53.4 percent were among persons born 1945–1965[12]. The overall HCV burden was higher among males than females. This data does not include up to 50 percent of patients who remain undiagnosed. AI/AN people have the largest increase in liver and intrahepatic bile duct cancer compared to any other race/ethnic groups. IHS data also identifies fewer than 1,000 HCV patients currently undergoing treatment. HCV death rates among AI/ANs are more than twice the national average compared to other ethnic groups.[13]

The CDC and the U.S. Preventive Services Task Force (USPSTF) recommends that all persons born from 1945-1965 should be screened for HCV. The IHS has sustained a steady increase in HCV screening. The national recommendations since 2012 are to screen persons born 1945-1965, or 'baby boomers.' More recently, the IHS screening recommendations were expanded to all persons 18 years and older – called 'universal screening' – in large part because of data emphasizing the importance and effectiveness of early diagnosis, treatment, and cure.

IHS tracks both the baby boomers and universal screening measures nationally. For boomers, IHS screening coverage increased from 11 percent in 2012 to 66 percent in 2019. These improvements in screening go hand-in-hand with changes at I/T/U facilities. Many have added clinical 'reminders' to ensure that patients who have never been tested are offered an HCV test. Just as important, if a patient tests positive, I/T/U facilities can treat in-house, rather than referring out. Drugs for HCV treatment are free to IHS patients and treatment for most patients is simple enough (a course of 1-3 pills per day, for 8 to 12 weeks) that it can be done in primary care. This course of treatment has more than a 95 percent cure rate.

IHS aligned program initiatives with the National Viral Hepatitis Action Plan (NVHAP) 2017-2020, to eliminate new viral hepatitis infections, increase knowledge of hepatitis diagnoses, improve access to high quality health care and curative treatments, and eliminate stigma and *discrimination (IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a*

[11] Centers for Disease Control and Prevention. 2019 Viral Hepatitis Surveillance Report. https://www.cdc.gov/hepatitis/statistics/SurveillanceRpts.htm. Published July 2021.

[12] Reilley, B., Leston, J., Doshani, M. et al. Assessing Disparities in the Rates of HCV Diagnoses Within American Indian or Alaska Native Populations Served by the U.S. Indian Health Service, 2005–2015. J Community Health 43, 1115–1118 (2018). https://doi.org/10.1007/s10900-018-0528-7

[13] https://www.cdc.gov/hepatitis/statistics/2016surveillance/commentary.htm

dedicated, competent, and caring workforce, 1.2 Build, strengthen, and sustain collaborative relationships, & 1.3 Increase access to quality health care services; HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.2 Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs Expand safe, high-quality healthcare options, and encourage innovation and competition, & Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health). IHS clinical data shows that screening for HCV among AI/ANs born from 1945-1965, increased from 8 percent in 2012, to 65.6 percent in 2019. This achievement is due in part to the *integration of the Department's Strategic Plan Goal 4: Restore Trust and Accelerate Advancements in Science and Research for All* through the development of technical support tools like electronic health record (EHR) clinical reminders, publication of IHS policy guidelines for HIV and HCV, and creation of clinical linkages to care *(HHS Strategic Plan FY 2022-2026 Goal 4, Objective 4.3 Strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions, & Objective 4.4 Improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience*). IHS anticipates higher costs associated with HCV care in FY 2018 and FY 2019 associated with the increased rate of diagnosis (based on increased screening of Baby-Boomers and women of reproductive age) and the substantially high cost of curative medications.

In FY 2019, IHS established universal screening for HCV for all patients over the age of 18 years at least once in their lifetime, followed by guideline-based treatment, as appropriate (*IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce*, Objective 1.2 *Build, strengthen, and sustain collaborative relationships*, & Objective 1.3 *Increase access to quality health care services*; *HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.2 Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs Expand safe, high-quality healthcare options, and encourage innovation and competition, & Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health*).

Sexually Transmitted Disease (STD) rates continue to rise in Indian Country, and recurrent STDs can increase the likelihood of HIV transmission. Gonorrhea and syphilis often present as co-morbid conditions with HIV diagnosis, particularly among men who have sex with men (MSM). Data show that the incidence rates of chlamydia and gonorrhea among AI/AN people are approximately four times that of whites, and AI/AN have the second highest overall rates for both conditions when compared to all other races and ethnicities.[14] Regional differences in STDs in Indian Country are also observed, and AI/AN youth and AI/AN women, particularly women of reproductive age, have a disparate and increased STD burden.[15] Recent and sustained outbreaks

[14] https://www.cdc.gov/std/stats17/minorities.htm

[15] https://www.ihs.gov/sites/epi/themes/responsive2017/display_objects/documents/std/Indian_Health_Surveillance_Report_STD_2015.pdf

of syphilis have also been observed among AI/AN communities, some related to injection drug and methamphetamine use, and both are recognized risk factors for HIV transmission.

Domestic Violence Prevention (DVP) Program – Domestic and intimate partner violence has a disproportionately large impact on AI/AN communities. According to a 2016 report by the National Institute of Justice,[16] more than four in five AI/AN women (84.3 percent) have experienced violence in their lifetime. In fact, Data from the National Institutes for Justice and the Center for Disease Control show that more than 1.5 million American Indian and Alaska Native women have experienced violence, including sexual violence in their lifetimes[17] with 66.4 percent of AI/AN reported having experienced psychological aggression by an intimate partner. Intimate partner violence is preventable and many of the projects supported by the DVP program address this public health problem.

The DVP program was established in 2015, as a nationally coordinated program that provides culturally appropriate domestic violence and sexual assault prevention and intervention resources to AI/AN communities with a focus on providing trauma informed services. The DVP program supports HHS *Goal 3: Strengthen Social Well-Being, Equity, and Economic Resilience, Objective 3.4: Increase safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence.* In FY 2021, a total of 83 DVP projects completed projects that focused on the following objectives:

1. Build Tribal, Urban Indian Health Programs, and Federal capacity to provide coordinated community responses to AI/AN victims of domestic and sexual violence,
2. Increase access to domestic and sexual violence prevention, advocacy, crisis intervention, and behavioral health services for AI/AN victims and their families,
3. Promote trauma-informed services for AI/AN victims of domestic and sexual violence and their families,
4. Offer health care provider and community education on domestic violence and sexual violence,
5. Respond to the health care needs of AI/AN victims of domestic and sexual violence, and
6. Incorporate culturally appropriate practices and/or faith-based services for AI/AN victims of domestic and sexual violence.

DVP program achievements between FY 2018-2019 include an approximate 94,454 service contacts. DVP program projects focused on coordinated community responses, advocacy, forensic healthcare, integration of traditional healing, faith-based and culturally competent services. By the fourth year, projects experienced an expansion of behavioral health and case management services delivered to victims of domestic violence and intimate partner violence. The majority of projects (80.5 percent) have implemented one evidence-based practice. As the DVP program emphasizes the importance of community and culturally based, projects, recent data shows that 17,407 individuals received culturally-tailored services while 1,233 received a form of faith-based services. Disseminating lessons learned and best practices is a priority and prior to the pandemic IHS hosted a platform for monthly collaborative learning session. In FY 2021, IHS converted these efforts to spotlight videos available on-demand[18]. In

[16] https://www.ncjrs.gov/pdffiles1/nij/249736.pdf
[17] https://www.whitehouse.gov/presidential-actions/missing-murdered-american-indians-alaska-natives-awareness-day-2019/

[18] https://www.youtube.com/watch?v=UZ9FkcO843E

FY 2022, IHS released a series webinars focused on prevention, services and resources for victims of domestic violence and sexual assault.

In addition, these funds support Forensic Health Care (FHC) services within IHS HQ. The Forensic Health Care program established in 2009 has developed multiple policies within the Indian Health Manual to increase recognition of and prevention of sexual assault and child maltreatment (all forms including sexual abuse). The FHC team works with the DVP program to enhance intimate partner violence efforts, and strategy and resources to address human trafficking. The FHC team provides subject matter expertise and high-quality staff training, assistance to local facilities to create or sustain appropriate acute forensic care services, and strengthen on-going comprehensive services that enhance survivor healing. In FY 2020, IHS released a trauma informed care policy and has worked to implement the principles of trauma informed care to ensure its system understands the prevalence and impact of trauma, facilitates healing, avoids re-traumatization, and focuses on strength and resilience. Through the DVP/FHC program, more than 2,108 health professionals received training in Trauma Informed Car with projects offering a combined estimated 138 trainings. In addition, the FHC program has established a strong partnership with the International Association of Forensic Nurses. The services provided through this agreement include didactic and clinical forensic examination courses, quarterly educational webinars, and technical assistance to sexual assault programs operating within the I/T/U system.

National Community Health Aide Program (CHAP): provides a network of health aides trained to support licensed health professionals while providing direct health care, health promotion, and disease prevention services. These providers work within a referral relationship under the supervision of licensed clinical providers that includes clinics, service units, and hospitals. The program increases access to direct health services, including inpatient and outpatient visits through a focus on primary, emergency, behavioral, and dental health to equip Tribal communities with a network that expands the system of care and aids in the mobilization of healthcare in America's most rural and remote communities where access to care is few and far in between. In 2016, the IHS begun the efforts to expand the program nationally and in July 2020, the IHS announced the policy that formally established the national CHAP which sees to the use of health aides in the field of primary care, behavioral health, and oral health. In January 2022, the Division of Clinical and Community Services hired the Community Health Aide (CHA) Specialist to support the development of the CHA workforce. *(IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, Objective 1.2 Build, strengthen, and sustain collaborative relationships, & Objective 1.3 Increase access to quality health care services; HHS Strategic Plan FY2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Health Care, Objective 1.3.Expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while recognizing social determinants of health & Objective 1.5 Bolster the health workforce to ensure delivery of quality services and care*).

Maternal Health
All federal hospitals providing planned birth services have earned the "Baby Friendly" designation by Baby-Friendly USA. Comprehensive breastfeeding education and continued lactation support are mainstays of this designation. The Baby Friendly Hospital Initiative (BFHI) designation ensures education is provided during prenatal care and lactation support is routinely offered throughout the hospital stay and postpartum. IHS further promotes breastfeeding opportunities through the Baby Friendly Hospital Initiative, building organizational capacity and

practice-based resources, developing partnerships to advance breastfeeding, and incorporating breastfeeding into its robust public health programs. Breastfeeding education has also been included in many trainings offered to IHS, Tribal, and Urban Health staff, including those offered in partnership with the ACOG Committee on American Indian and Alaska Native Women's Health.

Baby-Friendly designation naturally leads to education and support of breastfeeding to become engrained in daily operations of the hospitals. Education on early warning signs, how to recognize these warning signs, when to return to care, whether that should be for routine or emergent care, and information on a large network of resources available for new mothers are important pieces of this breastfeeding support post-discharge. In addition to efforts specifically related to maintaining the BFHI designation, IHS continues to monitor Government Performance and Results Act (GPRA) rates and several sites have initiated intensive QI projects around breastfeeding. IHS has built partnerships between Tribes and the AIM Community Care Initiative (AIM CCI), and has enjoyed a long standing partnership with the American Academy of Pediatrics-Committee on Native American Child Health (CONACH) and works closely with these entities in implementation of any recommendations to improve infant feeding outcomes and resultant child health indicators.

IHS partners with Tribes, urban Indian organizations, and local and state governments in order to ensure comprehensive, culturally appropriate lactation services are provided for the American Indian and Alaskan Native women and families served. One example includes linking patients with postpartum resources available to them after discharge, which include a variety of ways to access support, online, by phone, or in person including home visitation programs. Postpartum visits are also offered by public health/community health programs in many communities; offering 1:1 assistance and support, in home, which helps to remove access to care barriers such as transportation or childcare for other children, and also helps to ensure cultural sensitivity for those patients practicing traditional beliefs and customs surrounding childbirth. Several certified lactation consultants and counselors are employed by IHS, and sites have offered incentives for this continued education and certification. Referrals can be placed by the public health/community health programs for additional lactation support or other resources as needed. IHS offers resources about breastfeeding promotion and support on the Baby Friendly webpage. This public facing page is available on the general website for patients, staff and other interested individuals to access freely. The page includes information about breastfeeding promotion and support, standard of care, breastfeeding benefits, common problems, clinical challenges, and a toolkit on providing education on breastfeeding.

The Baby Friendly designation efforts support IHS Strategic Plan Goal One: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, and HHS Strategic Plan Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes.

Alzheimer's

In FY 2021, IHS received $5 million to address Alzheimer's and related cognitive health issues in American Indian and Alaska Native (AI/AN) communities. On March 31, 2021, the IHS initiated Tribal Consultation and Urban Confer on the FY 2021 appropriations seeking specific feedback on priorities necessary to implement and build the Alzheimer's Grant Program for maximum success in Federal, Tribal, and Urban Indian Organization facilities. The IHS hosted several Tribal Consultation and Urban Confer conference calls with Tribal and Urban Indian Organization Leaders in March, April, and May 2021. The IHS will utilize the FY 2021 funds in FY 2022 due to the importance of Tribal Consultation and Urban Confer. The Alzheimer's Grant

Program will include funding for Tribes, Tribal Organizations, IHS Direct Service programs working directly with Tribes to address Alzhiemer's disease and related dementia, and Urban Indian Organizations. Funding will support a national media campaign, clinical training, caregiver coach training, and provide national infrastructure to support the new Initiative. *(IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, Objective 1.2 Build, strengthen, and sustain collaborative relationships, & Objective 1.3 Increase access to quality health care services; HHS Strategic Plan Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Health Care, Objective 1.3.Expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while recognizing social determinants of health & Objective 1.5 Bolster the health workforce to ensure delivery of quality services and care*).

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and FY 2021, the Indian health care system modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount	DVPP
2019	$2,178,088,000	($12,967,278)
2020	$2,323,898,000	($12,967,278)
2021 Final	$2,237,633,000	($12,967,278)
2022 Enacted	$2,399,169,000	($12,967,278)
2023 President's Budget	$3,365,792,000	($12,967,278)

TRIBAL SHARES

H&HC funds are subject to tribal shares and are transferred to Tribes when they assume responsibility for operating associated programs, functions, services, and activities, unless otherwise specified in the annual appropriations bill. A portion of the overall H&HC budget line is reserved for inherently federal functions and is therefore retained by IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2023 budget submission for Hospitals and Health Clinics is $3.4 billion, which is $967 million above the FY 2022 Enacted level.

FY 2022 Base Funding of $2.4 billion - supports the largest portion of clinical care at IHS and Tribal health facilities, including salaries and benefits for hospital/clinic administration; salaries and benefits for physicians, nurses, and ancillary staff; pharmaceuticals; and medical supplies. These funds make up the lump sum recurring base distribution to the Areas each fiscal year. Funding to support IHS facilities to promote efficient, effective, high quality care to the AI/AN population is also included in the base.

FY 2023 Funding Increase of $967 million includes:

- Current Services: +$118 million for current services including:
    - Pay Costs +$67 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$8 million – to fund inflationary costs of providing health care services.
    - Population Growth +$43 million – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2023 based on state births and deaths data.
- Staffing for New Facilities: +$68 million - these funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated healthcare facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Naytahwaush Health Center (JV), Naytahwaush, MN	$9,101,000	70
NEACC (Salt River) Health Center, Scottsdale, AZ	$10,900,000	84
Phoenix Indian Medical Center Central, Phoenix, AZ	$676,000	9
Ysleta Del Sur Health Center (JV), El Paso, TX	$2,673,000	23
Alternative Rural Health Center, Dilkon, AZ	$12,181,000	92
Elbowoods Memorial Health Center (JV), New Town, ND	$3,064,000	10
North Star Health Clinic (JV), Seward, AK	$3,500,000	20
Rapid City Indian Health Service Hospital, Rapid City, SD	$25,912,000	232
Grand Total:	**$68,007,000**	**540**

- General Program Increase: +$215 million to expand access to direct health care services. These resources will support efforts to reduce health disparities and improve the overall health status for American Indians and Alaska Natives by increasing the availability of health care services in Indian Country. This funding level will support an estimated 40,536 inpatient admissions and 15,825,423 outpatient visits at IHS and Tribal facilities in FY 2023.
- National Community Health Aide Program: +$20 million to support the expansion of CHAP to the lower 48 states. These additional resources would support the training, certifying, and hiring of health aides, as well as national program management activities.
- Assessments and Other Related Costs: +$27 million, to offset the increasing costs of central

assessments charged to the IHS since FY 2014. To address the growing costs of shared services at HHS, the IHS has delayed hiring and investments in critical systems, working to shield direct health care services to the maximum extent possible. However, the IHS is now at a point where it can no longer sacrifice oversight and management of national health programs to absorb these rising costs.

- Indian Health Care Improvement Fund Consolidation and Funding Increase: +$317 million to consolidate funding for the Indian Health Care Improvement Fund into the Hospitals and Health Clinics funding line (+$74 million), and increase funding (+$243 million), to provide additional health services and address resource disparities across the Indian health system. Prior to 2018, funding for the Indian Health Care Improvement Fund was appropriated in the Hospitals and Health Clinics funding line. In FY 2018, Congress created a separate budget line for the Indian Health Care Improvement Fund. As a result, these funds are now appropriated, accounted for, monitored, and allocated from two separate locations in the IHS budget. Consolidating the funds into the Hospitals and Health Clinics funding line will allow for a more streamlined approach to managing and allocating these resources. While these resources would be realigned to the Hospitals and Health Clinics PPA, IHS would continue to distribute them under the existing Indian Health Care Improvement Fund formula.

- Elimination of HIV, Hepatitis C, and Sexually Transmitted Diseases: +$47 million - to support efforts to diagnose all HIV-positive IHS patients as early as possible after infection, treat those living with HIV rapidly to achieve and sustain viral suppression, and protect individuals at high risk of HIV using pre-exposure prophylaxis (PrEP). These resources will also help the IHS to effectively identify, treat, and prevent related conditions and risks for HIV infection, including hepatitis C virus (HCV) and sexually transmitted disease (STD) infections, and respond rapidly to growing HIV clusters to prevent new HIV infections.

  Rates of STDs other than HIV also continue to rise in Indian country and can increase risk for HIV transmission. Additionally, IHS serves a population that is disproportionately affected by HCV—the AI/AN population has more than twice the rate of HCV incidence and nearly three times the rate of HCV-related mortality as the general U.S. population (CDC 2018). Without concerted intervention that includes expanded HIV, STD, and HCV prevention, testing, and treatment, along with increased clinical and public health resourcing and infrastructure, including associated pharmaceuticals and data generation and analysis capacity, rates of AI/AN HIV, STDs, and HCV will likely continue to increase in FY 2023 and beyond. Additional health statistics about these priority diseases are provided in the program accomplishments section of this narrative.

  The additional $47 million requested above FY 2022 would:
  - Expand patient screening and treatment for those living with HIV, STDs, and HCV,
  - Provide targeted PrEP and expedited partner therapy to those at greater risk for acquiring HIV and other STDs,
  - Effectively screen and treat those patients living with HIV and HCV,
  - Sufficiently staff and resource oversight activities to ensure success,
  - Bolster public health surveillance and data infrastructure,
  - Evaluate these efforts, and
  - Support outreach, education, and training.

  The proposed funding level directly supports IHS's efforts to provide high quality health care

across the Indian health system, as well as IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 *Recruit, develop, and retain a dedicated, competent, and caring workforce, Objective 1.2 Build, strengthen, and sustain collaborative relationships, & Objective 1.3 Increase access to quality health care services; HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.2 Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs Expand safe, high-quality healthcare options, and encourage innovation and competition, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health & Objective 1.5 Bolster the health workforce to ensure delivery of quality services and care*). IHS will concentrate efforts on building up its HIV and HCV infrastructure in the 12 Area Offices and Service Units.

- Maternal Health: +$4 million – to expand the reach of this HHS-wide initiative in Indian Country. The new resources will:

  - Support preventive, perinatal, and postpartum care,
  - Address the news of pregnant women with opioid or other substance use disorder,
  - Improve quality services and health outcomes to reduce maternal morbidity.

  Specifically, these funds will support expended efforts identified through Tribal Consultation and Urban Confer, and increase the number of maternal case managers in IHS and Tribal Health Programs to expand access to evidence-based training for health care professionals and patients.

- Partially Sustain American Rescue Plan Investments: +$77 million - to partially sustain the ARPA investments that were provided to expand the public health workforce in Indian Country.

  The American Rescue Plan Act provided a historic investment in public health workforce activities for American Indian and Alaska Native communities. The IHS distributed the $240 million appropriated in the ARPA to all IHS, Tribal, and urban Indian Heath programs.

  However, the ARPA appropriation provided one-time, non-recurring funding to support mental health and substance abuse prevention and treatment services. Ongoing resources are necessary to ensure that IHS, Tribal, and urban Indian health programs do not have to significantly reduce public health workforce activities as the one-time ARPA resources are expended.

- Nurse Preceptorship Program: +$1 million to create a new program to provide training, development, mentoring, and other on-the-job supports to improve placement rates of first year nurses in IHS and Tribal Health Programs.

  Analysis indicates that the IHS has difficulty placing newly-graduated nurses in IHS and Tribal health programs, despite vacancy rates in the mid-20 percent range for nursing professions. IHS and Tribal health programs prefer to hire nurses with on-the-job experience to nurses who have just completed their studies, and are joining the IHS either through the Scholarship or Loan Repayment programs.

This new program will improve placement rates for recently graduated nurses with Bachelors of Science in Nursing (BSN) and Master of Science in Nursing (MSN) by providing on the job development, training, and mentorship. Many IHS and Tribal health programs have a critical need for nurses, but do not have the resources or the capacity to provide the additional supports necessary to ensure a high level of success for recently graduated nurses. This new program will create that infrastructure at the local level, in partnership with federal, tribal, and relevant state entities. The proposed funding level will support IHS Strategic Plan FY 2019-2023, *Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, Objective 1.3 Increase access to quality health care services*; and HHS Strategic Plan FY 2022-2026, *Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.1 Improve capabilities to predict, prevent, prepare for, respond to, and recover from emergencies, disasters, and threats across the nation and globe, Objective 2.2 Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines, and Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death.*

Funds will support:

- Contract or IAA with Established Academic Preceptor Program. Leveraging an established program would allow for rapid implementation of the applicable infrastructure, training, and ladder toward advance certifications. One example of a similar program is the CDC Epidemic Intelligence Service program, which was established in 1951, and has a unique combination of on-the-job-learning and service.

- Two New FTE. These positions will oversee, monitor, and evaluate program activities.

    - There are currently no Nurse Consultant positions at HQ to oversee Nurse Recruitment or a Nurse Preceptorship program. Fully funding 2 FTE positions for a Nurse Consultant for Recruitment and a Nurse Consultant for a Preceptorship Program would allow for these individuals to focus more discriminately on newly hired Registered Nurses and Advance Practice Nurses onboarding and preparation via preceptorship program, and nurse recruitment and retention; particularly in rural areas, or those areas lacking a sufficient nursing workforce.

    - One FTE would establish and run the preceptorship program and one FTE would reestablish the link to recruiting and monitoring through the Nurse Education Center for Indians (NECI) program and oversee the IHS Nursing Scholarship recipients (for sections 103, 104, 105, and 112 programs).

    - The 2 FTEs would actively work with other OPDIVs to leverage preceptorship opportunities, monitor and track success rates, serve

as the COR when needed for contracts with established academic preceptor programs and nurse recruitment and retention activities, and leverage what is offered in the federal, public and private sectors with organizations like HRSA, Uniformed Services University, John Hopkins University, etc.

- Emergency Preparedness: +$10 million - to support emergency preparedness personnel, training, and activities across the IHS.

  Prior to and during the COVID-19 pandemic, IHS has implemented emergency preparedness with limited staff dedicated to these activities. As funding through state-level healthcare preparedness grants has waned, most IHS Area Offices and many facility level emergency preparedness programs rely solely on existing IHS staff performing emergency preparedness as collateral duties. The HQ emergency preparedness position has been vacant for several years, only two IHS Areas have emergency preparedness positions (Nashville and Navajo), and only one IHS hospital has a dedicated position for emergency preparedness. The IHS is led and staffed by a wide range of dedicated healthcare and public health professionals. These staff are highly trained in their areas of expertise, but have traditionally had little emergency preparedness training and experience. Dedicated resources both internally and through contractual support would serve as force multipliers supporting and coordinating IHS staff to undertake their essential duties. An additional +14 FTEs would help to identify strategic and tactical level needs, and would then have time and resources to pursue and ensure resolution. These resources build on the investment initially made through the American Rescue Plan Act.

  - The proposed funding level will support IHS Strategic Plan FY 2019-2023, *Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, Objective 1.3 Increase access to quality health care services*. This funding will also help IHS Emergency Preparedness meet the HHS Strategic Plan FY 2022-2026, *Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.1 Improve capabilities to predict, prevent, prepare for, respond to, and recover from emergencies, disasters, and threats across the nation and globe, Objective 2.2 Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines, and Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death.*

- Emergency Medical Services: +$20 million – to address critical needs for Emergency Medical Services in Indian Country, where stagnating funding creates difficulties in maintaining equipment, retaining staff, and other challenges. EMS programs provide important services in communities to respond to injuries and other acute situations, as well as providing patient transport to higher level of care.

  There are over 100 IHS and Tribal EMS programs nationwide providing services in American Indian and Alaska Native communities. Funding for these programs has not kept pace with the growing needs of the populations served.

During the COVID-19 response, EMS programs played a vital role in responding to calls for respiratory distress and providing critical patient transport to get patients to the appropriate level of care. EMS programs also provide vaccinations, COVID-19 testing, and assist with infusion services as appropriate for EMTs, AEMTs, and Paramedics. In this way, EMS programs served as a force multiplier during the pandemic. In addition, EMS programs were able to provide treat and release services to alleviate overloading of Emergency Departments and inpatient facilities under the Public Health Emergency. The presented funding amount supports IHS Strategic Goal One: *To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people,* and the HHS Strategic Plan FY 2022-2026 *Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes and Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability, Objective 5.3 Uphold effective and innovative human capital resource management resulting in an engaged, diverse workforce with the skills and competencies to accomplish the HHS mission.*

IHS and Tribal EMS programs face two main challenges:

1. **Stagnating funding levels**. Funding amounts established for individual IHS and Tribal EMS programs have stagnated overtime, making it increasingly difficult to recruit and retain staff, upgrade ambulances and other emergency medical equipment, and meet CMS Conditions of Participation for accreditation. In some cases, Tribal Health Programs have discussed relinquishing direct operation of these programs to the IHS due to low funding levels, even though the IHS does not have additional resources for the operation of EMS programs.

2. **Conversion of inpatient facilities**. Many IHS and Tribal facilities operate in rural and remote locations. As some inpatient facilities are no longer able to maintain full Emergency Department (ED) services due to low patient census and increased ISDEAA contracting and compacting at multi-tribe facilities, the need for patient transport grows. The next closest full service ED might be many miles or several hours away, straining the already limited capacity of existing EMS programs. For example, many communities lose access to critical EMS services when an ambulance and its crew transport a patient to a facility that could be more than 3 hours away.

Additional resources are necessary to address the many issues caused by both of these challenges. For example, the requested funding level would support multiple crews in individual EMS programs that could handle community emergencies and provide necessary patient transport without a gap in coverage.

- Division of Graduate Medical Education: +$4 million - to expand and support Graduate Medical Education programs to create a pipeline for future physicians to address longstanding vacancy issues at IHS.

  Currently, two physician residency programs are in development at IHS-operated health programs. One program is at the Northern Navajo Medical Center at Shiprock, partnered with the University of New Mexico. The other is in the Rosebud Service Unit in the Great Plains Area, partnered with Mass General Hospital. In both cases, the partner academic affiliates have received HRSA rural residency program development planning grants. Once established, these residency programs will support recruitment and retention efforts of high quality health care professionals in Indian Country.

The IHS must establish consistent policies and procedures for these programs, and provide appropriate oversight of these activities. An Agency-wide approach will allow for growth at other IHS service units, and will support consistency in how the IHS handles important business functions, like access to the IHS Electronic Health Record, and onboarding of medical residents. Funds are also necessary to develop these programs in the relevant IHS health programs, including for faculty development and other critical activities. The VA has a large Graduate Medical Education office, and these resources would help the IHS to develop a small, targeted effort.

In addition to establishing the Office of Graduate Medical Education Programs, these funds will support the development of residency programs in up to four facilities per year.

- Division of Telehealth: +$10 million - to provide resources to appropriately manage and oversee a comprehensive telehealth program at the IHS that would expand telehealth services, develop governance structures, provide training to users, and integrate with clinical services.

  The IHS is the only major Federal healthcare organization that does not have a dedicated office or division to support policy, standardization, and coordination for enterprise wide telehealth. This activity would provide resources to appropriately manage and oversee a comprehensive telehealth program at the Agency level that could expand telehealth services nationwide. This new Division would also incorporate the activities of the IHS Tele-Behavioral Health Center for Excellence (TBHCE), which is provides direct services and on-line education focused specifically on behavioral and mental health.

  During the COVID-19 pandemic, the IHS significantly expanded the use of Telehealth to sustain the provision of health care services while many facilities had to reduce their service provision and hours to prevent the further spread of COVID. In April 2020, IHS expanded the use of an Agency-wide video conferencing platform that allows for telehealth on almost any internet-connected device and in any setting, including patients' homes. Around the same time, IHS also permitted the emergency use of certain commonly available mobile apps to enable the provision of services remotely while minimizing exposure risk to both patients and staff. These actions, along with the actions taken by the Centers for Medicare and Medicaid Services to allow payment for previously non-billable services, made it possible for IHS to dramatically increase our use of telehealth from an average of under 1,300 visits per month in early 2020 to a peak of over 40,000 per month in June and July of that year. More recent data suggests a plateau of around 30,000 monthly telehealth visits. It is important to note that on average, about 80 percent of telehealth encounters across IHS are conducted using audio only, largely related to the limited availability of technologies and bandwidth capacity in the communities we serve across the country. IHS is currently working to implement an additional cloud-based telehealth platform to complement our existing solutions and distributed COVID-19 supplemental telehealth funds to sites for equipment and devices to improve access for more interactive telehealth encounters.

- Cancer Prevention and Intervention Initiative: +$8 million - to develop a coordinated public health and clinical cancer prevention initiative to implement best practices and prevention strategies to address incidence of cancer and mortality among AI/ANs. While there have been advances in cancer detection and treatment, certain ethnic groups continue to experience disparities. For example, the incidence of all cancer combined have decreased among males for all ethnic groups, but rates did not decrease or have remained stable for certain types of cancer among AI/AN populations. CDC reported that lung, colorectal, liver, and kidney

cancers are much higher among AI/AN people compared to non-Hispanic White people in the U.S. These funds would support:

- **Additional FTE** to develop and implement multi-level and multidisciplinary approaches to increase preventive screenings for early detection and treatment, to increase educational outreach, and to improve access to cessation services.

- **Competitive cooperative agreements** to Tribes, Tribal Organizations, and Urban Indian Organizations to support innovative and culturally relevant promotion of preventive screenings, educational outreach, address modifiable behavioral risk factors (commercial tobacco use, poor diet, and physical inactivity), integrate client/provider reminders system, implement e-referrals to cessation services, and implement policies that are supportive of healthy lifestyle.

- **Establish Clinical/Community Demonstration Projects** with the IHS Improved Patient Care (IPC) and community health programs (public health nursing, health education, CHRs) to implement evidence-based interventions to increase preventive screenings, enhance referrals for follow-up and/or treatment.

- **Trainings and Best Practice Sharing** to plan, coordinate, and provide cancer prevention and control trainings to clinical and community health personnel, to share best practices/strategies, and develop self-paced training modules. Target audience include physicians, nurses, radiologist, health promoters, public health nurses, health education, CHRs behavioral health and other disciplines using virtual platform, online modules, IHS Telehealth webinars, and national/regional conferences and meetings.

- **Information Technology** investments to create bundled provider reminders into the Electronic Health Record, integrate e-referrals to cessation services, and integrate client reminders into the Patient Health Records.

- Office of Quality: +$10 million - to support activities that ensure high quality service provision and that CMS accreditation standards are met including a mock survey program, gap analyses for at-risk facilities, quality measures and reporting enhancements, training on medical quality issues, and expanded risk management activities.

  IHS has made significant progress in improving the quality of patient care delivery and infection prevention and control. However, significant gaps remain related to achieving and sustaining a highly reliable system that best meets the needs of AI/AN people. The IHS organizational structure has historically depended largely on local efforts to comply with quality standards. While successful at producing care tailored to local needs and circumstances, system-wide improvement has been uneven. A well-resourced national program focused on establishing and supporting a unified vision for quality and safety in health care is critical to creating the necessary consistency in excellence across the IHS's 24 hospitals and 31 health centers. While important progress had been made, sustainable change cannot be maintained without the resources to train and support the workforce and monitor implementation of system redesign and improvement practices.

  In addition, the GAO and OIG have recommended that the IHS establish a central owner quality oversight to improve accountability and compliance (OEI-06-14-00010: More Monitoring Needed to Ensure Quality Care; OEI-06-14-00011: Longstanding Challenges

Warrant Focused Attention to Support Quality Care; OEI-06-19-00330: Indian Health Service Has Strengthened Patient Protection Policies but Must Fully Integrate Then Into Practice and Organizational Culture; OEI-06-16-00390: Organizational Challenges to Improving Quality of Care in Indian Health Service Hospitals; GAO-17-181: Actions Needed to Improve Oversight of Quality of Care; and, GAO-16-333: Actions Needed to Improve Oversight of Patient Wait Times).

Bolstering the resources to enable continuous organizational quality improvement is crucial. At the root of many of the past failures within the IHS are core organizational challenges that if identified, tested, and corrected, will create local and system-wide change. If such a program is not funded, IHS will remain at risk for future failures.

The structure of the IHS appropriation and statutory requirements governing the use of third-party collections make it extremely difficult to make needed investments in quality, oversight, and compliance activities without additional appropriated resources. Without the resources to support these national efforts, the IHS remains at risk of regression, recreating past challenges with unable to address future challenges.

The program aligns with IHS Strategic Plan Goal Two, To promote excellence and quality through innovation of the Indian health system into an optimally performing organization communities; IHS Strategic Plan Goal Three To Strengthen IHS program management and operations; and, the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high-quality healthcare options, and encourage innovation and competition and the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high-quality healthcare options, and encourage innovation and competition; and, the HHS Strategic Plan Goal One, Strategic Objective 1.3, Improve Americans' access to healthcare and expand choices of care and service options.

Requested funding for the Office of Quality would:

- Support expanded testing, mock surveying, training, education, and consultation activities with federal hospitals, critical access hospitals, behavioral health centers, and ambulatory care health centers ($10 million).
    - Implement mock survey program:
        - Conduct program across IHS facilities of mock surveys, follow-up, and resurvey. These surveys would ensure early identification of accreditation issues and maintain survey readiness by IHS facilities. This would allow IHS management to provide critical resources and oversight to avoid more significant problems developing.
    - Provide gap analyses for at-risk facilities:
        - Fund several more in-depth gap analyses at key IHS facilities to identify accreditation and other quality issues, and then fund the development of a corrective action plan and work with the facility leadership to implement and test improvements.
    - Training and Education:
        - Funding would support the development and delivery of training/education (virtual and onsite) to IHS's federal system on

medical quality issues to ensure consistency in health care quality across the agency.
        - Training would focus on:
            - Improving local oversight of quality assurance and performance improvement.
            - Performance improvement focused on monitoring and enhancing patient safety.
            - Methods for improving experience of care.
        - Provide training and resources to support compliance with required certifications/accreditations.
        - Where requested, provide similar services to Tribal and Urban Indian Organizations.

    - Develop quality measures and reporting enhancements to existing information systems, to better leverage existing investments:
        - Funds will be used to design, refine/test, and implement quality measures, including making changes to existing data systems to automate collection/reporting.
        - In addition, work with existing IHS data systems, including Qlik reporting to enhance quality and oversight reporting.

    - Early integration of quality reporting/metrics in the IHS's Electronic Health Record modernization efforts:
        - Requested funds would support contract hours, within the existing EHR project or with an outside contractor to ensure quality reporting/metrics are integrated within the EHR modernization project. This contractor would provide a technical bridge between the IT project staff and the programmatic staff within the Office of Quality.
        - As sites are "rolled out" within the new project, these funds would support site visits and user acceptance training on quality/reporting metric-specific issues, separate from the overall EHR implementation.

- Expanded risk management activities, including process mapping and implementing system improvements to promote safety and risk mitigation
    - Identify high-risk activities that undermine the quality of care within IHS facilities, map process, and design/test system improvements.

- National Business Improvement Center: +$3 million - to establish a new program to ensure proper monitoring and management of the revenue cycle and purchase of care, ensure compliance with internal controls to maximize revenue at the national level, and quickly identify threats to the revenue cycle and proactively assist Areas/facilities to mitigate adverse outcomes.

  IHS revenue has grown tremendously in the past decade from $711 million in 2010 to nearly $1.1 billion in FY 2020, an increase of 55 percent. As these collections have grown, so has the need for additional staff and capacity for effective monitoring and oversight of these public resources.

The need for increased oversight and follow up by IHS was identified by the General Accountability Office (GAO) in a 2010 study. GAO found that IHS national monitoring activities were inadequate to ensure Area Office and Service Unit compliance with billing, collection, and debt management policies and procedures. In February 2021, GAO returned to review the third party collection process, specifically on IHS policies, guidance, and oversight.

The IHS has established policies and procedures for billing and collecting revenue from private insurers that are consistent with federal standard business processes for billings and collections. IHS lacks the necessary staff capacity to provide regular and consistent review and updates to these policies. Additional staff would enable IHS to update the policies and procedures more frequently and further assist the IHS Area Offices and Service Units in developing local policies and procedures to supplement the national guidelines.

The 2010 GAO Report also recommended improvements in analyzing available data and further developing tools to monitor and manage billings and collections, as well as developing a risk-based approach using the information obtained from the new data sources to prioritize which IHS Service Units receive future on-site compliance reviews. These funds would similarly support those efforts.

Specifically, these funds would support staffing costs and contractual services.

The NBIC will provide training and technical assistance to Area Office and Service Unit staff on Medicare, Medicaid and private insurance programs, and how to best negotiate lower rates for health care services that are contracted to the private sector. This training will be instrumental in increasing the skill sets of the employees that directly impact managing contract health fee negotiation and expanding alternate resources. Many contracted health services and third-party collection features are unique to the Indian Health system, and the training will be specifically designed for Indian Health programs. On-site technical assistance will be offered on the same subjects.

OUTPUTS/OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
20 100 percent of hospitals and outpatient clinics operated by the Indian Health Service are accredited or certified (excluding tribal and urban facilities). (Outcome)	FY 2021: 98 % Target: 100 % (Target Not Met) FY 2020: 96% Target: 100% (Target Not Met)	100 %	100 %	Maintain
44 Years of Potential Life Lost (YPLL) in the American	FY 2012: 82.7 years Target: Not Defined (Target Not In Place)	Not Defined	Not Defined	Maintain

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
Indian/Alaska Native population (Outcome)				
45 Hospital admissions per 100,000 service population for long-term complications of diabetes (Efficiency)	FY 2020: 40.02 Target: Not Defined (Target Not In Place)	Not Defined	Not Defined	Maintain
55 Nephropathy Assessed (Outcome)	FY 2021: 41.5 % Target: 45.5 % (Target Not Met but Improved) FY 2020: 38.8 % Target: 48.1 % (Target Not Met)	43.7%	45.1%	+1.4%
56 Retinopathy Exam (Outcome)	FY 2021: 41.1 % Target: 51.4 % (Target Not Met but Improved) FY 2020: 37.4 % Target: 53.5 % (Target Not Met)	41.2%	44.7%	+3.5%
57 Pap Smear Rates (Outcome)	FY 2021: 33.6 % Target: 38.4 % (Target Not Met) FY 2020: 35.3 % Target: 39.2 % (Target Not Met)	Discontinued	Discontinued	N/A
59 Colorectal Cancer Screening Rates (Outcome)	FY 2021: 27.9 % Target: 32.6 % (Target Not Met) FY 2020: 28.6 % Target: 34.7 % (Target Not Met)	Discontinued	Discontinued	N/A
66 American Indian and Alaska Native	FY 2021: 37.6 % Target:	47.8%	40.9%	-6.9%

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
patients, aged 19-35 months, receive the following childhood immunizations: 4 DTaP (diphtheria, tetanus, and acellular pertussis); 3 IPV (polio); 1 MMR (measles, mumps, rubella); 3 or 4 Hib (Haemophilus influenzae type b); 3 HepB (hepatitis B); 1 Varicella (chicken pox); 4 Pneumococcal conjugate. (Outcome)	42.8 % (Target Not Met) FY 2020: 39.9 % Target: 45.9 % (Target Not Met)			
67 Influenza Vaccination Rates among children 6 months to 17 years (Outcome)	FY 2021: 18.2 % Target: 26.6 % (Target Not Met) FY 2020: 25.7 % Target: 26.1 % (Target Not Met)	29.7%	19.8%	-9.9%
68 Influenza vaccination rates among adults 18 years and older (Outcome)	FY 2021: 18.1 % Target: 24.4 % (Target Not Met) FY 2020: 24.3 % Target: 25.4 % (Target Not Met)	28%	19.7%	-8.3%
69 Adult Composite Immunization (Output)	FY 2021: 37.5 % Target: 55.1 % (Target Not Met) FY 2020: 39.1 % Target: 59.7 % (Target Not Met)	44.4%	Discontinued	N/A
70 Statin Therapy for the Prevention and Treatment of Cardiovascular	FY 2021: 34.8 % Target: 33.3 % (Target Exceeded)	40.6%	37.8%	-2.8%

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
Disease among American Indians and Alaska Natives (Outcome)	FY 2020: 34.5 % Target: 35.7 % (Target Not Met)			
72 Tobacco Cessation Intervention (Outcome)	FY 2021: 22.5 % Target: 34 % (Target Not Met) FY 2020: 25.3 % Target: 31.4 % (Target Not Met)	29.8%	24.4%	-5.4%
73 HIV Screening Ever (Outcome)	FY 2021: 35.8 % Target: 32 % (Target Exceeded) FY 2020: 33.7 % Target: 28.4 % (Target Exceeded)	38.0%	38.9%	+0.9%
74 Breastfeeding Rates (Outcome)	FY 2021: 39.2 % Target: 40 % (Target Not Met but Improved) FY 2020: 39.3 % Target: 43.6 % (Target Not Met)	42%	42.6%	+0.6%
75 Controlling High Blood Pressure - MH (Outcome)	FY 2021: 42.1 % Target: 42.9 % (Target Not Met but Improved) FY 2020: 37.9 % Target: 52.6 % (Target Not Met)	40.9%	45.8%	+4.9%
81 Increase Intimate Partner (Domestic) Violence screening among American Indian and Alaska Native (AI/AN) Females (Outcome)	FY 2021: 27.2 % Target: 37.5 % (Target Not Met) FY 2020: 30.2 % Target:	36.3%	29.6%	-6.7%

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
	41.5 % (Target Not Met)			
87 Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. (Output)	FY 2021: 26.4 % Target: 43.4 % (Target Not Met) FY 2020: 36.9 % Target: 42.0 % (Target Not Met)	39.7%	28.7%	-11.0%
88 Colorectal Cancer Screening Rate (Outcome)	FY 2022: Result expected December 31, 2022 Target: Set baseline (Pending)	Set Baseline	Maintain Baseline	N/A
89 Cervical Cancer Screening (Outcome)	FY 2022: Result Expected Dec 31, 2022 Target: Set Baseline (Pending)	Set Baseline	Maintain Baseline	N/A
91 Adult Composite Immunization (Output)	FY 2023: Result Expected Dec 31, 2023 Target: Set Baseline (Pending)	Set Baseline	Maintain Baseline	N/A

GRANT AWARDS - H&HC funds support the Healthy Lifestyles in Youth Project,[19] a $1.3 million cooperative agreement with the National Congress of American Indians. This grant program promotes healthy lifestyles among AI/AN youth using the curriculum "Together Raising Awareness for Indian Life" at selected Boys and Girls Club sites across the country and represents responsiveness to Tribal input for more prevention activities.

H&HC also funds 83 DVP Program grants.

(whole dollars)	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget
Number of Awards	84	84	84
Average Award	$148,207	$148,207	$148,207
Range of Awards	$49,750-$1,250,000	$49,750-$1,250,000	$49,750-$1,250,000

AREA ALLOCATION

Hospital and Health Clinics

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2021 Final			FY 2022 Estimated			FY 2023 Estimated			FY '23 +/- FY '22
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$7,528	$398,421	$405,950	$8,072	427,184	$435,255	$11,324	599,296	$610,619	$175,364
Albuquerque	53,129	36,501	89,630	56,964	39,136	$96,100	79,915	54,904	$134,819	$38,719
Bemidji	23,879	97,434	121,313	25,602	104,468	$130,070	35,918	146,558	$182,476	$52,405
Billings	54,498	17,692	72,190	58,432	18,969	$77,401	81,975	26,611	$108,586	$31,185
California	5,833	83,860	89,693	6,254	89,914	$96,168	8,774	126,140	$134,914	$38,746
Great Plains	144,114	47,115	191,228	154,517	50,516	$205,033	216,772	70,869	$287,641	$82,608
Nashville	13,964	75,917	89,882	14,972	81,398	$96,370	21,005	114,193	$135,198	$38,828
Navajo	192,173	83,706	275,878	206,046	89,748	$295,794	289,061	125,908	$414,969	$119,175
Oklahoma	118,330	302,535	420,865	126,872	324,375	$451,247	177,988	455,066	$633,054	$181,807
Phoenix	117,586	88,467	206,053	126,074	94,854	$220,928	176,870	133,070	$309,940	$89,012
Portland	26,778	63,739	90,517	28,711	68,340	$97,051	40,278	95,874	$136,153	$39,102
Tucson	2,379	22,579	24,958	2,551	24,209	$26,760	3,579	33,963	$37,542	$10,782
Headquarters	159,477	0	159,477	170,989	0	$170,989	239,881		$239,883	$68,894
Total, H&HC	**$919,667**	**$1,317,966**	**$2,237,633**	**$986,059**	**$1,413,111**	**$2,399,169**	**$1,383,341**	**$1,982,451**	**$3,365,792**	**+$966,625**

Note: FY 2022 and FY 2023 are estimates.

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$2,237,633	$2,399,169	$3,365,792	+$966,623
Epi Centers	*$10,433*	*$24,793*	*$24,793*	--

Authorizing Legislation ..... 25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended

FY 2023 Authorization ..... Permanent

Allocation Method ..... Cooperative Agreements

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Tribal Epidemiology Center (TEC) Program was first authorized by Congress in fiscal year (FY) 1992. The IHS program supporting TECs was first funded in FY 1996. The program was founded to develop public health infrastructure by augmenting existing Tribal organizations with expertise in epidemiology and public health via Epidemiology Centers. Funding is distributed to the TECs through cooperative agreements to Tribes and Tribal organizations such as Indian Health Boards.

The TECs play a critical role in IHS' overall public health infrastructure. Operating within Tribal organizations and governments, TECs are uniquely positioned to provide support to local Tribal disease surveillance and control programs, and assess the effectiveness of public health programs. All TECs monitor the health status of their constituent Tribes, produce a variety of reports annually or bi-annually that describe activities and progress towards public health goals, and provide support to Tribes who self-govern their health programs.

The TEC program funds eleven TECs that provide comprehensive geographic coverage for all IHS administrative areas and one additional TEC serving American Indian and Alaska Native (AI/AN) populations residing in major urban centers nationally. The IHS Division of Epidemiology and Disease Prevention (DEDP) functions as the national coordinating center and provides technical support and guidance to TECs. The DEDP and TECs collect, analyze, interpret, and disseminate health information in addition to identifying diseases to target for intervention, suggesting strategies, and evaluating the effectiveness of implemented health interventions. The TEC Program supports Tribal communities by providing technical training and assistance in applied public health practice and prevention-oriented research, and by promoting public health career pathways for Tribal members. In FY 2021, a significant portion of TEC activities were devoted to supporting Tribes in confronting the COVID-19 public health emergency.

Annually, approximately 90 percent or more of the TEC Program budget is distributed to TECs through cooperative agreements based on a 5-year competitive award cycle. In the current 5-year award cycle

beginning FY 2021, the average annual award across all 12 TECs was $ $699,073. The current funding award cycle extends through FY 2025.

The TECs are fundamental to the IHS' partnership with Tribes through support for essential epidemiology and public health functions that complement direct healthcare services. Independent TEC goals are set as directed by their constituent Tribes and health boards. The DEDP tracks these goals and objectives as written in their cooperative agreements (e.g., surveillance of disease and control programs; collecting epidemiological data for use in determining health status of Tribal communities).

The TEC funds provide critical support in strengthening the collaborative partnerships among the 12 TECs' constituent AI/AN communities as a part of the Agency's work to address the IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2 (*Build, strengthen, and sustain collaborative relationships)* and the HHS Strategic Plan 2022-2024 Objective 4.3 (Strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions).

The work of the TECs to collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the IHS, Indian Tribes, Tribal organizations, and urban Indian organizations in each IHS service area is an essential part of meeting the IHS Goal 1, Objective 1.3, Strategy 7 (*Reduce health disparities in the AI/AN population*) by highlighting disparities in the AI/AN population so they can be reduced through Public Health efforts. This includes the significant and disproportionate health impacts of the ongoing COVID-19 pandemic, the Opioid crisis in Indian Country, and the epidemic of HIV/AIDS, HCV, and sexually transmitted diseases in AI/AN communities. Significant improvements in reducing the burden of each of these and many other health disparities in this population strongly supports the HHS Goal to *Safeguard and Improve National and Global Health Conditions and Outcomes*.

PROGRAM ACCOMPLISHMENTS

The TEC funds provide critical support in strengthening the collaborative partnerships among the 12 TECs, AI/AN communities, and the IHS *(IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2)*. Below are key TEC activities.

Data Projects that Engage Local Resources

Data generated locally and analyzed by TECs enable Tribes to evaluate Tribal and community-specific health status for planning the needs of their Tribal membership. Immediate feedback is provided to the local data systems and leads to improvements in Indian health data overall. The Indian Health Care Improvement Act (Section 130) includes language that designates the TECs as public health authorities in regards to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This designation permits TECs to access IHS-generated data sets used to support various public health activities.

Improving Public Health Data Quality and Reporting for AI/AN Communities

In public health administrative records, AI/AN people are often misidentified as another race, called racial misclassification. Racial misclassification occurs more often in AI/AN records than in records from other racial groups, which often makes it hard to accurately measure and describe the health status of AI/AN people using traditional public health data. A specific effort by the Urban Indian Health Institute TEC recently drew attention to the omission or misclassification of American Indian and Alaska Native people in current standard data collection practices by many federal, state, and local entities in the report entitled, "Best Practices for American Indian and Alaska Native Data Collection." To further TEC efforts to correct for racial misclassification to improve public health data quality, in 2019, IHS launched a pilot project with one TEC permitting the use of IHS patient registration data to correct records within

numerous existing public health data sets for AI/AN race. This TEC performed eight linkages to state public health data sets from September 2020 to April 2021, with data sets ranging in size from 1,355 records to 1,428,289 records. Misclassification of AI/AN varied widely, from 7.3 percent to 62.5 percent. AI/AN were most often misclassified as "White" race. Notably, a state-based COVID-19 disease registry misclassified 41.2 percent of IHS patients with known AI/AN status as non-Native. This work is ongoing and directly supports the IHS Strategic Plan Goal 3, Objective 3.3, Strategy 8 (*Assure system of data sharing to solidify partnerships with Tribal and urban Epidemiology Centers and other Tribal programs and Urban Indian Organizations*). This increase in information sharing with our TEC partners acknowledges and strengthens the statutory Public Health functions of the TEC program and builds on the expertise developed over the life of the program.

Based on the success of this pilot work, two other TECs have proposed similar data linkage projects within their Areas. Of these, one TEC request has been approved and has begun work, and the other is nearing the final stages of development.

Disease Surveillance and Evaluation

In the expanding environment of Tribally-operated health programs, TECs provide additional public health services, such as disease control and prevention programs, in areas such as sexually transmitted disease control, HIV, and cancer prevention.

TEC efforts build capacity in the Indian health system by evaluating and monitoring the effectiveness of health and public health programs. This allows TECs to assess access, use, and/or quality of care, and to develop recommendations for the targeting of services needed by the populations served. They manage public health information systems, investigate diseases of concern, manage disease prevention and control programs, communicate vital health information and resources, respond to public health emergencies, and coordinate these activities with other public health authorities.

Collaboration

The DEDP collaborates with the National Institutes of Health, the Centers for Disease Control and Prevention (CDC), and others to supplement TEC activities, create stronger interagency partnerships, and prevent costly duplication of effort.

TECs support national public health goals by working to improve data for the Government Performance and Results Act, agency performance reports, and monitoring of the Healthy People 2030 objectives at the Tribal level. Health status reports across all TECs will lead to a more comprehensive picture of Indian health. In the long term, these activities create opportunities for IHS to improve the delivery of services by calling attention to health disparities or concerns experienced by the population the Agency serves.

COVID-19 Response

As part of the Public Health Response to the COVID-19 emergency, TECs coordinated across their centers to hold weekly calls sharing best practices and collectively address concerns and problems, linked their websites to facilitate a single COVID-19 response webpage, and shared new tools and materials as they were developed to improve the speed of their collective response.

Using budgeted funds, TECs have conducted a range of COVID-19 response activities, including:

1) Direct responses to various technical assistance requests from Tribes.

2) Publishing COVID-19 case report and contact tracing tools.
3) Publishing community-specific fact sheets on COVID-related topics.
4) Identifying gaps in existing fact sheets and communications, including coding data and how to talk to young children about COVID-19.
5) Developing fact sheets and communication materials to address tribal needs for community education.
6) Collaborating with local command teams as part of the Public Health response to the COVID-19 crisis.
7) Developing and releasing situational awareness reports to inform Tribal governments of local caseloads, treatment capacities, and vaccination efforts.
8) Launched Weekly COVID-19 Extension for Community Healthcare Outcomes (ECHO) clinic call for providers.
9) COVID 19 Contact Tracing: IHS headquarters developed a data sharing agreement for implementation on the Area level which supports local COVID-19 contact tracing efforts. This data sharing requires sharing of patient-level, identifiable data from the IHS electronic health record (EHR) to effectively support contact tracing efforts. To date, one IHS Area-TEC partnership has established such an agreement serving the Oklahoma City Area.

The TECs collectively developed and launched a COVID-19 specific website summarizing the work of other Public Health experts and collating their response work: https://tribalepicenters.org/tec-covid-19-resources/.

As the COVID-19 response has progressed, TECs have continued to collaborate with each other, IHS, other agencies, and the communities they serve. Notable activities and successes of TECs include:

- Connected with Tribal Incident Command Structures to determine effective communication interfaces.
- Assessed immediate communication needs of communities, then created and disseminated risk communication materials.
- Developed and disseminated Service Area- level COVID-19 Situational Reports that included summary case and testing information, COVID-19 morbidity and mortality, testing locations, public health orders, etc.
- Provided COVID-19 case investigation, contact tracing and/or case/contact monitoring to communities.
- Provided COVID-19 contact tracing trainings for tribal health program staff.
- For the time period March 2020 – September 20, 2021, conducted 95 COVID-19 ECHO clinics with 10,920 attendees from throughout the US, Canada, and Guam.
- Conducted trainings on contact tracing, COVID-19 vaccine, data visualization and mapping software and displays, cultural awareness of suicide as it relates to COVID-19, and data collection.
- In response to the FDA's Emergency Use Authorization of COVID-19 Vaccines, one TEC launched a National COVID-19 Vaccine Campaign focused on creating accurate and culturally attuned COVID-19 vaccine resources. The campaign is informed by results from a National COVID-19 Vaccination Survey on the knowledge, attitudes, and beliefs among AI/ANs regarding the vaccine(s). The TEC was able to collect over 1,400 survey responses from AI/AN individuals in December 2020. To date, this program has developed several COVID-19 vaccine resources, including fact sheets on the Pfizer and Moderna vaccines, a #vacciNATION poster series for use in clinics, and a two-video series discussing COVID-19 in Native communities.
- One TEC continues to provide Tribal Nation-specific COVID-19 surveillance reports to all Tribal Nations in their IHS Area. In addition to the number of COVID-19 positive cases, the program is

reporting the percentage of the population that has been fully vaccinated for the current and past week, and the percentage of delivered COVID-19 vaccination doses that have been administered.

FUNDING HISTORY

Fiscal Year	Amount*
2019	*$4,433,361*
2020	*$5,433,361*
2021 Final	*$10,433,361*
2022 Enacted	*$24,793,361*
2023 President's Budget	*$24,793,361*

*Funded under the Hospitals & Health Clinics budget.

BUDGET REQUEST

The FY 2023 budget submission for the TECs under Hospitals and Health Clinics (H&HC) is $25 million and is the same as the FY 2022 Enacted level.

The funding per TEC covers the salaries of a Director, one full-time Epidemiologist, administrative assistance/support, evaluation capacity, Public Health response and collaboration capacity, comprehensive local Public Health planning efforts, special projects specific to disease states or local outbreaks, and the execution of additional pressing disparity projects or tribal priorities.

Tribal Epidemiology Centers and Locations		
1	Alaska Native Tribal Health Consortium	Anchorage, AK
2	Albuquerque Area Indian Health Board	Albuquerque, NM
3	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI
4	Inter-Tribal Council of Arizona	Phoenix, AZ
5	Rocky Mountain Tribal Leaders Council	Billings, MT
6	Navajo Nation Division of Health	Window Rock, AZ
7	Great Plains Tribal Chairmen's Health Board Northern Plains – Great Plains Area	Rapid City, SD
8	Northwest Portland Area Indian Health Board	Portland, OR
9	Southern Plains Tribal Health Board Foundation	Oklahoma City, OK
10	Seattle Indian Health Board	Seattle, WA
11	United South and Eastern Tribes, Inc.	Nashville, TN
12	California Rural Indian Health Board	Sacramento, CA

DISCUSSION

The TECs provide critical support to the communities they serve. In FY 2021, TECs responded to 4,870 requests for technical support (EPI-4) and completed 937 TEC-sponsored trainings for tribal public health capacity building (EPI-5). The increase in technical assistance from 2018-2019 requests and responses may reflect increased Tribal Public Health activities during the COVID-19 response. Technical support delivery was roughly sustained from 2020 activity levels. The increase in trainings and public health capacity building was supported by a significant increase in technical capacities to offer virtual training.

TEC funding strengthens the capacity to translate emerging public health strategies, resources, and information, which are critical in providing support to Tribes and necessary in quickly responding to the COVID-19 pandemic and in general public health decision-making.

Completed trainings and technical support to Tribes and Tribal organizations show the sustained efforts of the TECs to engage, train, and collaborate with the Tribes in their service area. These efforts are responsive to Tribal priorities as they are driven by Tribal requests and invitations, not directed by IHS.

GRANTS AWARDS

(whole dollars)	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget
Number of Awards	12	12	12
Average Award	$338,675	$422,000	$422,000
Range of Awards	$265,250 -$412,000	$715,000 - $1,015,000	$715,000 - $1,015,000

* Administrative and technical support of the TEC's is provided by the DEDP and is included in the average award amount.

OUTPUTS AND OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2022 Target**	**FY 2023 Target**	**FY 2023 Target +/-FY 2022 Target**
EPI-4 Number of requests for technical assistance including data requests for T/U organization, communities, or AI/AN individuals responded to. (Output)	FY 2021: 4870 Target: 1897 (Target Exceeded)	1897	1897	Maintain
EPI-5 Number of TEC-sponsored trainings and technical assistance provided to build tribal public health capacity. (Output)	FY 2021: 937 Target: 89 (Target Exceeded)	89	89	Maintain

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$2,237,633	$2,399,169	$3,365,792	+$966,623
HIT	*$182,149*	*$182,149*	*$191,149*	*+$9,000*

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

Allocation Method .....Direct Federal; PL 93-638 Tribal Contracts/Compacts, Tribal shares

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Health Information Technology (HIT) Portfolio uses secure and reliable information technology (IT) in innovative ways to improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions. IHS HIT provides support for the IHS, Tribal, and Urban (I/T/U) programs that care for 2.6 million American Indian and Alaska Native (AI/AN) people across the Indian health system. IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS HIT also supports the mission-critical health care operations of the I/T/U with comprehensive health information solutions including an Electronic Health Record (EHR) and more than eighty applications. IHS' EHR received 2015 certification for meeting requirements set by the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC), which established standards and other criteria for structured data that EHRs must use. The IHS HIT portfolio directly supports better ways to: 1) care for patients, 2) pay providers, 3) refer care when needed, 4) recover costs, and 5) distribute information, resulting in better care, wiser spending of our health dollars, and healthier communities, economy, and country.

The HIT Portfolio is dedicated to providing the most innovative, effective, cost-efficient, and secure HIT system in the federal government. The HIT portfolio is comprised of two Mission Delivery IT investments: 1) Health Information Technology Systems and Support (HITSS); 2) National Patient Information Reporting System (NPIRS); and eight Standard investments: 1) IT Management; 2) IT Security and Compliance; 3) Data Center and Cloud Standard Investment; 4) Network Standard Investment; 5) Platform Standard Investment; 6) Delivery Standard Investment; 7) End User Standard Investment; and 8) Application Standard Investment.

1) **Health Information Technology Systems and Support (HITSS)** investment provides an enterprise health information system supporting IHS Strategic Goal 2, *"To promote excellence and quality through innovation of the Indian health systems into an optimally performing organization" and* Goal 3, *"To strengthen IHS program management and operations."* The HITSS enterprise information system is the underlying IT layer of the

clinical, practice management and revenue cycle business processes at I/T/U facilities across the country and supports Objective 2.1, *"Creates quality improvement capability at all levels of the organization" and* Objective 2.2, *"Provides care to better meet the health care needs of American Indian and Alaska communities."* The HITSS investment encompasses the Resource and Patient Management System (RPMS) EHR that is certified according to criteria published by the ONC and is in use at approximately 430 health care facilities across the country in support of Objective 3.1*, " Improve communication within the organization with Tribes, Urban Indian Organizations and other stakeholders, and with the general public,* Objective 3.2, *"Secures and effectively manages the assets and resources",* and Objective 3.3, "*Modernizes information technology and the information systems to support data driven decisions."* In pursuit of expanding capabilities, the HITSS investment supports IHS Strategic Goal 1, *"To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people."* The RPMS Network is evolving to support health information sharing within the I/T/U enterprise, external connections through the eHealth Exchange, and better patient engagement to support quality initiatives and the Medicare Access & Children's Health Insurance Program Reauthorization Act (MACRA) of 2015 in support of Objective 1.3, *"Increase access to quality health care services."*

2) **National Patient Information Reporting System (NPIRS)** investment supports IHS Strategic Goal 2, "*To promote excellence and quality through innovation of the Indian health system into an optimally performing organization."* and Goal 3, *"To strengthen IHS program management and operations"*. NPIRS is an enterprise-wide data warehouse and business intelligence environment that produces standardized reports required by statute and regulation and provides a broad range of clinical and administrative information, and associated analytical tools, to managers at all levels of the Indian Health system. The NPIRS investment hosts an enterprise business intelligence and business analytics platform that promotes a data centric approach to data mining, discovery, reporting and analytics. The NPIRS BI/BA platform enables actionable insights into primary care, disease management and promotes outcome improvements that are aligned with the agencies strategic and tactical business objectives. Reporting and analytics are available at the site, area and national levels. The NPIRS enterprise information strategy leverages Business Intelligence (BI) technology to collect, manage, govern and turn data into formation for use across the agency in support of Objective, *2.1 Create quality improvement capability at all levels of the organization.* This enterprise information strategy promotes collaboration between IHS, tribes and urban stakeholders for posturing data for enterprise reporting, data sharing and assures data confidence to support I/T/U and supports Objective, *2.2 Provide care to better meet the health care needs of American Indian and Alaska Native communities".* This investment is evolving to mature the analytic platform, adding additional data domains, defining a data governance framework, adopting industry standards and best practices to exploit Business Intelligence capabilities, and is enabling IHS to produce and make more informed, quality decisions against agency-level measurement, performance and enterprise data. The NPIRS enterprise business intelligence environment leverages technology and industry best practices for enterprise information and data management to promote data accuracy and availability in support of Objective 3.3, *"modernize information technology and information systems to support data driven decisions."* In an effort to support collaboration for the expansion of services the NPIRS investment supports Strategic Goal 1, *"To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people."* The NPIRS investment is expanding services within the BI environment in a continued effort to provide reusable, shared reporting solutions that are made available in a collaborative platform to communicate enterprise

reporting solutions globally, across IHS, tribal organizations and Urban Indian programs in support of Objective 1.2, *Build, strengthen, and sustain collaborative relationships.*

3) **IT Operations** investments support IHS Strategic Goal 3, *"To strengthen IHS program management and operations"* by providing the technical infrastructure for federal, and limited tribal, healthcare facilities that is the foundation upon which all health IT services are delivered. The IT Operations program consists of six IT investments: Data Center and Cloud Standard Investment, Network Standard Investment, Platform Standard Investment, Delivery Standard Investment, End User Standard Investment, and Application Standard Investment. These investments enhance and maintain critical IT infrastructure required for HIT modernization and support Objective 3.3, *"modernize information technology and information systems to support data driven decisions."* The IT Operations program includes a highly available and secure wide area network that includes locations with unique telecommunication challenges, a national e-mail and collaboration capability that is designed specifically to support health care communication and data sharing, enterprise application services and supporting hardware including servers and end-user devices in support of Objective 3.1, *"improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public."* This program incorporates government and industry standards for the collection, processing, storage, and transmission of information and is poised to respond to new and pioneering opportunities by adopting the IT Infrastructure Library (ITIL) IT Service Management (ITSM) framework to optimize the delivery of IT services in support of Objective 3.2, *"secure and effectively manage assets and resources."*

4) **IT Security and Compliance** investment supports IHS Strategic Goal 3, *"To strengthen IHS program management and operations."* The IHS Cybersecurity Program implements security controls and assesses the efficacy of those controls annually while managing information security risk on an ongoing basis. The IHS Cybersecurity Program protects the information and information systems that support IHS operations by implementing cybersecurity policy, securing centralized resources, and providing cybersecurity training for all employees and contractors. The IHS Cybersecurity Program supports Objective 3.2, "*secures and effectively manages the assets and resources"* and Objective 3.3, *"Modernizing information technology and information systems to support data driven decisions."*

5) **IT Management** investment supports IHS Strategic Goal 3, *"To Strengthen IHS program management and operations,* Objective 3.3, *"Modernize information technology and information systems to support data driven decisions."* This investment is an enterprise-wide IT Governance program that provides IT Management, Capital Planning Investment Control, Strategic Planning, Enterprise Architecture, IT Finance, and IT Vendor Management activities for all IHS IT investments. These essential activities promote compliance with federal laws and regulations to improve efficiency and effectiveness of all IHS HIT portfolio investments.

PROGRAM ACCOMPLISHMENTS

The Office of Information Technology (OIT) successfully provided a secure and effective suite of technology solutions to support the agency and its mission throughout the country. Collaboration with tribal health programs and other federal agencies is key to the success of the HIT Portfolio. IHS works closely with the ONC, CMS, Agency for Healthcare Research and Quality, VA, and other federal entities on IT initiatives to ensure the direction of its HIT systems are consistent with other federal agencies. In addition, IHS has routinely shared HIT artifacts

(e.g., design and requirement documents, clinical quality logic, etc.) with both public and private organizations.

The Health Information Technology Systems and Support (HITSS) program completed development for the 2015 Certified Electronic Health Record criteria. Deployment of the certified software is nearly complete and will be completed by the end of FY 2021. The HITSS program supported rapid development and deployment of software updates in response to the COVID-19 pandemic to support new diagnoses code sets, laboratory testing and resulting, and vaccine administration and reporting to the Centers for Disease Control (CDC). The program's work to support COVID includes major development to provide mechanisms for centralized reporting through the AIMS portal for COVID lab testing, as well as the development of a centralized COVID vaccine reporting system, which also feeds a national dashboard available to IHS stakeholders. As part of the Agency effort for stabilization and modernization, the HITSS program is in the final stages to complete the 4 Directions Hub pilot project focused on health information exchange within government as well as the eHealth Exchange. Pilot sites are onboarded and testing is underway with the Veteran's Administration (VA). The HITSS program certified our software to the FY 2021 eCQM certification requirements, and also completed the bi-annual re-certification of Electronic Prescribing of Controlled Substances (EPCS) capabilities. The HITSS program completed a major software infrastructure database upgrade, which facilitates the ability for sites to participate in planned health information exchange and interoperability requirements that will be delivered with the 21 Century Cures Act initiative. HITSS also successfully implemented a replacement for the Immunization Forecasting software used across our facilities. In addition to the high velocity response to COVID, our HITSS program staff delivered 14 full version updates and 96 required maintenance updates across the health IT portfolio for FY 2020 and 7 full version updates and 72 required maintenance updates as of June FY 2021. In response to the social distancing guidance, IHS adjusted the delivery of training to focus on virtual offerings. The program provided 309 HIT training courses to 9,331 I/T/U users in FY 2020. As of June 2021 for FY 2021, the program provided 255 HIT training courses to 15,519 I/T/U users – the number of participants greatly increased as additional COVID focused trainings were provided. Over 477,000 messages were exchanged between patients, providers, administrators, message agents and received from external HISPs through approximately 42,660 unique direct e-mail addresses since Sept 2015. The IHS Personal Health Record (PHR) has approximately 39,500 total users, and 54 percent of these registered PHR users were verified/linked to their IHS Medical Record. The remaining 46 percent are registered but not yet verified/linked.

The National Patient Information Reporting System (NPIRS) investment leveraged its agile rapid application development and deployment lifecycle model to support the development of the IHS Disease Surveillance solutions in response to the COVID-19 pandemic. NPIRS continues to maintain COVID surveillance testing solutions that enable data collection and reporting of critical COVID-19 test data across Indian country. The agencies COIVD-19 data collection and reporting solutions enable data collection for over 300 federal, tribal and urban users and provides immediate insight into testing results at the site, area and national levels. NPIRS also created customized BI reports that are auto-generated and distributed to tribal and urban partners unable to access the national dashboard. The COVID-19 testing solution automated the process by 95 percent and alleviated massive amounts of manual data collection and reporting. NPIRS also collaborated with HHS and developed a custom data feed to support HHS Protect reporting. As part of the COVID-19 vaccination initiative, NPIRS worked closely with the HITSS Investment and the Centers for Disease Control (CDC) to define the strategy for immunization collection and reporting. NPIRS developed several business intelligence/business analytic solutions to support vaccine administration (patient and employee), vaccine manufacturer, dosage, demographic and

population information. In addition, a file management and tracking dashboard was developed that provides near real-time information on the submission of standard HL7 v2.5 messages containing patient vaccination information sent to IHS and CDC. All of the NPIRS BI/BA products enable federal, tribal and urban programs to track individual and national views (area, state, headquarters) of COVID data and enables users to validate data and identify gaps data in reporting to CDC. As part of this effort, daily office hour sessions and virtual training in the use of these products was provided to users. NPIRS developed an Opioid Surveillance dashboard for the National Committee on Heroin Opioids and Pain Efforts (HOPE) to promote appropriate and effective pain management, reduce overdose deaths from heroin and prescription opioid misuse, and improve access to culturally appropriate treatment. In support of this effort, a BDW-C Scorecard was created which provides information on data provisioning from the sites to support Opioid Surveillance. Iteration 2 of this effort continues into FY 2021. NPIRS continues to maintain and support the Enterprise BI/Analytic solutions within the Qlik Enterprise Environment to include user access support, data refresh activities and enhancements for the agency. Enterprise BI solution support is provided to headquarters program offices, tribal, urban, area, service unit, and facility stakeholders. This support enables reporting, data discovery, data mining, predictive analysis and trending of key performance indicators supporting patient care and patient care management by providing strategic actionable information to key stakeholders. NPIRS continues to facilitate and improve reporting capabilities for programs, such as the Office of Urban Indian Health Program (OUIHP) Uniform Data Set (UDS) reporting requirements, the Office of Clinical and Preventive Services (OCPS) GPRA/GPRAMA national reporting, Maternal Child Health, Partnership to Advance Tribal Health, Behavioral Health, Pharmacy reporting, and Quality initiatives. Quality initiatives include, but are not limited to the Inpatient/Outpatient Quality Reports, National Accountability for Quality, Wait Time and Improved Patient Care. In addition, extensive support has been provided to the Office of Finance and Accounting (OFA) national reporting efforts for budget execution and monitoring solutions. These efforts are ongoing and support national adhoc and recurring reporting requirements.

IT Operations completed over 350 projects and acquired over 100 products and services. Notable projects and accomplishments are as follows:

- Expanded the ServiceNow platform to standardize processes, capabilities, and service alignment across IHS. The IHS implemented the Incident Management capability across the enterprise.
- Replaced all end-of-life hardware servicing approximately 160 Active Directory Domain Controllers.
- Expanded the Virtual Private Network (VPN) solution to meet the increased telework demands caused by the COVID-19 pandemic.
- Sustained above 99.9 percent network availability across all WAN and Internet connections used by HQ and Area Offices.
- Upgraded network circuits to increase bandwidth to approximately 18 IHS facilities.
- Awarded an enterprise clinical video telehealth (CVT) solution that is cloud based, utilized the acquisition process to develop and submit an request for proposal, formed a clinical and technical panel to meet with and rate the vendor to support the selection process.

IT Cybersecurity Program has three new cybersecurity policies pending approval: Security Assessment and Authorization; Audit and Accountability; and Configuration Management. Implementation of these new policies will help ensure cybersecurity activities are defined and executed consistently across the IHS enterprise to protect both information and information systems. In response to cybercriminal efforts to launch coronavirus-related scams, the IHS

Cybersecurity Program developed a COVID Vaccine Cybersecurity Awareness Website that provides education about coronavirus scams, phishing attacks, and telework dangers employees might encounter. The website is located at: https://www.ihs.gov/oit/security/covid-vaccine-cybersecurity-awareness. The IHS Cybersecurity Program implemented a new GEO-IP blocking solution that reduces the attack landscape for various command and control malware variants, malicious websites, and denial-of-service attacks targeting IHS. The new solution disrupts traffic bound for IHS from non-NATO countries or sent to non-NATO countries from IHS resulting in a significant reduction in denial-of-service attacks. Data from existing network devices was successfully imported into Splunk to search, monitor and analyze IHS network traffic and provide transparency for network security analysis and threat awareness and remediation. In addition, the IHS Cybersecurity Program is enhancing the threat analysis capability by adding tools to inspect encrypted and plain text traffic for external and internal networks to identify, evaluate and remediate threats in real-time. The IHS Cybersecurity Program is implementing user behavior analysis to develop an anomaly based threats response strategy. We are also leveraging a centralized data integrator for log management, capturing and analyzing threats and creating automated alerts to make informed and timely decisions. Our roadmap includes leveraging technologies such as artificial intelligence and machine learning to advance threat hunting capabilities and improve risk analysis across the enterprise. Additionally, we are in the process of implementing a Security Orchestration Automation and Response (SOAR) technology that will combine the security infrastructure orchestration, playbook automation, case management capabilities and integrated threat intelligence to streamline processes and tools to respond quickly to security incidents. We continue to remediate open audit findings and weaknesses within OIT. Seven recommendations from OIG auditors have been implemented and forty-four weaknesses have been remediated through the Plan of Action and Milestones quarterly review process. IHS has responded timely to all Emergency Directives and Cybersecurity Executive Orders to ensure compliance levels are met as mandated. The IHS Cybersecurity Program has managed creation of more than 200 IHS facility backup/recovery plans for patient-care IT systems; and processed 137 new firewall rule requests and 698 annual firewall renewals.

IT Management has improved IT governance through enhanced utilization of the Planview Portfolio Management System that provides an enterprise IT portfolio and project management capability enabling IHS to improve project performance oversight and monitor corrective actions through to completion. The Planview system also provides a comprehensive Enterprise Architecture capability enabling line of sight linkage between IHS strategic goals & objectives, business capabilities, and the IT requirements needed to support those capabilities. These continued enhancements provide management tools to help ensure IHS prioritizes IT spend on investments that directly support strategic goals. OIT staff provided virtual presentations on HIT initiatives at various tribal or tribal health board conferences and meetings such as TribalNet, National Tribal Health Conference, Tribal Technical Advisory Group, National Indian Health Board (NIHB), NIHB Medicare, Medicaid, and Health Reform Policy Committee, IHS Tribal Self Governance Advisory Committee, and the Direct Service Tribes Advisory Committee quarterly meetings, etc. OIT staff regularly participated virtually in Tribal Delegation Meetings and the Alaska Area Pre-negotiation/Negotiation meetings to address IT/HIT issues. The OIT Healthcare Connect Fund Program provided support to 111 federal and 70 tribal locations. The IHS Enterprise Mobile Services Program was established and accomplished the requirements of M-16-20 by establishing enterprise contracts with AT&T FirstNet and Verizon, and has transitioned over 99 percent of all IHS mobile devices to these contracts achieving both cost savings and cost avoidance by eliminating unnecessary MiFi devices and duplicative acquisition actions.

Immediate Priorities and Challenges

The IHS HIT Portfolio continues to face increased demand for systems improvements and enhancements, rising costs, and increased IT security requirements driven in part by medical advances, and ever-growing and more complex requirements for health information technology capabilities. These requirements come from government and industry initiatives, needs of health programs, and operational requests of I/T/U health care facilities. Each new program initiative has information technology requirements for functionality, modality, data collection, and reporting which then must be added to a clinician's work flow and managed within the HIT portfolio.

A major priority of and challenge to the current HIT Portfolio is continuous improvement to and sustainment of the RPMS suite while simultaneously engaging in HIT Modernization. As described elsewhere in this document, IHS has embarked on a major, multi-year initiative to modernize its HIT solutions. The intent is to fully replace RPMS, which has its origins in the 1970s, with a modern, commercial off-the-shelf suite of applications that address the full range of capabilities that RPMS currently supports. The build and rollout of a new system to replace RPMS is expected to take 7-10 years, during which RPMS must be continuously maintained to support high-quality, safe healthcare services and revenue cycle management nationwide. This will inevitably include enhancements to remain current with the ever-changing regulatory environment, as well as to meet evolving program needs at IHS. Many of the core components of RPMS are derived from the VA's VistA system, which is also scheduled for retirement over the next several years. Choices made by the VA regarding maintenance and enhancement of VistA will affect IHS, and possibly even shift a maintenance burden to IHS if we remain dependent on components that VA no longer supports. In any case, the requirement to support a legacy system while simultaneously designing and implementing a modernized one will substantially challenge the capacity of information technology staff at all levels of the organization.

CyberSecurity challenges include minimizing unsecured systems and data to reduce the possibility of data loss, ransomware infections, identity theft, risk to patient health data, system breaches, and loss of business continuity in the event of a disaster. System breach or intrusion into an unsecure network puts patient data at risk, impacts the IHS mission by delaying or halting patient care, and harms IHS patients leading to a lack of trust in patient services.

Human resource shortages and slow staff backfill contributes to challenges in keeping up with evolving technology and new Federal, Department and Operating Division projects/initiatives including FITARA Implementation. OIT has a persistent vacancy rate of 40 percent.

FUNDING HISTORY

Fiscal Year	Amount[1]
2019	$182,149,000
2020	$182,149,000
2021 Final	$182,149,000
2022 Enacted	$182,149,000
2023 President's Budget	$191,149,000

[1]This represents the total cost of HIT within IHS federal programs. The majority is from Hospitals & Health Clinics budget line with a small amount from Direct Operations for federal personnel and travel.

TRIBAL SHARES

H&HC (IT is funded out of H&HC) funds are subject to tribal shares, currently at approximately 25 percent, and are transferred to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities. A small portion of the overall H&HC budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2023 budget submission of $191 million for Health Information Technology is +$9 million above FY 2022 Enacted level.

This funding will continue progress made in past years by minimizing infrastructure costs and maintaining a high level of productivity and commitment by both federal and contractor staff supporting the IHS-developed health information solutions. IHS uses open source tools where possible to minimize acquisition costs. Following the VA announcement to sunset their VistA EHR application the IHS and HHS CTO began an analysis of alternatives to assess the sustainability of the entire RPMS HIT platform. The HHS-IHS HIT Modernization Research Project was completed in FY 2020 to examine alternatives to replace or modify RPMS as the IHS HIT platform. The HIT Modernization Project identified the need to change the current EHR platform to a modern commercial-off-the-shelf (COTS) EHR that will improve the impact and quality of direct patient care, increase cost recovery and promote continuous health improvements such as, expanded telehealth care services and predictive population health analytics. These potential returns highlight the value of health IT and its impact on the agency mission.

FY 2023 Funding Increase of $9 million includes:

General Increase: +$9 million to support new FTE and existing salary costs. Funding for the Office of Information Technology has remained stagnant for the last 10 years, and pay costs and tribal shares have impacted the ability of this critical program to support its full salary cost and hire the staff necessary to ensure appropriate operations at the Agency. During this time demand for IT services, and costs associated with new IT requirements have grown significantly. As a result of stagnating funding and increasing demands, the IHS has delayed performing routine maintenance and system upgrades, and many systems are beyond their industry best practices life cycle, while trying to preserve funding for existing staff salaries. This creates unnecessary risk for all IHS programs that rely on digital capabilities.

Currently, the IHS has enough funding to support approximately 51 of the 75 staff currently supported by the Health Information Technology budget. The IHS charges costs to the Area Offices where appropriate to address the funding gap, but this is not a sustainable approach. In addition to the 75 current FTE, an additional 20 FTE are required to appropriately manage the Health Information Technology workload.

The requested funding would bolster the existing Health IT budget, supporting salary costs, alleviating pressure on needed upgrades and modifications, and onboarding additional FTE to ensure that IHS digital capabilities can support key management and oversight functions, and support high quality care.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
HIT-1 OMB IT Dashboard - All IHS Major Investments will Maintain a score of 4/5 or greater (Outcome)	FY 2020: 3.0 Target: 4.0[2] (Target Not Met)	4.0	3.0	-1

[2] >=t of 5 for all investments.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
ELECTRONIC HEALTH RECORD SYSTEM

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$34,500	$145,019	$284,500	+$139,481
FTE*	6	106	178	+72

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

Allocation Method .....Direct Federal; PL 93-638 Tribal Contracts/Compacts, Tribal shares

PROGRAM DESCRIPTION

Electronic Health Record System Modernization - The health information technology (HIT) system currently in use at IHS is the Resource and Patient Management System (RPMS), a comprehensive health information suite that supports a broad range of clinical, population health, and business processes from patient registration through the billing cycle. RPMS was internally developed by IHS, leveraging a decades-long collaboration with the Department of Veterans Affairs (VA), and is certified to the 2015 Edition criteria published by the Office of the National Coordinator for Health Information Technology (ONC). In recent years, advances in health-related standards and technologies, an increasingly complex regulatory environment around HIT, and the decision of the VA to move to a commercial off-the-shelf HIT solution, have combined to make the current approach to IHS HIT development and support non-sustainable going forward. In 2018-19, IHS, in collaboration with HHS, engaged in comprehensive research and analysis of the current state of its HIT infrastructure and options for modernization. Informed by the outcomes of that project, IHS has published its intent to move forward with modernization by transitioning from its legacy RPMS to state of the art, commercial off-the-shelf systems. The approach to modernization is not limited to an Electronic Health Record (EHR), but must support a true enterprise approach to HIT, enabling the highest quality inpatient, ambulatory, behavioral health, dental, pharmacy, laboratory, imaging, referral, and revenue cycle services, with standards-based interoperability and analytics capabilities, positioning IHS in the best possible way to accomplish its mission in the coming years. The replacement of RPMS support the HHS Strategic Goal 4 "Restore Trust and Accelerate Advancements in Science and Research for All" and HHS Strategic Goal 5 "Advance Strategic Management to Build Trust, Transparency, and Accountability"

In early FY 2021, the IHS executed a Task Order to the Centers for Medicare and Medicaid Services (CMS) Alliance to Modernize Healthcare Federally Funded Research and Development Center (Health FFRDC) to formally launch the IHS health IT modernization initiative. The Health FFRDC, managed by the MITRE Corporation, is responsible for standing up the Program Management Office, supporting the governance structure for the initiative, assisting with acquisition planning, market research, stakeholder engagement, communication, and numerous other aspects of the initiative. IHS issued Requests for Information (RFI) from industry and one

or more subsequent Requests for Proposals (RFP) before the end of FY 2022, with an intent to award initial HIT modernization contracts in early FY 2023. In the meantime, IHS will be adding permanent staff to manage the numerous aspects of HIT modernization that are inherently federal and will need to be sustained for the foreseeable future.

IT Infrastructure and Operations Modernization - Significant improvements are required in order for the information technology (IT) infrastructure at IHS to fully support the deployment of a new, modern HIT solution. IHS must enhance cybersecurity, improve IT service management, expand storage and computing capacity, and increase network bandwidth at dozens of rural locations to enable a successful EHR transformation. IT operations throughout IHS will need to be managed and coordinated more effectively to successfully execute a complex modernization project. Part of the work tasked to the Health FFRDC referenced above is a comprehensive analysis of infrastructure gaps, conducted in collaboration with the IHS technology operations staff. This analysis will facilitate planning and prioritization of infrastructure upgrades in preparation for EHR modernization (HHS Objective 5.4: Ensure the security and climate resiliency of HHS facilities, technology, data, and information, while advancing environment-friendly practices.)

Current active projects in support of the modernization goal include establishing a national hub for connection to the eHealth Exchange in order to support health information exchange (HIE) with the VA, Department of Defense, and other external partners, as well as leveraging the experience of COVID-19 to improve the agency's capabilities for enterprise reporting of immunizations, laboratory results, and public health notifications to state and federal entities (HHS Objective 2.2: Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines.)

The IHS Modernization of Health IT System & Support (mHITSS) investment is the primary mechanism IHS will utilize to modernize HIT in support of IHS Strategic Plan Goal 3, Objective 3.3, *"Modernize information technology and information systems to support data driven decisions" (HHS Goals 1,2,4&5)*.

FUNDING HISTORY

Fiscal Year	Amount
2019	$0
2020	$8,000,000
2021 Final	$34,500,000
2022 Enacted	$145,019,000
2023 President's Budget	$284,500,000

BUDGET REQUEST

The FY 2023 budget submission for Electronic Health Record Modernization is $285 million. This is an increase of $140 million above the FY 2022 Enacted level.

The current IHS electronic health record is over 50 years old, and the GAO identifies it as one of the 10 most critical federal legacy systems in need of modernization. The IHS relies on its electronic health record for all aspects of patient care, including the patient record, prescriptions, care referrals, and billing public and private insurance for over $1 billion reimbursable health care services annually. Depending on the availability of appropriations, the IHS expects to begin the site implementation phase in FY 2023, which will require significant additional resources to

analyze the needs of hundreds of sites, implement the new system, replace outdated equipment, and other related steps.

This funding will lay the groundwork to improve the quality of care, reduce the cost of care, promote interoperability, simplify IT service management, increase the security of patient data, enhance cybersecurity, and update infrastructure across rural locations to enable a successful Electronic Health Record transition. This will include the continuation of project management operations, acquisition planning, EHR selection, additional tribal consultation, initial infrastructure build, site implementation planning, and continued RPMS stabilization and support. The project will follow industry standards for modernization or replacement of Electronic Health Record systems to leverage expertise and experience in the private sector (HHS Objective 5.3: Uphold effective and innovative human capital resource management resulting in an engaged, diverse workforce with the skills and competencies to accomplish the HHS mission.) This effort directly supports IHS's entire Strategic Goals structure.

- Health Information Technology Modernization – The IHS Health Information Technology Modernization effort will use the additional FY 2023 resources to execute several core activities in FY 2023. Specifically, the IHS expects to address the following:

    - RPMS Stabilization: IHS will complete updates to the legacy systems to achieve compliance with the 21st Century Cures updates for 2015 Edition ONC certification. Significant development, testing, patching, rollout and training efforts will be required, using expanded contract resources.
    - Interoperability: The IHS will complete its interoperability pilot in FY 2023, and then begin a national rollout to enable exchange both within the IHS enterprise and with external referral network partners. This effort will require substantial testing with partners as sites are on-boarded in order to ensure seamless and accurate interoperability (HHS Objective 4.4: Improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience.)
    - Immunization Information Systems: The IHS is planning additional initiatives to move certain capabilities from the local to the enterprise level, including centralized systems to accomplish exchange with state immunization information systems and reporting to public health agencies (HHS Objective 2.2: Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines.)
    - Initial Build of EHR Environment: With a vendor selection for the new EHR system in early FY 2022, work will begin on the design and build steps, to prepare the commercial system for operation in the IHS environment. This activity typically takes twelve months with significant resources required to convene and gather input from subject matter experts across a range of disciplines and move decisions that could number in the thousands through governance processes to meet the agency's configuration requirements.
    - Local Needs: Once the IHS selects an EHR product, the Agency can define the technology architecture required for optimal performance of and support for the system. The IHS can then target identified gaps at local facilities and in the wide

area network and hosting systems. This effort will include both capital (equipment) and resource (contract) costs.

- Initial Site(s) Transition Planning: Resources will support the development of a core planning template and master deployment schedule. This will also accommodate individual site planning using the template to address technology infrastructure remediation, site configuration, end user training, change management, communication, and stakeholder engagement at the local level near the deployment target for each site. Many of these activities need to be completed in a short amount of time immediately prior to a site's go-live.

The IHS anticipates building the enterprise solution and preparing and planning site deployments in FY 2023.

- This project holds an extremely high degree of mission criticality given the ability to provide much-anticipated clinical and administrative capabilities used in modern systems for the delivery of timely and impactful healthcare. Expected benefits from adopting and implementing a modernized system include, but are not limited to: improved patient safety, improved patient outcomes, better disease management, enhanced population health, improved clinical quality measures, opioid tracking, patient data exchange, third party revenue generation, agency performance reporting, and more. Additionally, the IHS intends to achieve the best possible interoperability with the Department of Veterans Affairs, Department of Defense, Tribal and Urban Indian health programs, academic affiliates, and community partners, many of whom use different HIT platforms. The IHS must acquire a state-of-the-art EHR system that supports a true enterprise approach to HIT, enabling the highest quality inpatient, ambulatory, behavioral health and other ancillary healthcare and business office services, with standards-based interoperability and analytics capabilities, positioning IHS in the best possible way to accomplish its mission in the coming years.

  During the estimated 10-year implementation, IHS expects to temporarily increase the HIT workforce to acquire and implement this system (HHS Objective 1.5: Bolster the health workforce to ensure delivery of quality services and care.)

- IHS Legacy EHR System Modernization - The current IHS EHR, Resource and Patient Management System (RPMS), has been identified by the Government Accountability Office as one of HHS's top three systems in most need of modernization due to lack of development and enhancement work over the past decade. IHS must maintain the existing EHR system until implementation of the new system is complete.

- IT Infrastructure and Operations Modernization - These IT Infrastructure Modernization initiatives are required to provide the platform for which the EHR operates and support redundancy capacity. IHS Strategic Goal 1, Objective 1.2, *"Build, strengthen, and sustain collaborative relationships."*

IHS will build a mature governance body to ensure the enterprise HIT investment is properly maintained and configured nationwide. IHS Strategic Goal 2, Objective 2.1 *"Create quality improvement capability at all levels of the organization"*, and Objective 2.2, *"Provide care to better meet the health care needs of American Indian and Alaska Native communities."*

The Dentrix software will be upgraded nationwide to coordinate care in a national enterprise HIT environment. Additionally, funding will allow for improved recruitment and retention of providers and reduced industry risk by adopting standards and systems used by a broader base of healthcare systems. IHS Strategic Goal 3, Objective 3.3, *"Modernize information technology and information systems to support data driven decisions."*

Funding will allow for improved revenue from third party payers, improved training through standardized user interfaces and integration across health facilities, reduced workload to support the infrastructure, and improved quality and operational oversight through improved national reporting and data analytics (HHS Objective 5.2: Sustain strong financial stewardship of HHS resources to foster prudent use of resources, accountability, and public trust.)

OUTPUTS/OUTCOMES

As IHS reviews options, costs, and potential benefits; output and outcome measures will be developed. The new EHR environment will support existing measures for the Government Performance and Results Act (GPRA) and electronic quality measures to support healthcare accreditation.

GRANT AWARDS

Not applicable to this funding.

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

(Dollars in Thousands)

	FY 2022	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$214,687	$235,788	$309,193	+$73,405
FTE*	530	585	681	+96

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The purpose of the Indian Health Service (IHS) Dental Health Program (DHP) is to raise the oral health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level through the provision of quality preventive and treatment services, at both community and clinic sites. The DHP is a service-oriented program providing basic dental services (e.g., diagnostic, emergency, preventive, and basic restorative care), which represents approximately 90 percent of the dental services provided. In FY 2021, the DHP provided a total of 2,594,836 basic dental services, only a slight decline from FY 2020, in which the DHP provided 2,595,059 services. These two years marked a 36 percent decline in services when compared to pre-pandemic levels, and during the pandemic many programs provided fewer services due to dentists and staff providing non-dental pandemic-related services and providing fewer dental services because of the incorporation of new infection control and prevention pandemic-related mitigation strategies. More complex rehabilitative care (e.g., root canals, crowns and bridges, dentures, and surgical extractions) is provided where resources allow and accounted for the additional 192,372 dental services in FY 2021, a 7 percent increase from FY 2020 but still a 30 percent drop from FY 2019 pre-pandemic levels. The DHP provided these services through 886,266dental visits in FY 2021, a 3 percent drop from FY 2020, again due to factors such as deployment of dental staff to non-dental pandemic roles (vaccinations, contact tracing, etc.) and the increased time DHP clinics took to implement new infection control and prevention procedures caused by the pandemic.

Across all age groups, AI/ANs suffer disproportionately from dental disease. When compared to other racial or ethnic groups, AI/AN children 2-5 years old have more than double the number of decayed teeth and overall dental caries experience as the next highest ethnic group, U.S. Hispanics, and more than four times that of U.S. white children.[1] In the 6-9 year-old age group,

[1] Phipps KR, Ricks TL, Mork NP, and Lozon TL. The oral health of American Indian and Alaska Native children aged 1-5 years: results of the 2018-19 IHS oral health survey. Indian Health Service data brief. Rockville, MD: U.S. Department of Health and Human Services. Indian Health Service, 2019.

8 out of 10 AI/AN children have a history of dental caries compared with only 45 percent of the general U.S. population, and almost half of AI/AN children have untreated tooth decay compared to just 17 percent of the general U.S. population in this age group.[2] In the 13-15 year-old age group, three out of four AI/AN dental clinic patients have a history of tooth decay, compared to half of 13-15 year-olds in the general U.S. population, and almost three times as many 13-15 year-old AI/AN youth have untreated decay compared to the general U.S. population.[3] In adults, the disparity in disease is equally as pronounced. 64 percent of AI/AN adults 35-49 years have untreated decay compared to just 27 percent of the general U.S. population, and across all other age groups studied (50-64 years, 65-74 years, and 75 and older), AI/AN adults have more than double the prevalence of untreated tooth decay as the general U.S. population. In addition, the rate of severe periodontal disease in AI/AN adults is almost double that of the general U.S. population.[4]

Prevention activities improve health and reduce the amount and cost of subsequent dental care. The DHP measures performance in part through the delivery of preventive services. The DHP maintains data and tracks three key program objectives:

1. Increase the proportion of 2-15 year-olds with dental sealants;
2. Increase the proportion of 1-15 year-olds receiving at least one application of topical fluorides; and
3. Increase access to care across all age groups.

The DHP funds provide critical support for direct health care services focused upon strengthening the collaborative partnerships among direct care providers, patients, communities, and internal and external stakeholders. Funds are utilized to ensure IHS, Tribal, and urban Indian health organizations have comprehensive, culturally appropriate services and personnel available and accessible, promotes excellence and quality through implemented quality improvement strategies, and strengthens the IHS program management and operations to address health disparities and raise the health status of AI/AN populations to the highest level possible.

The DHP provides critical services in support of the IHS Strategic Plan FY 2019-2023 (IHS SP) and the HHS Draft Strategic Plan (HHS Draft SP). Dental services are important in ensuring comprehensive, culturally appropriate personal and public health services are available to AI/AN people (IHS SP Goal 1). DHP implements several efforts to improve quality (IHS SP Goal 2) of dental health services and in strengthening management and operations (IHS SP Goal 3). Central to DHP efforts is support of cross-collaboration and partnerships among I/T/U stakeholders (IHS SP Objective 1.2). The DHP provides essential services to increase dental health access and education which supports the HHS SP Draft Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Health Care, and Draft Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability. The program accomplishments section below provides details about DHP efforts.

[2] Phipps KR and Ricks TL. The Oral Health of American Indian and Alaska Native children aged 6-9 years: results of the 2016-2017 IHS oral health survey. Indian Health Service data brief. Rockville, MD: U.S. Department of Health and Human Services. Indian Health Service 2017.
[3] Phipps KR, Ricks TL, Mork NP, Lozon TL. The Oral Health of 13-15 year old American Indian and Alaska Native (AI/AN) Dental Clinic Patients – A Follow-Up report to the 2013 Survey. Indian Health Service data brief. Rockville, MD: Indian Health Service 2020.
[4] Phipps KR and Ricks TL. The Oral Health of American Indian and Alaska Native adult dental patients; results of the 2015 IHS oral health survey. Indian Health Service data brief. Rockville, MD: Indian Health Service 2016.

PROGRAM ACCOMPLISHMENTS

Early Childhood Caries Collaborative

The IHS Early Childhood Caries (ECC) Collaborative was a nationwide initiative that was conducted from 2009 to 2017 and focused on preventing tooth decay in AI/AN children under the age of 71 months. Dental caries are the most common health problem in children, almost eight times more common than childhood asthma, and have significant consequences such as delayed speech development, more missed school days when children begin school, poor self-esteem, and a greater chance of tooth decay in permanent teeth.[5] As previously described, AI/AN children suffer disproportionately from this disease, with more than double the number of decayed teeth as the next highest minority population, U.S. Hispanics, and more than 3 times the number of decayed teeth as U.S. White children.[6] The ECC Collaborative began with the goal of reducing dental caries in the AI/AN population through a coordinated, nationwide collaborative utilizing not only dental programs but also medical and community partners such as medical providers, public health nurses, community health representatives, pharmacists, and Head Start teachers. (*Supports IHS SP 1.2 and HHS Draft SP Objective1.2: Reduce costs, improve quality of health-care services, and ensure access to safe medical devices and drugs*.) By the end of this collaborative, the IHS had increased access to dental care for AI/AN children under 71 months by 7.9 percent and significantly increased prevention and early intervention efforts (sealants increased by 65.0 percent, the number of children receiving fluoride varnish increased by 68.2 percent, and the number of therapeutic fillings increased by 161 percent). (*Supports IHS SP Objective 1.3: Increase access to quality health care services; and HHS Draft SP Objective 1.3: Expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while recognizing social determinants of health.*) This resulted in a 5 percent reduction in caries (tooth decay) experience from 2010 to 2019, and a 14 percent reduction in untreated decay in 1-5 year-olds (with statistical significance) at a national level; in addition, the Navajo, Oklahoma City, and Phoenix Areas had statistically significant reductions in caries experience from 2010 to 2019. (*Supports the IHS SP Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization, IHS Objective 2.2: Provide care to better meet the health care needs of American Indian and Alaska Native communities; and HHS SP Objective1.2.)* This represents the first recorded decrease in tooth decay in young children in the IHS and is evidence of success of the Early Childhood Caries Collaborative. Furthermore, this success has impacted older children: the 2016-17 survey of 6-9 year-old children showed that caries experience decreased from 92 percent to 87 percent in this age group from 1999 to 2016-17, while untreated caries decreased from 73 percent to 47 percent over the same time period. These data represent the first recorded decrease in tooth decay in this age group as well and reflects positively on the ECC Collaborative and the ongoing prevention efforts of the DHP focusing on schoolchildren. Since the Collaborative ended in 2017, the core concepts – early access to dental care, fluoride varnish applications three to four times a year, dental sealants in primary teeth, and interim therapeutic restorations – have all been institutionalized across the system. In FY 2018 and FY 2019, access to dental care, fluoride varnish, sealants, and interim therapeutic restorations all continued to be performed across the system at the same level as the 2009-2017 time period. However, the pandemic caused a steep decline in these services, and the problem was exacerbated by this age group (1-5year-olds) not being able to receive COVID-19 vaccinations. Consequently, access to dental care for 1-5 year-olds decreased by 61 percent from the 2009-2019 time period to FY 2021, dental sealants decreased by 69 percent over the same time period, fluoride varnish

application decreased by 58 percent over the same time period, and the interim therapeutic restorations decreased by 67 percent over the same time period.

Dental Clinical and Preventive Support Centers

In recent years, the DHP has utilized field dental programs in conjunction with its Dental Clinical and Preventive Support Centers (DSC) to achieve national performance objectives, support IHS Area initiatives, and support the IHS Strategic Plan for FY 2019-2023. (*Supports IHS SP Objective 1.2 and HHS SP Objective1.2*.) The DSCs were designed and implemented in FY 2000 to augment the dental public health infrastructure necessary to best meet the oral health needs of AI/AN communities. The current five-year funding cycle began December 1, 2020, with six DSCs funded through grants and three DSCs funded through program awards. In FY 2021, the Division of Oral Health received an additional $1,000,000 to increase the number of DSCs. The increase in FY 2021 funding allowed for the establishment of a ninth DSC and allowed each DSC to receive an increased amount of annual funding, resulting in an expansion of services to AI/AN communities in all twelve IHS Areas. Expansion of the number of DSCs, utilizing best practices learned from the existing DCSs, will assist in controlling oral disease and decrease oral health disparities experienced in susceptible or high-risk populations. In FY 2022 an additional $1,000,000 was received and will assist the 9 DCPSCs to continue to expand the services provided to AI/AN communities. The primary purpose of a DSC is to provide technical support, training, and assistance in clinical and preventive aspects of dental programs providing care to AI/AN communities. As a direct result of the advocacy efforts of the DSCs, the number of key preventive procedures such as fluoride and sealant applications have been maintained throughout the last decade. In FY 2013, the DHP began tracking the coverage or prevalence of children and adolescents receiving sealants and topical fluoride, rather than simply counting dental procedures. These assessments allow improved comparisons with data from the U.S. population compiled by the Healthy People 2030 initiative.

DSCs were initially funded in FY 2000. In the ensuing years, the DSCs have had an immediate positive impact on the direct delivery of dental care in a number of ways:

- All DSCs advocated for an appropriate focus on the dental Government Performance and Results Act (GPRA) performance objectives to increase specific clinical and community-based oral health services.
- All DSCs provided continuing education opportunities for clinical staff to enhance the quality of care delivered.
- Several DSCs provided on-site clinical and community based program reviews to enhance the quality of care, assuring that field programs maintain a high level of expertise with respect to challenges such as infection control, preparing for program accreditation and certification reviews, and patient scheduling practices aimed at maximizing access to care.
- Several DSCs provided an array of health education materials or designed materials customized to the specific needs of the IHS Areas they serve. These materials have increased the quality and quantity of IHS oral health education efforts throughout Indian Country.
- Several DSCs provided or arranged for direct clinical services that otherwise would not have been provided.
- By providing clinical support in collaboration with IHS Area Dental Officers, the DSCs have contributed to a 70 percent increase in basic dental services (2.44 million in FY 2001 to 4.16 million in FY 2019) over the first 19 years of their existence.

Dental Health Data

Access to dental services is a prerequisite to the control of oral disease in susceptible or high-risk populations. The access to care GPRA objective is aligned with the Healthy People 2030 methodology as a percentage of patients who have visited the dentist within the previous 12 months. (*GPRA measure data supports the IHS SP Objective 1.3 and HHS SP Objective1.3.*) Unfortunately, the COVID-19 pandemic greatly affected dental care to the AI/AN population. Most IHS facilities ceased routine care, including preventive services, beginning in mid-March 2020, and while a few began to re-open routine care in late May 2020, a substantial number of dental facilities continued to provide emergency or scaled back services well into FY 2021. The dentist to population ratio in the IHS system continues to be very low when compared to the ratio in the U.S. private sector. This low dentist to population ratio and an increase in population growth in the AI/AN population will continue to present a challenge in achieving the access rate goal. The IHS has 1,058 dentists (including part-time) in the system, according to the IHS Dental Directory.[7] In 2019, there were 3,015,921 AI/AN in the U.S., according to the most recent user population estimate.[8] That means that the IHS system has approximately 1 dentist per 2,850 patients served. According to the U.S. Bureau of Labor Statistics, there were an estimated 139,200 dentists in the U.S. in 2021[9] serving a population of 331,893,745,[10] meaning that there is approximately 1 dentist per 2,384 people served.

The DHP continues to assess the care provided by its programs through a robust, continuing oral health surveillance program that started in 2010 and is planned through 2030. (*Supports the IHS SP Goal 3: To Strengthen IHS program management and operations through Objective 3.3: Modernize information technology and information systems to support data driven decision. It also supports the HHS Draft Strategic Plan Goal 4: Restore trust and accelerate advancements in science and research for all through HHS Draft Objective 4.3: Strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions.)* 0-5 year-old AI/AN children were surveyed in 2010, 2014, and 2018-19; 6-9 year-old children were surveyed in 2011-12 and 2016-17: 13-15 year-old youth were surveyed in 2013 and 2019-20; and AI/AN adults were surveyed in 2015. In FY 2021, the DHP is once again conducting surveillance of AI/AN adults with over 80 programs participating and a final data brief expected in late 2022. The surveillance program has been used as a model nationally and helps highlight disparities in disease burden and distribution in the AI/AN population. Results of all surveys can be found in data briefs located on the IHS Dental Portal at www.ihs.gov/doh, and data from this surveillance program is also included in the CDC National Oral Health Surveillance System, allowing public health advocates to compare AI/AN disease prevalence with individual state or national data.

Dental Health Service Delivery Improvements

The DHP continues to make significant improvements in the way dental services are delivered. Through support of implementation of an electronic dental record (EDR), over 82 percent of IHS Federal, Tribal, and Urban (I/T/U) dental clinics have transitioned to an EDR system to support the delivery of effective quality dental services. The IHS Dentrix Enterprise (DXE) EDR program has been successfully implemented at 274 of these I/T/U dental clinics. There remains

[7] Indian Health Service, Department of Health and Human Services. IHS Dental Directory Report. www.ihs.gov/doh, accessed 15 March 2022.
[8] Indian Health Service, Department of Health and Human Services. User Population Estimates – FY 2019 Final, Revised 12/27/19.
[9] Bureau of Labor Statistics, U.S. Department of Labor. Occupational Outlook Handbook: Dentists. https://www.bls.gov/ooh/healthcare/dentists.htm, accessed 15 March 2022.
[10] U.S. Census Bureau. Population Estimates, July 1, 2021. https://www.census.gov/quickfacts/fact/table/US/PST045217, accessed 15 March 2022.

approximately 40 IHS clinics that have not transitioned to an EDR system. The EDR capability provides accurate data collection and dissemination through the IHS National Data Warehouse. This data supports evaluation of Oral Health Initiatives such as the Early Childhood Caries collaborative and future data development could improve outcome measurements. In FY 2020, the DHP received a $2 million appropriation to supplement the DHP-provided funds for the EDR project to complete additional implementations. For FY 2021, a funding increase of $500,000 was received to support new EDR implementations, enhance the EDR including interfaces with multiple electronic health record (EHR) and other healthcare network systems. In FY 2022, a funding increase of $1,000,000 was received to continue to support new EDR implementations and continue to enhancements to the EDR and provide necessary updates. Despite the pandemic-related travel restrictions, the DHP EDR Implementation and Support contract (EDR Contract) was able to install the IHS version of Dentrix for 13 new locations in FY 2021. In addition, the increased $2.5 million funding allowed the DHP to assist 144 I/T/U clinics to upgrade to Windows 10 supported Dentrix versions. This upgrade to Windows 10 supported versions is necessary for all 274 IHS Dentrix-using sites to ensure patient data is safely processed and archived. As the funds are expected to be recurring annually, the plan is to enhance the EDR as follows: in addition to the 9-12 more new EDR implementations each year, the DHP expects to support all I/T/U clinics to upgrade to the Windows 10 supported and most current versions of the IHS Dentrix Enterprise EDR system. The additional funding will also be used to enhance reporting capability for the IHS individual patient-based Oral Health Status (OHS) measure that allows the local clinic to identify patients in need of urgent and/or preventive oral health care. Additional IHS-specific EDR development in FY 2020-2021 included the development of several IHS Dentrix EDR to EHR systems used by Tribal and Urban medical clinics that do not use the IHS Resource, Patient, and Management System (RPMS) EHR program. Other IHS Dentrix EDR developments include: standardized Provider Clinical Notes templates (to streamline accurate patient treatment notes in the EDR); standardized data reporting updates; Dentrix scanned document QA review; and additional Quality of Care review reports. Additional improvements in billing capabilities could increase third party collections for all I/T/U dental clinics. (*Supports IHS SP Goal 3: To Strengthen IHS program management and Operations through Objective 3.3: Modernize information technology and information systems to support data driven decisions. It also supports the HHS Draft Strategic Plan Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability through HHS Draft Objective 5.2: Sustain strong financial stewardship of HHS resources to foster prudent use of resources, accountability, and public trust.)* A second way the DHP has improved the delivery of care is through ongoing support of long-term training (LTT) of general dentists to build the cadre of dental specialists in the IHS and tribal dental programs. (*The DHP LTT program supports the IHS SP Objective 1.1: Recruit, develop, and retain a dedicated, competent, and caring workforce, and HHS Draft SP Objective1.5: Bolster the primary and preventive health care workforce to ensure delivery of quality services and care.*) Dentists completing DHP- sponsored LTT to become specialist such as pediatric dentists, periodontists, and endodontists have a service payback obligation to serve AI/AN patients. In the past 5 years, an Oral Maxillofacial Surgeon and seven pediatric dentists have returned from LTT to serve AI/AN patients. A third way the DHP is improving the delivery of services is through the adoption of an integrated care model, specifically in promoting depression screenings by dental health providers through a collaboration with the IHS Behavioral Health Program. (*The collaborative efforts between the DHP and the IHS Behavioral Health Program to improve the delivery of services support the IHS SP Objective 2.1. These 2 accomplishments also support the HHS Draft SP Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families.)*

The DHP continues to improve the delivery of services is through a sustained (20+ years) continuing dental education (CDE) program. The IHS CDE program provides high quality continuing education accredited through the American Dental Association Continuing Education Provider Recognition Program. In FY 2021, despite a significant decrease of in-person educational opportunities due to the ongoing pandemic, the IHS CDE program still accounted for 263 courses, offering 1,177 hours of training. Subsequently, 1934 dentists participated in the CDE program as well as 1,787 dental hygienists and dental assistants and a total of 26,588 hours of CDE credits were awarded to dental staff working in IHS, Tribal, and Urban dental programs. In the past, one CDE credit has been estimated to be valued between $100 -$200. This valuation includes the equivalent tuition cost that would be incurred seeking CDE in the private sector and the cost of the time and travel away from the office to attend CDE outside the IHS CDE program. Therefore, the total financial benefit to the IHS from the CDE Program in FY 2021 was between $2.6 and $5.2 million. Since 2016, the IHS CDE Program has provided over $32.2 million in free CDE through over 1,500 CDE courses. The accomplishments of this program over the last 6 years ranks it as one of the largest CDE programs in the country within and outside of the federal government.

The DHP has also been the largest trainer of expanded function dental assistants (EFDA) in the Nation. The EFDA workforce model was introduced to the profession in 1961 by the IHS. EFDAs are trained and certified dental assistants with competencies to allow them to perform simple dental cleanings and fillings under the general supervision of a dentist, thereby increasing productivity , efficiency, and effectiveness of IHS, tribal, and urban dental programs. Since 2016, the IHS CDE Program has held 110 different in-person EFDA courses that have resulted in 557 dental assistants initiating EFDA training (over one-fourth of the dental assistant workforce) and 483 completing the training and certification requirements. The models of expanded function dental assistants have been shown to increase access to dental care in the DHP by up to 3.0 percent, increase total services delivered by dental programs up to 5.1 percent, and increase the total services per patient visit by up to 14 percent. *(The DHP CDE program supports the IHS SP Objective 2.1 through strategies that focus on providing training, coaching, and mentoring to ensure quality improvement and accountability of staff at all levels of the organization. The DHP continues to evaluate training efforts and staff implementation of improvements, as appropriate. The DHP CDE program also supports the HHS Draft SP Objective 1.2.)*

The DHP continues to be on the forefront of hot issues in public health dentistry. The DHP, through the CDE Program, addressed public health issues such as antibiotic stewardship, opioid overdose reversal in dental settings, managing opioid use disorder through medication-assisted therapy, the growing threat of e-cigarettes in adolescents, community water fluoridation, the phase-down of dental amalgam, the new periodontal disease classification standards, improving oral health literacy, issues related to COVID-19 and oral health, silver diamine fluoride (SDF), and the integration of oral health and primary care. Additionally, the DHP developed new guidelines on the use of SDF for dental caries arrest and initiated new projects including integration of prevention services by medical providers to use SDF, and a summary of initiatives and guidelines that can be viewed at the IHS Dental Portal at www.ihs.gov/doh. (*The IHS Pain Management Guidelines support the IHS SP Objective 1.3 and HHS Draft SP Objective1.3.*)

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic

whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount
2019	$197,949,000
2020	$210,602,000
2021 Final	$214,687,000
2022 Enacted	$235,788,000
2023 President's Budget	$309,193,000

TRIBAL SHARES

Dental funds are subject to tribal shares and are transferred to tribes when they assume the responsibility for operating the associated programs, functions, services, and activities, unless otherwise specified in the annual appropriations bill. A portion of the overall Dental budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2023 budget submission for Dental is $309 million which is $73 million above the FY 2022 Enacted level.

FY 2022 Base Funding of $236 million will support oral health care services provided by IHS and tribal programs, maintain the program's progress in raising the quality of and access to oral care through continuing recruitment of oral health care professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2023 Funding Increase of $73 million includes:

- Current Services: +$11 million for current services including:
    - Pay Costs +$7 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$626,000 – to fund inflationary costs of providing health care services.
    - Population Growth +$4 million – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2023 based on state births and deaths data.
- Staffing for New Facilities: +$14 million - these funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities

allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Naytahwaush Health Center (JV), Naytahwaush, MN	$1,409,000	10
NEACC (Salt River) Health Center, Scottsdale, AZ	$2,213,000	14
Ysleta Del Sur Health Center (JV), El Paso, TX	$285,000	2
Alternative Rural Health Center, Dilkon, AZ	$1,333,000	10
Elbowoods Memorial Health Center (JV), New Town, ND	$3,112,000	20
Rapid City Health Center, Rapid City, SD	$5,997,000	57
Grand Total:	**$14,329,000**	**113**

- General Program Increase: +$33 million to expand access to dental health services in American Indian and Alaska Native communities by addressing the unmet need for direct health care services identified by the FY 2018 Indian Health Care Improvement Fund Work Group. IHS and Tribal health programs can use these funds to develop new dental health programs, increase the size and scope of existing dental health programs, grow number of dental health professionals serving Indian Country, and other related activities based on the unique needs of the American Indian and Alaska Native communities they serve. This funding increase will support an estimated 1,001,481 patient visits and 3,149,545 total dental services provided in FY 2023.

- Targeted Dental Health: +$15 million, for critical program improvements to increase implementation of the Electronic Dental Record, expand Dental Clinical and Preventive Support Center Grants, modernize existing dental infrastructure for post-pandemic improvements, and other activities.

    - Continued IHS Dentrix Electronic Dental Record Implementation and Modernization ($3 million): Implement the IHS Dentrix EDR to as many IHS I/T/U dental clinics as possible to maximize standardization of the IHS EDR system in preparation for the IHS Electronic Health Record modernization. Funds will also support IHS enhancements of the commercially available Dentrix Enterprise (DXE) version, which significantly improves the efficiency and standardization of dental charting documentation, data collection, and automation of information reporting capability of the IHS DXE EDR version when compared to the commercial version.

    - Increased funding level of the Dental Clinical and Preventive Support Center Program grants and program awards ($3 million): The IHS Dental Clinical and Preventive Support Centers (DCPSC) have demonstrated the ability to increase Tribal communities' access to oral health promotion/disease prevention services, resulting in improved oral, and overall, health status of the AI/AN population. While each DSC received an increased funding level in FY21, an increased level of DSC annual funding would further increase the access to OHP/DP services, with the expected result of additional improvements in the oral health status of AI/AN communities.

    - Expansion of the IHS Continuing Dental Education (CDE) Program ($500,000): The IHS Division of Oral Health CDE Program consists of 300 in-person and webinar-based courses each year, with 30,000 CDE participant hours awarded each year to I/T/U dental staff. Over two-thirds of all I/T/U dental staff participate in CDE activities. The CDE

program needs to be augmented to improve the delivery of care and access to care in the AI/AN population. Specifically, dental assistants providing basic services and expanded functions (fillings or cleanings) are critical to improving access and delivery of dental services. A study conducted by Johns Hopkins University's Bloomberg School of Public Health showed that efficient expanded function dental assistants in the IHS system can increase access to dental services by 10 percent or more.

- Purchase of Portable Dental Equipment to increase community and school based dental services outreach in AI/AN communities ($1 million): The goal of the IHS Dental Health Program is to improve the access and quality of oral health care services to communities served by I/T/U dental programs. The increased availability of strategically staged portable oral health care delivery equipment to support community and school-based outreach programs. The availability of this equipment will further enhance our outreach relationship with BIE schools.

- Increase funding for the IHS Dental Externship Program ($200,000): The IHS Dental recruitment program receives approximately 300 applicants per year from dental students from the 66 US Dental schools. The goal is to place dental students so that there is representation in the selection pool from all schools from which we receive applications. This creates ambassadors that return to the dental schools that can share their experience with other classmates during their 4th and final year of dental school. In 2013 the IHS placed 133 dental students in dental externship opportunities. In 2019, the IHS placed 100 dental student in externships. Travel costs have escalated over the last 8 years leading to a reduction in the number of students placed and more out of pocket travel costs for some participants. A $200,000 increase would allow IHS to increase the allocation to the 100 dental extern travelers we currently place as well as allow IHS to offer placement for up to 30 more dental externs.

- Modernization to existing dental physical infrastructure to accommodate necessary improvements for post-pandemic dental operations ($7.3 million): In order to make physical plant enhancements and remodeling for a post-pandemic dental operations, this allocation will be distributed to IHS and Tribal programs will allow them to begin the process of taking action to mitigate the impact future pandemics may have on their ability to provide oral health care services.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
61 Topical Fluorides (Outcome)	FY 2021: 16.8 % Target: 27.6 % (Target Not Met) FY 2020: 22.1% Target: 34.5 % (Target Not Met)	26.8 %	21.1%	-5.7%

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
62 Access to Dental Services (Outcome)	FY 2021: 19.5 % Target: 26.6 % (Target Not Met) FY 2020: 22.9 % Target: 29.7 % (Target Not Met)	28.8 %	24.4%	-4.4%
63 Dental Sealants (Outcome)	FY 2021: 8.0 % Target: 13.8 % (Target Not Met) FY 2020: 11.2 % Target: 17.2 % (Target Not Met)	13.7 %	9.9%	-3.8%

GRANTS AWARDS

The DHP solicited, through a Federal Register Notice of Funding Opportunity in June 2020, applications for the Dental Clinical and Preventive Support Centers (DSC) Program. For a five-year cycle starting December 1, 2020, six grant awards were made, at an annual funding level of $350,000 each, with the purpose being to establish DSC Programs. $1,000,000 of new FY 2021 funding for DSCs was utilized to increase the number of DSCs and the grant funding to each DSC, resulting in an expansion of services to AI/AN communities. The DSCs combine IHS and tribal resources and infrastructure in order to address broad challenges and opportunities associated with preventive and clinical dental programs. The DSCs also rigorously measure and evaluate their work with the goal of demonstrably improving dental health outcomes through the technical assistance and services they provide. The DHP has created an online reporting system which will streamline the process by which the DSCs will submit their quarterly progress reports, and will allow the DHP to efficiently collate and analyze DSC achievements. Centers may work simultaneously to improve many different dental programs in a region, providing support, guidance, training, and enhancement to these programs, which then provide services to patients.

(whole dollars)	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget
Number of Awards	6	6	6
Average Award	$350,000	$444,444	$444,444
Range of Awards	$350,000	$444,444	$444,444

AREA ALLOCATION

Dental Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2021 Final			FY 2022 Estimated			FY 2023 Estimated			FY '23 +/- FY '22
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$367	$38,592	$38,959	$403	$42,385	$42,789	$529	$55,581	$56,110	$13,321
Albuquerque	5,129	4,407	9,536	5,633	$4,840	10,473	7,387	6,347	13,734	$3,260
Bemidji	2,188	2,782	4,971	2,403	$3,056	5,459	3,151	4,007	7,159	$1,700
Billings	6,215	2,006	8,221	6,826	$2,203	9,029	8,951	2,889	11,840	$2,811
California	407	2,108	2,515	447	$2,315	2,762	586	3,036	3,622	$860
Great Plains	10,989	8,567	19,556	12,069	$9,409	21,478	15,826	12,339	28,165	$6,687
Nashville	777	7,019	7,796	854	$7,709	8,562	1,120	10,108	11,228	$2,666
Navajo	26,870	9,718	36,588	29,511	$10,673	40,184	38,698	13,996	52,694	$12,510
Oklahoma	10,212	37,937	48,149	11,216	$41,666	52,882	14,707	54,637	69,345	$16,463
Phoenix	9,276	9,937	19,213	10,188	$10,914	21,101	13,359	14,311	27,671	$6,569
Portland	4,666	4,054	8,720	5,124	$4,453	9,577	6,719	5,839	12,558	$2,981
Tucson	41	2,328	2,369	45	$2,557	2,602	59	3,352	3,411	$810
Headquarters	8,094	0	8,094	8,890	$	8,890	11,657	0	11,657	$2,768
Total, Dental	**$85,231**	**$129,456**	**$214,687**	**$93,608**	**$142,180**	**$235,788**	**$122,750**	**$186,443**	**$309,193**	**$73,405**

Note: FY 2022 and FY 2023 are estimates.

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$115,206	$121,946	$199,088	+$77,142
FTE*	175	198	240	+42

* FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Mental Health/Social Services (MH/SS) program is a community-based clinical and preventive service program that provides ongoing vital outpatient mental health counseling and access to dual diagnosis services, mental health crisis response and triage, case management services, community-based prevention programming, and outreach and health education activities. The MH/SS program supports several of the HHS Strategic Plan goals and objectives, including *Objective 1.3: Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health;* and, *Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families.* The most common MH/SS program model is an outpatient service staffed by one or more mental health professionals providing individual, family, and group psychotherapeutic services and case management. After hours emergency services are generally provided through local emergency departments and contracts with non-IHS hospitals and crisis centers. Inpatient services are generally purchased from non-IHS hospitals or provided by state or county hospitals providing mental health services. Intermediate level services such as group homes, transitional living support, intensive case management, and related activities are typically offered through state and local resources. Additionally, slightly more than one-half of the Tribes administer and deliver their own mental health programs.

IHS continues to support Tribal communities in their ability to address the mental health disparities experienced among the AI/AN population. In partnership with Tribal community entities, a collaborative community of learning will support IHS efforts to promote excellence and quality through the development of innovative, community-based projects to expand mental health services and treatment in integrated clinical settings.

PROGRAM ACCOMPLISHMENTS

Suicide Prevention: Suicide rates among AI/ANs are historically higher than other minorities within the U.S. population. As of 2020, AI/AN have the highest rate (23.9 per 100,000),[1] and the rate has increase 55.7 percent over the past ten years. [2] As of 2020, suicide rates for AI/AN adolescents and young adults has reached all-time highs, with 24.6 suicides per 100,000 among 15 to 24 year old AI/AN, and 29.8 per 100,000 among 25 to 34 year old AI/AN. The adolescent rates are 1.9 times higher than the national average for others in the same age group, and 2.1 times higher than the national average for other young adults.[3] Suicide is the eighth leading cause of death among all AI/AN across all ages.[4] Strategies to address behavioral health, alcohol, substance use disorder, and suicide prevention require comprehensive clinical strategies, and approaches.

In 2019, AI/AN adolescents (12 to 17 year olds) had the highest prevalence (11.5 percent) of major depressive episode with severe impairment compared to other ethnicities.[5] In 2019, AI/AN adults had the highest prevalence (9.4 percent) of major depressive episode with or without severe impairment compared to other ethnicities.[6] Furthermore in 2019, AI/AN adults had the second highest prevalence (18.7 percent) of serious mental illness among U.S. adults compare to other ethnicities.[7]

The IHS utilizes and promotes collaborations and partnerships with patients and their families, including Tribes and Tribal organizations, Urban Indian organizations, federal, state, and local agencies, as well as public and private organizations.

The IHS initiated a suicide surveillance data protocol focusing on suicide related behaviors to identify suicide within the IHS Electronic Health Records (EHR) in a standardized and systematic fashion. The suicide surveillance protocol will capture data related to suicide ideation; suicide attempts; and other suicide related behaviors through the use of a universal screening and associated clinical pathways to better understand local facility challenges, identify risk factors and target resources and services appropriately.

Ten percent of those who die by suicide had visited the emergency department within 2 months of death. In FY 2019, the IHS and the National Institute of Mental Health (NIMH) partnered by way of a Memorandum of Understanding (MOU) to address the high rates of suicide impacting the AI/AN communities. Throughout the three year partnership (FY 2019- 2021), IHS and NIH worked together to implement the Ask Suicide Screening Questions (ASQ) and its accompanying toolkit for universal screening within IHS Emergency Departments (EDs). The ASQ is a suicide screening resource developed by NIMH for medical settings to help nurses or physicians successfully identify individuals at risk for suicide. In FY 2019, IHS conducted a site visit and staff training on the ASQ, and partnered with IHS OIT to fully integrate the

[1] US Department of Health and Human Services, Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report, February 25, 2022. Changes in Suicide Rates – United States, 2019 and 2020.
[2] US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2020. Available from CDC WONDER Online Database, released in 2021. http://wonder.cdc.gov/ucd-icd10.html.
[3] Ibid.
[4] US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Deaths: Leading Causes for 2019.
[5] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health. Available from https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases.
[6] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health. Available from https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases.
[7] Ibid.

validated suicide risk screening instrument into the IHS electronic health records system for field implementation.

In FY 2020, IHS began reviewing preliminary surveillance data associated with the ASQ screening and suicide risk assessment. The implementation of the ASQ has allowed for identification of crisis situations within the pilot sites and supported immediate response by the Area office to ensure quality of care. To date, the pilot sites have completed 55,636 suicide risk screenings. Preliminary findings indicate screening AI/AN youth for suicide risk in the ED is important because rates are high, screening is feasible and, with iterative Quality Improvement processes, can be conducted in a way that will not overburden already busy IHS healthcare systems. Due to the impact of COVID-19, suicide screening has increased and has shown an increase in the need for behavioral health services such as telehealth and virtual outreach to augment traditional service modalities. These efforts support several HHS Strategic Plan goals and objectives, including *Objective 1.3: Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health;* and, *Objective 4.3: Strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions.*

Zero Suicide Initiative: In FY 2017, IHS received $3.6 million to fund 8 pilot IHS and Tribal sites to participate in its first cohort of the Zero Suicide Initiative. The Zero Suicide philosophy is a key concept of the National Strategy for Suicide Prevention (NSSP) and is a priority of the National Action Alliance for Suicide Prevention (Action Alliance). Zero Suicide focuses on developing a system-wide approach to improving care for individuals at risk of suicide who are currently utilizing health and behavioral health systems. Health care systems are uniquely poised to identify those struggling with thoughts of suicide considering 50 percent of those who die by suicide had contact with a primary care provider within 1 month of suicide. Furthermore, 80 percent of those who die by suicide had contact with a primary care provider within 1 year of suicide.

In FY 2017- FY 2020, IHS funded eight facilities in total, five Tribal and three federal facilities, at $400,000, to implement the Zero Suicide Initiative (ZSI) model within their healthcare system. Each ZSI project plan includes utilizing evidence-based treatments in suicide care, initiating safety plans with patients at risk for suicide, implementing intensive follow-up upon missed or cancelled appointments, universal suicide screening of all at-risk patients, increasing restriction of lethal means, implementing intensive case management, and initiating follow up with patients within 24 hours of transition of care. In year two, all project sites have successfully established a new Zero Suicide policy and have developed suicide risk screening procedures, clinical pathways, and data collection plans to enhance surveillance and analysis capabilities. Similar to other grant programs, the COVID-19 pandemic placed an unforeseen hardship on all facilities implementing ZSI in their Emergency Departments. Accordingly, the IHS authorized ZSI grantees one additional project year to continue their approved project activities, through October 31, 2021.

In FY 2021, ZSI projects trained over 1,475 staff in evidence-based suicide risk and assessment practices and over 10,000 patients received a positive suicide risk screening. Additionally, through ZSI, all sites established a Suicide Team to develop a Zero Suicide Work Plan.

Finally, in FY 2022, IHS will fund a new five-year cohort of ZSI projects and will establish a ZSI Coordinating Center that will provide technical assistance to address the unique needs of Tribes and Tribal organizations implementing the ZSI model. The second ZSI cohort will focus on promoting collaboration with the local, regional and federal health partners. These efforts

support several HHS Strategic Plan goals and objectives, *including Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families.;* and, *Objective 3.4: Increase safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence.*

Trauma-Informed Care: Trauma Informed Care supports the HHS Strategic Plan, as in the example of *Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families.* In 2019, IHS partnered with the University of New Mexico (UNM) to develop a comprehensive online training curriculum related to trauma and trauma-informed care. Topics included an overview for all staff, and specific training tailored to behavioral health staff, healthcare provider staff, non-provider staff, and supervisors. In FY 2021, IHS released 13 Trauma Informed Care on-demand trainings which included 361 attendees. IHS has worked to implement the principles of trauma informed care to ensure its system understands the prevalence and impact of trauma, facilitates healing, avoids re-traumatization, and focuses on strength and resilience. Developing and implementing a trauma informed care approach to address childhood trauma, including historical trauma, is necessary to comprehensively address the root causes of violence, suicide, depression, anxiety, self-harm, and chronic physical diseases.

Lessons learned from the 2016 Improving Patient Care and the Johns Hopkins University Pediatric Integrated Care Collaborative (PICC) pilot project were used by IHS to incorporate into the new trauma informed care policy in the Indian Health Manual released in FY 2020. In FY 2022, IHS will support the new trauma informed care policy by developing a mandatory on-demand, online training for clinical and non-clinical staff. This training will provide guidance to IHS facilities in delivering trauma-informed care services along with promoting self-care to prevent secondary traumatic stress, which can lead to compassion fatigue and burnout.
Behavioral Health Integration Initiative (BH2I): The statistics facing AI/AN peoples for suicide, alcohol-related deaths, domestic and sexual violence, and homicide require the Indian health system to develop a system of comprehensive screening and effective intervention to reduce morbidity and early mortality. IHS supports changing the paradigm of mental health and substance abuse disorder services from being episodic, fragmented, specialty, or disease focused to incorporating it into the patient-centered medical home.

In FY 2017, IHS received $6 million to launch the BH2I. BH2I prioritizes integration across the health care system by developing care teams, strengthening infrastructure, and enhancing clinical processes to include increased depression screenings in primary care clinics. In FY 2020, supporting the HHS Strategic Plan, *Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families,* IHS continued funding for a total of 12 federal, Tribal, and Urban Indian organizations to integrate behavioral health with primary care services in their local health facilities. In response to the COVID-19 pandemic, these efforts were extended into FY 2021, providing additional time in the project period to complete proposed activities with a focus on meeting the needs of the community and developing sustainability plans.

Technical assistance (TA) provided to each grantee focused on integrated care with expert psychiatrists, primary care physicians, and social workers. In addition, cross-site evaluation among the BH2I projects identified enhanced integration assessment tools, evidence-based

practices applicable to an integrated behavioral and primary care environment, best practices for priority objectives including an emphasis on co-located physical space, implementing measurement-based care using a practice management system for clinical measures and validated tools. BH2I projects reported structural successes including integration policies and procedures such as same day access to behavioral health providers within primary care and emergency room settings. Sites also reported increased screening rates for depression, anxiety, trauma and early childhood development disabilities and reduction in wait times to see a mental health counselor and psychiatrist with some sites focused on sustainability strategies.

In FY 2022, IHS awarded 14 new BH2I grantees, totaling $5.5 million, which will be on a five-year funding cycle through FY 2026. Additionally, IHS will contract with a technical assistance provider to assist grantees with the implementation of integrated care efforts.

Reflective of the Agency's priority to raise the mental health of the AI/AN population IHS Division of Behavioral Health initiatives have focused on increased implementation of depression screening in primary care clinics. In FY 2020, IHS reported 41.1 percent of AI/AN adults over the age of 18 screened for depression using a standardized screening assessment for depression. In FY 2020, this same measure was reported for youth ages 12-17 and data indicated 32.5 percent of eligible youth were screened for depression. For FY 2020, targets were based on prior year results and results indicate the targets were not met for both measures. The FY 2022 targets are set in consideration of the most recent results.

According to CDC, racial and ethnic minority groups have experienced disparities in mental health and substance misuse related to access to care, psychological stress, and social determinants of health. In FY 2021, IHS partnered with the Northwest Portland Indian Health Board to launch a free 24/7 Crisis Text Line for AI/ANs, which includes texting the keywords "Native" and "Indigenous" to 741-741. The Crisis Text Line connects individuals to a live, trained Crisis Counselor allowing for an increase in access to care and support during the COVID-19 pandemic.

TeleBehavioral Health and Workforce Development: The IHS TeleBehavioral Health Center of Excellence (TBHCE) was established in 2009, utilizing funds from the Methamphetamine and Suicide Prevention Initiative, to assess the feasibility of providing behavioral health services via televideo. Due to the rural nature of many IHS and Tribal facilities, I/T/U patients face many issues surrounding access to care, particularly specialty care. Providers working in these remote areas often face barriers to maintaining the required continuing education (CE) credits required for licensure and remaining up to date on current clinical guidelines. The TBHCE assists IHS, Tribal, and urban Indian organizations providers and facilities in overcoming these challenges by providing a range of telebehavioral health services and virtual training. There are 22 sites receiving direct care services through the TBHCE. These services include, adult counseling, child counseling, family counseling, trauma/Post Traumatic Stress Disorder (PTSD) counseling, child psychiatry, adult psychiatry, and addiction psychiatry. In FY 2021, the TBHCE provided 64,078 hours of telebehavioral health services.

Additionally, the TBCHE hosted webinars designed to meet the specific training needs of IHS, Tribal, and Urban Indian (I/T/U) health care providers. More specifically, IHS utilizes tele-education (otherwise known as distance learning) to deliver national continuing education (CE) programming to I/T/U healthcare providers. In FY 2021, TBHCE provided 75 webinars that included 4,751 attendees. Webinar topics were designed to assist communities in their response and recovery efforts due to COVID-19. TBHCE included topics on grief and loss, suicide prevention, domestic violence, and engaging patients in telehealth.

In FY 2021, TBHCE in partnership with the University of New Mexico provided a Mental Health and Resiliency ECHO in response to COVID-19. The ECHO aimed to support healthcare providers in treating the mental health concerns of AI/AN patients and supporting peers during the pandemic crisis and consequences, while also managing their own wellbeing. The ECHO included 21 sessions with 1,131 attendees.

Finally, TBHCE developed and maintains the online IHS Essential Training on Pain and Addiction. In FY 2021, 321 I/T/U providers completed this five-hour training. Additionally, 403 I/T/U providers completed the TBHCE hosted Essential Training on Pain and Addiction Refresher course.

COVID-19

The COVID-19 pandemic has disproportionately affected AI/AN populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount
2019	$101,255,000
2020	$109,036,000
2021 Final	$115,107,000
2022 Enacted	$121,946,000
2023 President's Budget	$199,088,000

TRIBAL SHARES

Mental Health funds are subject to Tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities, unless otherwise specified in the annual appropriations bill. A portion of the overall Mental Health budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2023 budget submission for Mental Health is $199 million, which is $77 million above the FY 2022 Enacted level.

FY 2022 Base Funding of $122 million – This funding will maintain the program's progress in addressing mental health needs by improving access to behavioral health services through tele-

behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

FY 2023 Funding Increase of $77 million includes:

- Current Services: +$5 million for current services including:
    - Pay Costs +$3 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$349,000 – to fund inflationary costs of providing health care services.
    - Population Growth +$2 million – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.
- Staffing for New Facilities: + $5 million - these funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Naytahwaush Health Center (JV), Naytahwaush, MN	$507,000	5
NEACC (Salt River) Health Center, Scottsdale, AZ	$709,000	6
Ysleta Del Sur Health Center (JV), El Paso, TX	$172,000	1
Alternative Rural Health Center, Dilkon, AZ	$482,000	4
Rapid City Health Center, Rapid City, SD	$3,164,000	32
Grand Total:	**$5,034,000**	**48**

- Partially Sustain ARPA Investments: +$67 million - to partiallysustain the ARPA mental health investments and prevent a significant reduction in mental health services. This funding level will support an estimated 1,183,698 mental health services in FY 2023.

  The American Rescue Plan Act provided a historic investment in mental health and substance abuse prevention and treatment services for American Indians and Alaska Natives. The IHS distributed the $420 million appropriated in the ARPA to all IHS, Tribal, and urban Indian Heath programs.

  However, the ARPA appropriation provided one-time, non-recurring funding to support mental health and substance abuse prevention and treatment services. Ongoing resources are necessary to ensure that IHS, Tribal, and urban Indian health programs do not have to significantly reduce mental health and substance abuse treatment services as the one-time ARPA resources are expended.

  The ARPA appropriated one amount for both mental health and substance abuse services, while the IHS budget includes two separate lines – one for Mental Health and one for Alcohol and Substance Abuse. The budget assumes an even split of these funds between the two funding lines.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
65 Proportion of American Indian and Alaska Native adults 18 and over who are screened for depression. (Outcome)	FY 2021: 35 % Target: 49.4 % (Target Not Met) FY 2020: 37.4 % Target: 45.7 % (Target Not Met)	42.9 %	36.4%	-6.5%
85 Depression Screening ages 12-17. (Outcome)	FY 2021: 28.4 % Target: 43.2 % (Target Not Met) FY 2020: 30.1 % Target: 38.0 % (Target Not Met)	33.9 %	29.5%	-4.4%
MH-1 Increase Tele-behavioral health encounters nationally among American Indians and Alaska Natives (Output)	FY 2021: 80,188 Target: 46,000 (Target Exceeded)	48,000	55,200	+7,200
MH-2 Suicide Screen and Assessment (Outcome)	FY 2020: Result Expected Oct 1, 2022 Target: Set Baseline (Pending)	Maintain Baseline	TBD	Maintain

GRANTS AWARDS

The proposed FY 2023 budget increases will be used, in part, for grants for IHS facilities, Tribes, Tribal organizations, and urban Indian organizations to develop innovative programs to address behavioral health services and deliver those services within and outside of the traditional health care system. The actual number of non-competitive grants are included below:

(whole dollars)	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget
Number of Awards	20	20	20
Average Award	$450,000	$450,000	$450,000
Range of Awards	$400,000 - $500,000	$400,000 - $500,000	$400,000 - $500,000

AREA ALLOCATION

Mental Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2021 Final			FY 2022 Estimated			FY 2023 Estimated			FY '23 +/- FY '22
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$78	$15,242	$15,321	$83	$16,134	$16,217	$135,252.21	$26,340	$26,476	$10,259
Albuquerque	1,871	3,411	5,282	1,980	3,610	5,591	3,233	5,894	9,127	$3,537
Bemidji	346	2,584	2,929	366	2,735	3,101	597	4,465	5,062	$1,961
Billings	2,758	1,651	4,409	2,919	1,748	4,667	4,766	2,853	7,619	$2,952
California	119	2,730	2,849	126	2,890	3,016	206	4,718	4,924	$1,908
Great Plains	7,553	3,292	10,844	7,995	3,484	11,479	13,052	5,688	18,740	$7,261
Nashville	344	2,988	3,332	364	3,163	3,527	594	5,163	5,758	$2,231
Navajo	9,568	8,591	18,159	10,128	9,093	19,221	16,535	14,845	31,380	$12,159
Oklahoma	3,317	16,414	19,731	3,511	17,374	20,885	5,732	28,365	34,097	$13,212
Phoenix	3,555	7,358	10,912	3,763	7,788	11,551	6,143	12,715	18,858	$7,307
Portland	527	4,788	5,315	558	5,068	5,626	912	8,274	9,185	$3,559
Tucson	12	1,920	1,932	13	2,033	2,045	21	3,318	3,339	$1,294
Headquarters	14,192	0	14,192	15,022		15,022	24,525	0	24,525	$9,503
Total, Mental	**$44,240**	**$70,966**	**$115,206**	**$46,828**	**$75,119**	**$121,946**	**$76,451**	**$122,639**	**$199,088**	**$77,143**

Note: FY 2022 and FY 2023 are estimates.

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$251,360	$258,343	$344,620	+$86,277
FTE*	232	241	244	+3

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

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

PROGRAM DESCRIPTION

Alcohol, substance abuse, and addiction are among the most severe public health and safety problems facing American Indian and Alaska Native (AI/AN) individuals, families, and communities. The purpose of the Indian Health Service (IHS) Alcohol and Substance Abuse Program (ASAP) is to raise the health status of AI/AN communities to the highest possible level through a comprehensive array of preventive, educational, and treatment services that are community-driven and culturally competent. The ASAP addresses several of the HHS Strategic Plan goals and objectives, including *Objective 1.3: Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health*; and, *Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families*. These collaborative activities strive to integrate substance abuse treatment into primary care. For instance, the Substance Abuse and Suicide Prevention Program (SASP) provides prevention and intervention resources developed and delivered by local community partners to address the dual crises of substance abuse and suicide in AI/AN communities.

AI/AN populations suffer disproportionately from substance use disorders (SUD) compared with other racial groups in the United States (U.S.). Research has consistently found that AI/AN experience higher rates of substance use compared with the U.S. general population. Findings from the 2019 National Survey on Drug Use and Health (NSDUH) reported the rate of AI/ANs aged 12 and over with an alcohol use disorder (6.4 percent) is higher than that of the total population (5.3 percent).[1] In 2017, the Centers for Disease Control and Prevention (CDC) reported that the AI/AN population had the second highest overdose rates from all opioids (15.7 deaths/ 100,000 population), and the highest rate from prescription opioids (7.2 deaths/100,000 population) during 2016-2017[2]. The overall rate of overdose deaths for AI/ANs increased by 13

[1]https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect5pe2019.htm#tab5-4a

[2] https://www.cdc.gov/drugoverdose/pdf/pubs/2019-cdc-drug-surveillance-report.pdf

percent between 2015-2017. In 2017, the age-adjusted rate of drug overdose deaths was 9.6 percent higher than the rate for 2016. During that time, deaths rose more than 500 percent among AI/ANs. Due to misclassification of race and ethnicity on death certificates, the actual number of deaths for AI/ANs may be underestimated by up to 35 percent.[3]

Additionally, in a recent study by the National Institute on Drug Abuse (NIDA), deaths involving methamphetamines more than quadrupled among non-Hispanic AI/AN from 2011-2018 (from 4.5 to 20.9 per 100,000 people) overall.[4]

PROGRAM ACCOMPLISHMENTS

As alcohol and substance abuse prevention and treatment have transitioned from IHS direct care services to local community control via tribal contracting and compacting, IHS' role has shifted to providing support to enable communities to plan, develop, and implement culturally informed programs. Organized to develop programs and program leadership, the major IHS ASAP activities and focus areas are:

Integrated Substance Abuse Treatment in Primary Care: IHS continues to support the integration of substance abuse treatment into primary care and acute care services. Integrating treatment into ambulatory health care offers immediate and same-day opportunities for health care providers to identify patients with SUDs, provide them with medical advice, help them communicate the health risks and consequences, obtain substance abuse consultations, and refer patients with more severe substance use-related problems to treatment.[5] One integration activity is the implementation of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) instrument. SBIRT is an early intervention and treatment service for people with SUD and those at risk of developing these disorders. IHS has broadly promoted SBIRT as an integral part of a sustainable, primary care-based activity that aims to support and integrate behavioral health into overall care. SBIRT is eligible for reimbursement from the Centers for Medicare and Medicaid Services (CMS). IHS has incorporated SBIRT as a Government Performance and Results Act (GPRA) national measure to be tracked and reported. Since FY 2018, the official GPRA measures have been calculated through the Integrated Data Collection System Data Mart (IDCS DM) utilizing National Data Warehouse (NDW) data. IHS facilities and participating tribal facilities are required to submit data into the NDW throughout the year. In FY 2020, the SBIRT screening measure was utilized in 14.9 percent of the patient visits for those ages 9 through 75. The target for this measure was 12.2 percent, therefore IHS efforts exceeded the expected percent of patients to be screened using the SBIRT. At the onset of the COVID-19 pandemic, IHS increased efforts to expand telehealth capacity across Indian Health Service/Tribal/Urban Indian Organizations (I/T/Us) to continue coordination of treatment and services to patients. Additionally, IHS continues to monitor the SBIRT administered through telehealth methods. IHS provides annual national training on SBIRT use, including guidelines for improved clinical documentation in the electronic health record. In FY 2020, IHS increased efforts that broadly promote the SBIRT measure to achieve targets at the regional and local levels, including a more focused education campaign on the importance of early detection and intervention using SBIRT screening among IHS operated programs. In addition, IHS is actively working to expand local SBIRT use, including a focus on substance use in women of childbearing age, to assist in early identification and referral for treatment and reduce illicit perinatal substance exposure for infants.

[3] https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6619.pdf

[4] https://jamanetwork-com.ezproxyhhs.nihlibrary.nih.gov/journals/jamapsychiatry/fullarticle/2774859

[5] U.S. Office of National Drug Control Policy. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.

Increasing access to Medication Assisted Treatment (MAT): IHS is committed to assuring access to MAT for patients struggling with opioid use disorder (OUD). The IHS strategy focuses on creating community and clinical resources and technical assistance to share best and promising practices. IHS continues to host the *Pain & Opioid Use Disorder* webinar and continuing education series. FY2021 MAT sessions included *Buprenorphine Micro-inductions and MAT in the Emergency Department Setting*. In tandem, IHS is expanding integrated team-based care models. In April 2021, the IHS *Advancing Pharmacist Roles in Substance Use Disorder Treatment and Recovery Teams learning model* launched. Participants engage in a learning collaborative to increase knowledge surrounding patient screening, assessments, evidence-based practices for the management of OUDs, and trauma-informed care principles. A total of 307 continuing education credits have been issued in the first six months of the program. This project is also exploring methods to expand tele-MAT services using hub-and-spoke information distribution models.

IHS is working to expand access to MAT in acute care settings. In December 2021, the IHS Pain and Addiction Care in the Emergency Department pilot program intervention funded five projects in direct-service emergency departments. The objective of this intervention is to improve access to Medications for Opioid Use Disorder (MOUD) or improve pain management outcomes in acute care settings. Secondary objectives are to leverage the opioid surveillance dashboard to inform stewardship activities, to create a learning collaborative to share promising practices, and to assist sites with obtaining relevant accreditation.

IHS has partnered with the Northwest Portland Area Indian Health Board and the Clinician Consultation Center to facilitate I/T/U clinician access to free Substance Disorder tele-consultation services. These services are intended to assist clinicians with patient treatment planning, facilitate didactic learning, and provide support for health systems that desire to create local protocols.

IHS continues to host training sessions for clinicians to receive the Drug Addiction Treatment Act (DATA) 2000 waiver to prescribe buprenorphine, and in FY 2018 added buprenorphine-containing medication and injectable naltrexone to the IHS National Core Formulary. In FY 2020, the IHS continues to evaluate new long-acting MAT therapies for inclusion on the National Core Formulary and creates formulary briefs and technical assistance to incorporate these new treatments into practice. In June 2019, the IHS released the Special General Memorandum *Assuring Access to MAT for OUD* that requires federal IHS facilities to create an action plan to identify local MAT resources and coordinate patient access to these services when indicated to assure equitable access to MAT services.[6] In addition, IHS created workforce development strategies that include SUD training for healthcare workers and technical assistance materials that support sites with integrated SUD approaches to care.

To address challenges that limit access to recovery services in remote and rural IHS locations and villages, the IHS released an *Internet Eligible Controlled Substance Prescriber Designation* (IECSP) policy in the Indian Health Manual (Chapter 38) to assure access to MAT using telemedicine models for remotely located Tribal members.[7] In January 2020, an IHS telehealth toolkit for MAT services was created and shared on the ihs.gov/opioids website. These resources assist prescribers and sites with creating tele-MAT services and implementing provisions within the IECSP policy. Additionally, a webinar was hosted in February 2020 to describe available

[6] https://www.ihs.gov/ihm/sgm/2019/assuring-access-to-medication-assisted-treatment-for-opioid-use-disorder/

[7] https://www.ihs.gov/ihm/pc/part-3/chapter-38-internet-eligible-controlled-substance-provider-designation/

MAT resources and policies. In March 2019, the IHS released the *Recommendations to the Indian Health Service on American Indian/Alaska Native Pregnant Women and Women of Childbearing Age with Opioid Use Disorder* developed in collaboration with the American College of Obstetricians and Gynecologists' (ACOG) Committee on AI/AN Women's Health.[8] This resource will help providers improve maternal participation in early prenatal care and support, improve screening for SUD, and increase access to MAT for pregnant women and women of child-bearing age. The goal of these clinical recommendations is to foster relationships and improve awareness surrounding trauma-informed approaches to maternal opioid use that may lead to recovery, hope, and healing. Additionally, the IHS and the American Academy of Pediatrics Committee on Native American Child Health (CONACH) recently released the *Recommendations to the Indian Health Service on Neonatal Opioid Withdrawal Syndrome* that includes clinical recommendations on the prevention and management of neonatal opioid withdrawal syndrome.[9] These recommendations provide standards of care for screening, diagnosing, support, and treatment of pregnant mothers and infants affected by prenatal opioid exposure

IHS has also created a robust workforce development strategy to include didactic training. In September 2019, IHS launched its *Pain Management and Opioid Use Disorder Continuing Medical Education* webinar series. The IHS has hosted learning sessions in this series that include buprenorphine prescribing in pregnancy, dental acute pain management recommendations, as well as, an auricular acupuncture-training program. For example, *Implementing an Integrated MAT Model-A Review of Resources, Assessment and Treatment of Pain and Co-occurring OUD In Individual with Serious Mental Illness, and Treatment of OUD in the ED, Should it be a Choice?* The IHS has expanded access to harm reduction interventions that include increased access to the opioid overdose reversal medication, naloxone. In 2015, the IHS signed a memorandum of agreement with the Bureau of Indian Affairs (BIA). The agreement allows IHS to provide BIA Law Enforcement Officers (LEO) with training and naloxone rescue kits for responding to incidents of opioid overdose. Between 2015 and 2017, this partnership trained and put naloxone in the hands of 324 BIA LEOs, who are often the first responders to incidents of opioid overdose in Tribal communities. In 2017, IHS turned the naloxone training program over to the BIA after certifying 48 BIA LEOs as naloxone trainers. IHS continues to support this program by re-supplying naloxone rescue kits to BIA LEO first responders as needed. In 2019, IHS conducted first-responder train-the-trainer sessions on naloxone and harm reduction strategies for community health workers from IHS and Tribal sites from across the country. During that training, 86 community workers were supplied with naloxone kits and certified to offer naloxone training within their local communities. IHS also supports naloxone co-prescribing and has created sample collaborative practice agreements to engage pharmacists in naloxone distribution efforts and has hosted an IHS *Grand Rounds* on naloxone co-prescribing to increase provider awareness of this life-saving procedure. A *First Responder Toolkit* that includes a training video, a law enforcement testimonial video, customizable forms, and a train-the trainer curriculum was created to support naloxone deployment in Tribal communities. The IHS formally expanded access to naloxone in March 2018 through a policy titled *Prescribing and Dispensing of Naloxone to First Responders*, which requires IHS federal pharmacies to provide naloxone to all Tribal law enforcement agencies and other trained first responders. These efforts have resulted in a 143 percent increase in naloxone procurement across IHS facilities that utilize the Prime Vendor.

[8] https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/acogguidelines2018.pdf

[9] https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/aapnowsrecommendationstoihs.pdf

IHS has further adapted the toolkit and strategy to equip community first responders and paraprofessionals with training on opioid overdose response and naloxone. These expanded collaborations with local law enforcement and community first responders resulted in an initial pilot community-health naloxone train-the-trainer program to include naloxone distribution. In December 2021, IHS revised the IHS Naloxone webpage to share technical assistance and resources to support access to naloxone and opioid overdose prevention strategies. IHS collaborated with the Northwest Portland Area Indian Health Board to record a virtual naloxone train-the-trainer program as free technical assistance to Tribes to support access to naloxone in a virtual/contactless approach.

In addition to the naloxone distribution, IHS expanded harm reduction strategies to include an evaluation of Safe Syringe Services. In FY 2020, IHS released a Safe Syringe Services toolkit that includes sample patient education pamphlets, a review of available resources, and information related to creating program financial sustainability. These expanded harm reduction services will support IHS Hepatitis C Elimination and HIV/AIDS efforts. In FY 2022, the IHS hosted technical assistance and resources to expand access to fentanyl test strips.

Proper Pain Management, Opioid Stewardship and Training:
The IHS has created and released a comprehensive Opioid Stewardship workbook to assist sites with creating best practices surrounding safe opioid prescribing and increasing access to integrative pain treatments. The workbook emphasizes utilizing opioid surveillance strategies to evaluate population health outcomes, target opioid interventions, enhance clinical decision support, and create professional practice evaluation strategies. The IHS opioid stewardship program evaluation considers metrics that evaluate trends in Morphine Milligram Equivalents versus a restricted focus on total opioid prescription fills. The IHS developed a total of fifteen opioid prescribing metric definitions for inclusion in the IHS Opioid Prescribing dashboard. The dashboard underwent a limited release in September 2021 and an Opioid Stewardship and Dashboard working group was created to develop dashboard super-users within each IHS region to support implementation, including clinician end-user training and applying population health/opioid stewardship principles and clinical decision support tools. These super-users will also suggest additional metrics to optimize dashboard utility at the local level. In July 2021, the IHS Academic Detailing Service pilot project was established in the Bemidji Area. Two IHS sites were selected to create tailored peer-to-peer interventions to support opioid stewardship activities, increase access to treatment services, and promote quality of care. Sample action plans and evaluation strategies are being developed to be shared with other IHS regions and programs.

The IHS has also increased access to non-pharmacologic pain management approaches. The IHS has collaborated with the Defense Veterans Center for Integrated Pain Management to expand access to focused auricular acupuncture through the creation of sample credentialing and privileging processes, protocols, documentation standards, and sustainability recommendations. Access to additional integrative pain management strategies such as dry needling, deep tissue mobilization, and electrical stimulation have increased.

IHS has created agency policy and clinical practice recommendations to improve patient outcomes and reduce unnecessary opioid exposure. In June 2014, IHS implemented Indian Health Manual Chapter 30 policy titled *Chronic Non-Cancer Pain Management* to promote appropriate pain management with revision in 2018 to align with CDC *Guideline for Prescribing Opioids for Chronic Pain.* This policy will be revised in FY 2021 to include enhanced recommendations related to de-prescribing and medical cannabis. The impact of Prescription Drug Monitoring Programs (PDMPs) on safe opioid prescribing is well documented. IHS implemented Chapter 32, *State Prescription Drug Monitoring Programs,* requiring providers to

check state PDMP data bases prior to prescribing opioids and requiring IHS federal pharmacies to report opioid prescribing data to these state PDMPs. Ongoing improvements to automate reporting electronic integration and audit reporting were funded in FY 2021 with implementation in FY 2022.

In May 2016, IHS implemented a policy on mandatory opioid training requiring all federally controlled substance prescribers to complete the *IHS Essential Training on Pain and Addiction* with required refresher training every 3 years. This training is now available on demand with continuing medical education credits. The IHS released its refresher training course in January 2018 including four sessions of its mandatory five-hour training course for providers on proper opioid prescribing. The refresher course was updated in FY 2021. In FY 2021, 276 new clinicians completed this course. The mandate also includes an additional refresher training after three years. In FY 2021, 327 clinicians completed the *Essential Training on Pain and Addiction Refresher* course. In FY 2020, course content was updated based on prescriber evaluations. These revisions include expanded modules on managing pain in special populations (e.g., older adults, pregnancy, SUD) as well as content on effective de-prescribing strategies. In FY 2021, IHS engaged in planning discussions with the Veterans Health Administration to promote synergy between safe opioid prescriber training curriculums. A revised training course is anticipated in July 2022.

In August 2021, the IHS released enhanced clinical decision support tools for the Resource and Patient Management System (RPMS) to assist providers in meeting documentation standards outlined in IHM, Part 3 - Chapter 30. The EHR Reminders and dialog note templates facilitate accurate and timely documentation to support best practices and implementation of pain management policy requirements.

<u>Improved Communication Related to Opioid Strategies:</u>
Enhanced communication during the opioid crisis response is vital to program development, policy implementation, and ongoing evaluation. The IHS created and released an Opioid Information Sheet that will serve as a public-facing logic model to share opioid-related measures, agency goals, and available resources for both clinicians and Tribal stakeholders.

IHS supports efforts to develop a unified user experience that includes an expanded website presence with best and promising practices and a communication plan to increase public awareness of agency opioid efforts. This website houses resources, clinical guidelines, and best practices for IHS providers. Additional communication outputs include maintenance of a listserv, quarterly newsletter, and special edition newsletters.

In December 2021, the IHS developed and released a sample recovery rack card as a health promotion and patient education pamphlet for positive messaging around resilience, treatment, and recovery. The resource is downloadable on the IHS website and customizable for local use.

In October 2021, the IHS developed and released technical assistance to address site challenges with procurement of long-acting formulations of buprenorphine. Long-acting buprenorphine was added to the IHS National Core Formulary in August 2021.

In FY 2020, the IHS expanded websites to include a new technical assistance page that will share best and promising practices related to clinical documentation, sample documentation templates and how-to guides, and links to clinician supports. Future content consolidation will include funding opportunities and promising clinical practices. Also in FY 2020, IHS provided *Pain Skills* intensive trainings in the Phoenix and Tucson Area and the Navajo Area. These trainings

focus on assessment and treatment of myofascial pain, including non-pharmacological interventions. Additionally, they include the half-and-half DATA Waiver training for buprenorphine MAT. A total of 35 clinicians attended these trainings. In FY 2021, IHS provided five webinars that addressed pain management, opioids, and opioid misuse with a total of 179 attendees.

- Ketamine in the Acute Care Setting
- Buprenorphine Micro-Induction
- Treatment of OUD in the ED, Should it be a Choice?
- Opioid Management in Primary Care: An Integrated Approach
- Novel Buprenorphine Induction Strategies

IHS has created agency policy and clinical practice recommendations to improve patient outcomes and reduce unnecessary opioid exposure. In June 2014, IHS implemented IHM Chapter 30 policy titled *Chronic Non-Cancer Pain Management* to promote appropriate pain management. IHS released new clinical guidelines to assist dentists with selecting the safest pain control options. The *Recommendations for Management of Acute Dental Pain* will limit opioid prescribing to patients who cannot safely use alternative pain medication. The guidelines also include a decision tree for pre-operative and post-operative pain management, as well as recommended dosing of systemic analgesics based on anticipated operative pain.

Substance Use Disorder and Chronic Pain Case Consultation Services: To provide ongoing clinical support for providers, IHS, in partnership with the University of New Mexico Pain Center, provided a *Substance Use Disorder and Chronic Pain ECHO*. ECHO is a case-based learning model in which consultation is offered through virtual clinics to healthcare providers by an expert team to share knowledge and elevate the level of specialty care available to patients. In FY 2021, a total of 20 ECHO sessions were offered with 748 attendees.

Youth Regional Treatment Centers (YRTCs): YRTCs are facilities which provide medically managed care and other essential treatment and recovery services to AI/AN youth experiencing SUDs. Congress authorized the establishment of YRTCs in each of the 12 IHS Areas, with two (northern and southern) specifically authorized for the California Area. The YRTCs provide quality holistic behavioral health care for AI/AN adolescents that integrate traditional healing, spiritual values and cultural identification. In FY 2020, all federal YRTCs in operation 18 months or longer have achieved accreditation status. COVID-19 significantly impacted service delivery across all YRTCs. In response to the challenges, YRTCs partnered with IHS, SAMHSA's Office of Tribal Affairs and Policy and the Addiction Technology Transfer Center (ATTC) Network Coordinating Office to identify and develop response and recovery resources specific to YRTCs continuity of care. The document, *Guidance for Caring for Patients in Youth Regional Treatment Centers During the COVID-19 Pandemic* was developed to support the delivery of care among the YRTCs during this ever-evolving situation.[10] In FY 2021, the YRTCs shifted delivery of services to enhance safety measures to prevent the spread of COVID-19 that impacted the census of AI/AN youth receiving treatment. Most YRTCs currently provide treatment in socially distanced settings at their sites.

Indian Children's Program (formerly, Fetal Alcohol Spectrum Disorders (FASD): Training and technical assistance on FASD is provided through the IHS TeleBehavioral Health Center of Excellence (TBHCE) Indian Children Program (ICP). The focus of the ICP is training clinicians

[10] https://attcnetwork.org/sites/default/files/2020-08/YRTC_Document_08_05_20.pdf

on developmental and neurobiological issues that can affect AI/AN children. In FY 2021, ICP provided five webinars on Autism Spectrum Disorder with a total of 218 attendees. The ICP provided three webinars on supporting families of children with neurodevelopmental disorders with a total of 78 attendees. The ICP also provides additional clinician supports. For example, clinicians can take advantage of the Pediatric Neurodevelopmental & Behavioral Health Consultation Clinic. This virtual consultation is designed to help clinicians successfully diagnose, manage, and treat AI/AN youth with FASD, ASD, and other neurodevelopmental issues.

Information Systems Supporting Behavioral Health Care: The Resource and Patient Management System (RPMS) includes functionality designed to meet the unique business processes of behavioral health providers and support behavioral health-related initiatives. Standardized instruments and clinical decision support tools are available to support routine and effective screening for alcohol and substance use, depression, domestic violence and smoking status. Additionally, surveillance tools are available to capture suicide data at the point of care. Aggregate national RPMS behavioral health data is maintained to support local, national and other program reporting requirements as well as quality performance measurements for numerous screening and prevention initiatives including screening for alcohol and substance use, depression, domestic violence, smoking, and suicide data collection.

Partnerships: IHS is collaborating with other agencies working in the field of SUDs such as Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Veterans Affairs, Health Resources and Services Administration, Office of National Drug Control and Policy, and Centers for Diseases Control and Prevention (CDC), National Institutes of Health (NIH), Department of Justice (DOJ), Department of Interior (DOJ), and Center for Medicare and Medicaid Services (CMS) to ensure that the best available information, trainings, protocols, evaluations, performance measures, data needs, and management skills are incorporated and shared with all agencies and organizations working on substance use disorders.

The DOI, through the Bureau of Indian Affairs (BIA) and the Bureau of Indian Education (BIE), and IHS have a Memorandum of Agreement (MOA) on *Indian Alcohol and Substance Abuse Prevention*, which was amended in 2011 as a result of the permanent reauthorization of the Indian Health Care Improvement Act. Through this MOA, BIA, BIE, and IHS coordinate and implement plans in cooperation with Tribes to assist Tribal governments in their efforts to address behavioral health issues. The MOA includes coordination of data collection, resources, and programs of IHS, BIA, and BIE.

The Tribal Law and Order Act (TLOA) requires interagency coordination and collaboration among HHS (IHS and SAMHSA), DOI (BIA/BIE), DOJ (Office of Justice Programs/Office of Tribal Justice), and the Office of the Attorney General. The coordination of Federal efforts and resources will assist in determining both the scope of alcohol and substance abuse problems as well as effective prevention and treatment programs. The MOA required by Section 241 of the TLOA was signed on July 29, 2011, by the Secretaries of the Departments of Health and Human Services, the Interior and the Attorney General to: (1) determine the scope of the alcohol and substance abuse problems faced by Tribes; (2) identify and delineate the resources each entity can bring to bear on the problem; (3) set standards for applying those resources to the problems; and (4) coordinate existing agency programs.

In April 2019, IHS expanded collaboration with the Defense Veterans Center for Integrated Pain Management to explore feasibility of creating an IHS auricular acupuncture program utilizing the Veterans Health Administration Battlefield Acupuncture protocol. IHS has created a pilot program that includes credentialing and privileging processes, clinical practice protocols,

documentation standards, patient education materials, and a sustainability plan. The initial training session was hosted in November 2019 and 23 IHS clinicians were certified in this modality. Auricular acupuncture is an evidence-based integrated treatment option and full implementation would require an *IHS Scope of Practice* for nurses and pharmacists to deliver this treatment modality. Ninety-six community-health workers completed training as naloxone trainers for their Tribal communities in one week. The train the trainer sessions were migrated to virtual platforms during the COVID pandemic.

ASA Grant and Federal Award Programs

The IHS Division of Behavioral Health administers community-based grants and cooperative agreements that promote the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to substance abuse from a community-driven context. In particular, the IHS Community Opioid Intervention Pilot Program and the Substance Abuse and Suicide Prevention Program will support several of the HHS Strategic Plan goals and objectives, including *Objective 2.3: Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death*; and, *Objective 3.4: Increase safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence*.

IHS Community Opioid Intervention Pilot Program (COIPP): In FY 2021, IHS awarded $16 Million in funding to combat the opioid epidemic in AI/AN communities. In FY 2022, IHS continued funding 35 Tribal and urban Indian organizations to support the development of innovative, locally-designed, culturally-appropriate prevention, treatment, recovery, and aftercare services for opioid use disorders. Awarded projects will focus on increasing public awareness and education about the impact of OUD on individuals, families and communities. Additionally, IHS established a contract to provide evaluation technical assistance (TA) to guide this pilot project through a national evaluation. The cross-site evaluation will integrate culturally appropriate care as grantees create comprehensive support teams to strengthen and empower families addressing the opioid crisis. Finally, all projects will prioritize efforts to reduce unmet needs and opioid overdose deaths through increased access to MAT. The IHS COIPP is a three year program and part of the Department of Health and Human Services' five-point strategy to fight the opioid overdose epidemic in America.

Substance Abuse and Suicide Prevention Program (SASP): The SASP is a nationally-coordinated $31.97 million program providing funds for culturally appropriate substance abuse and suicide prevention programming in AI/AN communities. The program funds 174 projects. In August 2019, IHS initiated Tribal Consultation and an Urban Confer regarding behavioral health initiatives and the National Tribal Advisory Committee on Behavioral Health recommendations regarding the distribution of funding for the SASP program. In total, 22 comments and recommendations were received and reviewed by IHS. On March 2, 2020, the IHS Director issued a decision to continue distribution of the SASP program funds using a competitive grant mechanism.
Due to the COVID-19 pandemic, the SASP notice of funding opportunity (NOFO) was published in FY 2022.

The goals of the SASP program include:

1. Increase IHS, Tribal, and Urban (I/T/U) capacity to operate successful substance abuse prevention, treatment, and aftercare and suicide prevention, intervention, and postvention

services through implementing community and organizational needs assessment and strategic plans.
2. Develop and foster data sharing systems among I/T/U behavioral health service providers to demonstrate efficacy and impact.
3. Identify and address suicide ideations, attempts, and contagions among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, intervention, and postvention strategies.
4. Identify and address substance use among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, treatment, and aftercare strategies.
5. Increase provider and community education on suicide and substance use by offering appropriate trainings.
6. Promote positive AI/AN youth development and family engagement through the implementation of early intervention strategies to reduce risk factors for suicidal behavior and substance use.

SASP projects were awarded funding in at least one of four purpose areas and work to address the corresponding SASP goal listed above. SASP Purpose Areas are:

1. Community Needs Assessment and Strategic Planning
2. Suicide Prevention, Intervention, and Postvention
3. Substance Use Prevention, Treatment, and Aftercare
4. Generation Indigenous (Gen-I) Initiative Support

Of the projects funded, 19 projects specifically focus on substance use prevention, treatment, and aftercare, while 107 focus on substance abuse and suicide prevention among Native youth.

In support of the SASP, IHS established the Universal Alcohol Screening (UAS) as a national measure to increase screening and improve detection and intervention strategies among patients 9 through 75 years of age. In FY 2020, 37.1 percent of patients were screened. In 2020, the pandemic impacted IHS primary care and emergency departments clinical settings, therefore the IHS did not meet the expected screening target of 42.4 percent.

Due to the COVID-19 pandemic, the majority of the 174 SASP projects reduced and/or ceased activities. Only a limited number of projects continued to operate and did so according to their local, state, and federal guidelines for COVID-19 by modifying in-person activities to virtual events. In FY 2020, IHS requested and received a one-year extension for all SASP grants from the Department of Health and Human Services (DHHS) due to the impact of COVID-19.

In the fourth year of the SASP, 100 percent of projects submitted progress reports as a requirement of funding. Positive strides in the delivery of substance use services have been accomplished and reported in preliminary data monitoring for SASP program activities. Successful outcomes during the fourth year of the program include expanded behavioral health services offered through school settings and home visiting with a total of 1,475 patients receiving care. Over 270 providers were trained in behavioral health integration with 163 of those providers located within a primary care setting. Project accomplishments include 67,168 individuals screened for suicidal ideation, 54 percent of the SASP program suicide prevention projects implemented an enhanced process for suicide screening, and over 11,003 community members have been trained in suicide and/or substance use prevention. Fifty three percent of projects hosted a successful prevention education community event, and 59 percent reported their trainings to have expanded staff knowledge (a 12 percent increase from year 2). Twenty nine percent reported implementation and documentation of a system change. In addition,

among projects supported, a total of 76,054 individuals received cultural services, a high percentage of projects have continued to offer integrated traditional healing into care, extended service hours, provision of follow-up care, new counseling and case management services. In summary, the SASP program continues to support Tribes, Tribal organizations, urban Indian organizations, and federal facilities offering care.

Preventing Alcohol-Related Deaths (PARD): In the 2017 Senate Appropriations Committee Report 114-281, the Committee directed IHS to "allocate $2,000,000 of the increase provided for the alcohol and substance abuse program to fund essential detoxification and related services." Specifically, the number of alcohol related deaths in the community of Gallup, New Mexico was addressed with the report stating, "these deaths underscore the urgent need for substance abuse treatment, residential services and detoxification services" in this community. In response, the IHS used the increased appropriated funds to address the urgent need in the city of Gallup. In addition, IHS was aware of the urgent need for alcohol detoxification services in the Great Plains Area after the removal of liquor licenses and alcohol sales in White Clay, Nebraska, leading to the potential for increased mortality if services were unavailable for alcohol detoxification. As a result, funds were also made available to address this urgent need. The funds provided to Gallup and the Great Plains Area (specifically the Oglala Sioux Tribe's Anpetu Luta Otipi) in FY 2017 were to address the need for social detoxification services through a cooperative agreement. The project period is for five years, from September 15, 2017, to September 14, 2022. With the additional funding, the Gallup site reported detoxification services to an average of 26,000 individuals from 2016-2019, with over 75 percent of those clients as males. In addition to services offered for monitoring, supervising, and managing detoxification, this site has increased coordination and transportation with the Gallup Indian Medical Center Emergency Department; and established a contract with the Gallup Police Department to transport patients to the detoxification center. The Great Plains' Antepu Luta Otipi site has used the funding to increase coordination with behavioral health programs, provide screenings and brief interventions to individuals incarcerated in jails, and serve as an immediate placement for individuals who are in need of treatment services following detoxification. In FY 2020, nearly 100 percent of individuals held in detoxification for more than two weeks were successfully admitted into a higher level of residential treatment care for their SUD. In FY 2022, the Antepu Luta Otipi held a grand opening for a new residential and detoxification center in Western Bennett County in South Dakota with a 48 bed capacity. The new residential and detoxification center substantially increases the capacity to serve up to 48 male and female clients simultaneously.

During the COVID-19 pandemic, services were temporarily interrupted at the City of Gallup detoxification site, and the Great Plains Anpetu Luta Otipi site. IHS continues to work with both sites to ensure each has adopted guidelines provided by the local and state health departments, and the CDC for continued operations for detoxification programs.

YRTC Aftercare Pilot Project: In December 2017, IHS utilized $1.8 million to implement a pilot project for aftercare services for AI/AN youth discharged from residential substance abuse treatment. The purpose of the YRTC Aftercare project is to identify appropriate aftercare services that can be culturally adapted to support AI/AN youth in their recovery journey once they leave YRTC care. Two YRTCs, Desert Sage Youth Wellness Center and Healing Lodge of the Seven Nations, were selected to develop innovative approaches to aftercare, recovery, and other support services for AI/AN youth that can be used across other YRTCs. These facilities are tasked with implementing best practices around effective reintegration processes while establishing a collaborative partnership and community-based approach to reduce alcohol and substance use relapse. With the additional funding, the two YRTCs have engaged Tribal and urban programs that refer adolescents to the YRTCs, to identify best practices for aftercare. This

has resulted in a more focused commitment to improving the coordination around aftercare and case management, training of community supports for the adolescents, identification of transitional living, increasing awareness of the use of social media, and improving follow-up with data collection after discharge. In FY 2021, best practices and lessons learned from the *YRTC Aftercare Pilot Project* have been evaluated. Findings from the evaluation indicated an urgent need to improve the scope of data collection from the point of the client's treatment and pursuit of employability to the cross-agency administration of program performance; as well as improvements in the continuum of care, to include services that lead to self-management of treatment, employment, and full benefits of services that affect sobriety.

COVID-19

The COVID-19 pandemic has disproportionately affected AI/AN populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount	SASP	Gen I
2019	$234,421,000	($15,475,000)	($16,500,000)
2020	$245,618,000	($15,475,000)	($16,500,000)
2021 Final	$251,360,000	($15,475,000)	($16,500,000)
2022 Enacted	$258,343,000	($15,475,000)	($16,500,000)
2023 President's Budget	$344,620,000	($15,475,000)	($16,500,000)

TRIBAL SHARES

Alcohol and Substance Abuse funds are subject to Tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities, unless otherwise specified in the annual appropriations bill. A portion of the overall Alcohol and Substance Abuse budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2023 budget submission for Alcohol and Substance Abuse is $345 million, which is $86 million above the FY 2022 Enacted level.

FY 2022 Base Funding of $258 million – This funding will maintain the program's progress in addressing alcohol and substance abuse needs by improving access to behavioral health services through tele-behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

FY 2023 Funding Increase of $86 million includes:

- Current Services: +$9 million for current services including:

  - Pay Costs +$4 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.

  - Inflation +$790,000 – to fund inflationary costs of providing health care services.

  - Population Growth +$9 million – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.

- Staffing for New Facilities: $855,000 - these funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Naytahwaush Health Center (JV), Naytahwaush, MN	$256,000	2
NEACC (Salt River) Health Center, Scottsdale, AZ	$352,000	2
Ysleta Del Sur Health Center (JV), El Paso, TX	$67,000	0
Alternative Rural Health Center, Dilkon, AZ	$180,000	1
Grand Total:	**$855,000**	**5**

- Opioid Grants: +$9 million to expand the IHS Opioid Grant program to a total of $20 million. These additional resources will support opioid use disorder prevention, treatment, recovery, and aftercare services. Increased funds will prioritize projects targeted at recovery and aftercare practices and efforts by supporting community-based peer recovery training programs. Funds will support access to peer-recovery specialists, including access to training platforms with virtual learning and collaborative support, shared resources, and information. Funds will also provide evaluation and technical assistance for ongoing OUD activities.

- Partially Sustain APRA Investments: +$67 million - to partially sustain the ARPA Alcohol and Substance Abuse activities, preventing significant reduction in alcohol and substance abuse treatment services. This funding level will support an estimated 116,719 outpatient visits and 2,456 inpatient treatment days in FY 2023.

  The American Rescue Plan Act provided a historic investment in mental health and substance abuse prevention and treatment services for American Indians and Alaska Natives. The IHS distributed the $240 million appropriated in the ARPA to all IHS, Tribal, and urban Indian Heath programs.

  However, the ARPA appropriation provided one-time, non-recurring funding to support mental health and substance abuse prevention and treatment services. Ongoing resources are necessary to ensure that IHS, Tribal, and urban Indian health programs do not have to significantly reduce mental health and substance abuse treatment services as the one-time ARPA resources are expended.

The ARPA appropriated one amount for both mental health and substance abuse services, while the IHS budget includes two separate lines – one for Mental Health and one for Alcohol and Substance Abuse. The budget assumes an even split of these funds between the two funding lines.

- Realign Funding for Former National Institute on Alcohol Abuse and Alcoholism (NIAAA): -$31,061 - to realign remaining funding for former National Institute on Alcohol Abuse and Alcoholism (NIAAA) programs from the Alcohol & Substance Abuse line into the Urban Health line (see Difference column in the table below). This shift reduces administrative burden.

Recurring Funding for Former NIAAA Programs - Alcohol/Substance Abuse Funding

Former NIAAA Program	FY 2018	Difference	FY 2019
Juel Fairbanks Chemical Dependency Services	$104,685	$2,727	$107,412
American Indian Council on Alcoholism, Inc.	$278,816	$7,262	$286,078
Native Directions, Inc.	$364,037	$19,029	$383,066
Kansas City Indian Center (Heart of America)	$118,353	$2,043	$120,396
Native American Connections	$502,656	$0	$502,656
TOTAL	**$1,368,547**	**$31,061**	**$1,399,608**

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
10 YRTC Improvement/Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more). (Outcome)	FY 2021: 100 % Target: 100 % (Target Met)	100 %	100%	Maintain
80 Universal Alcohol Screening (Outcome)	FY 2021: 31.1 % Target: 39.0 % (Target Not Met) FY 2020: 34.0 % Target: 42.4 % (Target Not Met)	39.2 %	32.2%	-7.0%
82 Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Outcome)	FY 2021: 15.8 % Target: 14.3 % (Target Exceeded)	13.5 %	Retire	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
	FY 2020: 14.9 % Target: 12.2 % (Target Exceeded)			
90 Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Outcome)	FY 2023: Result Expected Dec 31, 2023 Target: Set Baseline (Pending)	N/A	Baseline	Maintain

GRANTS AWARDS

(whole dollars)	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget
Number of Awards	143	178	178
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

AREA ALLOCATION

Alcohol and Substance Abuse

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2021 Final			FY 2022 Estimated			FY 2023 Estimated			FY '23 +/- FY '22
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$756	$34,364	$35,120	$777	$35,319	$36,095	$1,036	$47,114	$48,150	$12,055
Albuquerque	3,563	10,220	13,783	3,662	10,504	14,166	4,885	14,012	18,897	$4,731
Bemidji	2,268	8,993	11,262	2,331	9,243	11,574	3,110	12,330	15,440	$3,865
Billings	605	11,573	12,178	622	11,895	12,517	830	15,867	16,697	$4,180
California	4,012	14,941	18,953	4,124	15,356	19,480	5,501	20,485	25,985	$6,506
Great Plains	4,547	11,378	15,924	4,673	11,694	16,367	6,234	15,599	21,833	$5,466
Nashville	3,700	6,739	10,439	3,803	6,926	10,729	5,073	9,239	14,312	$3,583
Navajo	2,060	19,581	21,641	2,117	20,125	22,242	2,824	26,846	29,670	$7,428
Oklahoma	5,268	13,243	18,511	5,414	13,611	19,026	7,222	18,157	25,379	$6,354
Phoenix	8,731	11,432	20,163	8,974	11,749	20,723	11,970	15,673	27,644	$6,921
Portland	2,457	15,561	18,018	2,525	15,993	18,518	3,368	21,334	24,703	$6,184
Tucson	64	3,347	3,411	65	3,440	3,506	87	4,589	4,676	$1,171
Headquarters	51,957	0	51,957	53,401		53,401	71,234		71,234	$17,834
Total, ASA	**$89,987**	**$161,373**	**$251,360**	**$92,487**	**$165,856**	**$258,343**	**$123,375**	**$221,245**	**$344,620**	**$86,277**

Note: FY 2022 and FY 2023 are estimates.

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

(Dollars in thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$975,856	$984,887	$1,218,059	+$233,172
FTE*	89	89	89	--

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

Allocation Method ..... Direct Federal, PL 93-638 Tribal Contracts and Compacts, Commercial contracts, and Tribal shares

PROGRAM DESCRIPTION

The Snyder Act provides the formal legislative authority for the expenditure of funds for the "relief of distress and conservation of health of Indians."[1] In 1934, Congress provided the specific authority to enter into medical services contracts for American Indians and Alaska Natives.[2] These, among other authorities[3] established the basis for the Indian Health Service (IHS) and the Purchased/Referred Care (PRC) Program.[4]

The PRC Program is integral to ensure comprehensive health care services are available and accessible to eligible American Indians and Alaska Natives (AI/AN) (*IHS Strategic Plan Goal 1* and *HHS Strategic Plan FY 2022 - 2026 Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare*). The Indian health system delivers care through direct care services provided in an IHS, Tribal or Urban Indian Health Program (I/T/U) facility (e.g., hospitals, clinics) and through PRC services delivered by non-IHS providers to increase access to quality health care services (IHS Strategic Plan 1.3 and *HHS Strategic Plan FY 2022 - 2026 Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare*). The general purpose of the PRC Program is for IHS or Tribal facilities to purchase services from private health care providers in situations where:

1) No IHS or Tribal direct care facility exists,
2) The direct care element is not capable of providing required emergency and/or specialty care,
3) The direct care element has an overflow of medical care workload, and
4) Full expenditure of alternate resources (e.g., Medicare, private insurance) has been met and

[1] The Snyder Act, Public Law 67-85, November 2, 1921, 25 U.S.C § 13.

[2] The Johnson O'Malley Act of April 16, 1934, as amended, 25 U.S.C. § 452.

[3] Transfer Act, 42 U.S.C. § 2001; Indian Health Care Improvement Act, as amended, 25 U.S.C § 1601, et seq.

[4] The Consolidated Appropriation Act of 2014, Public Law 113-76, January 18, 2014, adopted a new name for the IHS Contract Health Services (CHS) program to Purchased/Referred Care (PRC). The IHS will administer PRC in accordance with all law applicable to CHS.

supplemental funds are necessary to provide comprehensive care to eligible Indian people.

In addition to meeting the eligibility requirements for direct services at an IHS or Tribal facility, PRC eligibility is determined based on residency within the service unit or Tribal PRC delivery Area; authorization of payment for each recommended medical service by a PRC authorizing official; medical necessity of the service and inclusion within the established Area IHS/Tribal medical/dental priorities; and full expenditure of all alternate resources (i.e., Medicare, Medicaid, private insurance, state or other health programs, etc.). Alternate resources must pay for services first because the IHS PRC Program is the payer of last resort.[5] Services purchased may include hospital, specialty physician, outpatient, and laboratory, dental, radiological, pharmaceutical, or transportation services. When funds are not sufficient to purchase the volume of PRC services needed by the eligible population residing in the PRC delivery area of the local facility, IHS PRC regulations require IHS or Tribal PRC programs to use a medical priority system to fund the most urgent referrals first.

Medical priority (MP) levels of care are defined as follows:

MP Level I: Emergent or Acutely Urgent Care Services are defined as threats to life, limb and senses.
MP Level II: Preventive Care Services are defined as primary health care that is aimed at the prevention of disease or disability.
MP Level III: Specialty Services are considered ambulatory care which include inpatient and outpatient care services.
MP Level IV: Chronic Tertiary and Extended Care Services are defined as requiring rehabilitation services, skilled nursing facility care.
MP Level V: Excluded Services are services and procedures that are considered purely cosmetic in nature, i.e., plastic surgery.

A PRC rate, a capitated rate based on Medicare payment methodology, is used to purchase care, and Medicare participating hospitals are required to accept this rate as payment in full for all hospital-based health care services (Public Law 108-173). This allows IHS to purchase care at a lower cost than if each service were negotiated individually increasing access to quality health care services and provide care to better meet the health care needs of AI/ANs (*IHS Strategic Plan 1.3.4 – Increase access to quality community, direct, specialty, long-term care and support services, and referred health care services and identify barriers to care for AI/AN stakeholders* and *HHS Strategic Plan FY 2022 - 2026 Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare*). Physician and non-hospital providers of supplies and services are purchased at the PRC rate. However, if a physician or non-hospital provider does not accept the PRC capitated rate, agreements or contracts can be negotiated with individual providers of supplies or services using the provider's most favored customer rate as a ceiling for negotiation (42 CFR 136 Subpart I) (*IHS Strategic Plan 3.2.7 – Develop policies, use tools, and apply models that ensure efficient use of assets and resources and HHS Strategic Plan FY 2022 - 2026 Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability*). Program funds are administered and managed at IHS Headquarters, at each of the 12 IHS Areas, and at IHS and Tribal facilities across the nation. The regulation has demonstrated that IHS is able to stretch the same amount of money to cover additional necessary health care services and improve access to care. This meets *the IHS Strategic Plan Goal 1: To ensure that comprehensive culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people. Objective 1.3 Increase access to quality health care services. HHS Strategic Plan FY 2022 - 2026 Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare.*

The PRC Program also administers the Catastrophic Health Emergency Fund (CHEF). Created in 1988,

[5]25 U.S.C. § 1621e, 1623; 42 CFR 136.61 (2010)

the CHEF was established for the sole purpose of meeting extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses.[6]The CHEF is used to reimburse PRC programs for high cost cases (e.g., burn victims, motor vehicle crashes, high risk obstetrics, cardiology, etc.) after a threshold payment amount is met, the current threshold is $25,000. The CHEF is centrally managed at IHS Headquarters.

The PRC Program contracts with a fiscal intermediary (FI), currently Blue Cross/Blue Shield of New Mexico, to ensure payments are made in accordance with IHS' payment policy, and coordinate benefits with other payers to maximize PRC resources. (*IHS Strategic Plan 3.2.7 – Develop policies, use tools, and apply models that ensure efficient use of assets and resources* and *HHS Strategic Plan FY 2022 - 2026 Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability*). All IHS-managed PRC programs and some tribally-managed PRC programs use the FI to ensure the use of PRC rates for inpatient services and PRC or negotiated rates for physician and non-hospital providers of supplies and services.

PRC funding provides critical access to essential health care services and remains a top request by Tribes in the budget formulation recommendations. (*IHS Strategic Plan 1.3 Increase access to quality health care services* and *HHS Strategic Plan FY 2022 - 2026 Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare).*

Note: On February 28, 2019, IHS updated the *Indian Health Manual,* Part 2, Services to Indians and Others, Chapter 3, Purchased/Referred Care. In this IHM update IHS adopted the policy that PRC funds may be used for staff administrating the PRC program at administrative levels. This adopts the GAO recommendation for the use of PRC funds for PRC staff where appropriate. This policy change requires Areas to ensure they are funding requests through Priority Level II before these PRC administrative expenses can be charged. This policy meets the (*IHS Strategic Plan 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce.)*

PROGRAM ACCOMPLISHMENTS

Purchased/Referred Care (PRC) Rates – The PRC rates for all hospital-based services implemented in 2007 and the PRC rates for physicians and non-hospital providers of supplies and services implemented in 2016 have increased access to care by allowing I/T/Us to purchase additional services with these Medicare methodology capitated rates, referred to as PRC rates. PRC rates were originally referred to as Medicare-like rates (MLR) for hospital based services but are now identified as PRC rates. PRC rates are based on the Medicare payment methodology for all hospital based services, physician and non-hospital providers of supplies and services. The PRC rates rule (42 CFR 136 Subpart I) for physicians and non-hospital providers of supplies and services applies to tribally-operated PRC programs only to the extent the programs agree to "opt-in" via its Indian Self Determination and Education Assistance Act contract or compact. The rule has flexibility that allows PRC programs to negotiate rates that are higher than the PRC rate based on Medicare methodology, but equal to or less than the rates accepted by the provider or supplier's most favored customer rate; in the absence of Medicare payment methodology for a service, the IHS payment amount is calculated at 65 percent of billed charges from the provider or supplier.

Medical Priorities – Recent PRC program increase in purchasing power through the PRC rates described above have allowed most of the IHS and Tribally-managed PRC programs to approve referrals in priority categories other than Medical Priority I (life or limb), including some preventive care services, thus increasing access to patient care services. In FY 2021, 94 percent of IHS-operated PRC programs were able to purchase services beyond Medical Priority II – Preventive Care Services. Prior funding increases

[6]25 U.S.C. § 1621a

and Medicaid expansion have enabled programs to purchase preventive care beyond emergency care services, such as mammograms or colonoscopies.

The IHS PRC Workgroup helped IHS develop a more accurate form for annually reporting denied and deferred PRC services. In FY 2021, PRC programs denied and deferred an estimated $787,046,253 for an estimated 169,953 services for eligible AI/ANs. Because Tribally-managed programs are not required to report denials data, it is difficult to provide a verifiable and complete measure of the total unmet need for the entire I/T/U system. Therefore, the denied services estimate is based on actual data from federal programs and estimated Tribal data.

Catastrophic Health Emergency Fund (CHEF) – In FY 2021, all high cost cases submitted for reimbursement from the CHEF have been reimbursed. It is estimated that more cases may qualify for CHEF reimbursement but were not reported by local IHS and Tribally-managed PRC programs. Catastrophic case requests are reimbursed from the CHEF until funds are depleted. The implementation of PRC rates for inpatient and non-hospital providers of supplies and services as well as the increase of I/T/U beneficiaries enrolled in Medicaid, Medicare and Private Insurance has enabled the CHEF to reimburse PRC programs for high cost catastrophic events and illnesses that occur through the end of the fiscal year.

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. Since the beginning of the PHE through February 21, 2022, the PRC Fiscal Intermediary has processed 26,417 COVID related claims in the amount of $49,443,129. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	PRC	CHEF	Total
2019	$911,819,000	$53,000,000	$964,819,000
2020	$915,015,000	$53,000,000	$965,015,000
2021 Final	$922,856,000	$53,000,000	$975,856,000
2022 Enacted	$931,887,000	$53,000,000	$984,887,000
2023 President's Budget	$1,165,059,000	$53,000,000	$1,218,059,000

TRIBAL SHARES

Purchased and Referred Care funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. The CHEF management is federally inherent and no part of CHEF or its administration can be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act. CHEF fund cannot be allocated, apportioned, or delegated on an Area Office, Service Unit or other similar basis (25 U.S.C. 1621(a)(c)).

BUDGET REQUEST

The FY 2023 budget submission for Purchased/Referred Care is $1.2 billion, which is $233 million above the FY 2022 Enacted level.

FY 2022 Base Funding of $985 million will support over 40,000 inpatient admissions, over 942,000 outpatient visits, and over 45,000 patient travel trips.

FY 2023 Funding Increases of $233 million includes:

- Current Services of +$26 million, including:
    - Pay Costs: +$291,000 – to fund pay increases for Federal and Tribal employees.
    - Inflation +$9 million to fund inflationary costs of providing health care services.
    - Population Growth +$17.4 million – to address the impact of the additional services need arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.
- Purchased/Referred Care General Program Increase: +$184 million to address the unmet need for direct health care services identified by the FY 2018 Indian Health Care Improvement Fund Work Group. These funds will support the following estimated increased services:
    - 7,333 Inpatient admissions
    - 182,319 Outpatient visits
    - 8,006 Patient travel trips
- Arizona State-wide PRC Delivery Area ($22 million): The Indian Health Care Improvement Act directs the IHS to establish a state-wide Purchased/Referred Care Delivery Area (PRCDA) in Arizona to serve members of Indian tribes that reside in the state, so long as it does not curtail health services provided to Indians residing on reservations located in the state. Currently, there are many American Indians and Alaska Natives that reside within the state of Arizona, but are not members of Tribes with reservations located within the state (predominately members of the Navajo Nation). As a result, these individuals are not able to access PRC services in Arizona.
    - This proposal would provide the funding necessary to create a state-wide PRCDA in Arizona without reducing the availability of services for members of Tribes that are located within the state.
    - The IHS previously conducted a feasibility study, which showed that there would be 67,434 newly eligible Tribal members under a state-wide PRCDA. The IHS multiplies the average PRC spending per currently eligible Tribal member ($326) by the newly eligible Tribal members to develop the $22 million estimate.
- North Dakota/South Dakota PRC Delivery Area Study (+$250,000): These funds would support a feasibility study for a North Dakota/South Dakota PRCDA, much like the feasibility study that was conducted for the Arizona state-wide PRCDA. The Indian Health Care Improvement Act also directs the IHS to designate the states of North Dakota and South Dakota as a PRC Delivery Area, without

impacting services for Indians residing on reservations either state. This funding would support a study to understand how many additional patients could be eligible under such a PRCDA to determine what funding may be necessary to create this new PRCDA without impacting services for Tribal members residing on reservations in either state.

- New Tribes (+$1 million): These fund will support the delivery of health care services for the Buena Vista Rancheria of Me-Wuk Indians of California ($67,039 estimated funding requested). The tribe has been federally recognized since 1985, but has not requested IHS funding until 2021. These resources would also support other newly federally recognized Tribes in FY 2023.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
PRC-2 Track IHS PRC referrals (Outcome)	FY 2021: 77.0 days Target: 60.0 days (Target Not Met but Improved)	60.0 days	60.0 days	Maintain
PRC-3 Track PRC self-referrals (Outcome)	FY 2021: 69.0 days Target: 45.0 days (Target Not Met but Improved)	45.0 days	45.0 days	Maintain

GRANT AWARDS. This program does not fund grant awards.

AREA ALLOCATION

Purchased/Referred Care

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2021 Final			FY 2022 Estimated			FY 2023 Estimated			FY '23 +/- FY '22
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$100,893	$100,893	$0	$101,827	$101,827	$0	$125,934	$125,934	$24,107
Albuquerque	27,172	18,804	45,976	27,423	18,978	46,401	33,916	23,471	57,386	$10,985
Bemidji	14,006	54,634	68,640	14,135	55,140	69,275	17,482	68,194	85,676	$16,401
Billings	44,152	21,345	65,496	44,560	21,542	66,102	55,110	26,642	81,752	$15,650
California	734	55,722	56,456	741	56,237	56,978	916	69,552	70,468	$13,490
Great Plains	68,021	23,625	91,646	68,651	23,843	92,494	84,904	29,488	114,392	$21,898
Nashville	6,217	35,007	41,225	6,275	35,331	41,606	7,761	43,696	51,456	$9,850
Navajo	58,352	45,959	104,312	58,892	46,385	105,277	72,835	57,366	130,201	$24,924
Oklahoma	46,368	75,691	122,058	46,797	76,391	123,188	57,876	94,477	152,353	$29,165
Phoenix	44,816	33,031	77,847	45,231	33,337	78,567	55,939	41,229	97,168	$18,601
Portland	13,337	94,494	107,831	13,460	95,368	108,828	16,647	117,947	134,594	$25,765
Tucson	282	21,430	21,713	285	21,629	21,914	352	26,749	27,102	$5,188
Headquarters	71,765	0	71,765	72,429		72,429	89,576		89,576	$17,148
Total, PRC	**$395,222**	**$580,634**	**$975,856**	**$398,879**	**$586,008**	**$984,887**	**$493,314**	**$724,745**	**$1,218,059**	**$233,172**

Note: FY 2022 and FY 2023 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

Services: 75-0390-0-1-551

INDIAN HEALTH CARE IMPROVEMENT FUND

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2023
PL	$72,280	$74,138	$0	-$74,138
FTE*	48	48	0	-48

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.

Authorizing Legislation ..... 25 U.S.C. § 1621 of the Indian Health Care Improvement Act (IHCIA), as amended

FY 2023 Authorization..... Permanent

Allocation Method ..... Direct Federal, P.L. 93-638 contracts and compacts, Tribal shares

PROGRAM DESCRIPTION

The Indian Health Care Improvement Act (IHCIA) at 25 U.S.C. § 1621 authorizes the Indian Health Care Improvement Fund (IHCIF) for purposes of eliminating deficiencies in health status and resources of all Indian tribes, eliminating backlogs in health care services to Indians, meeting the health needs of Indians in an efficient and equitable manner, eliminating inequities in funding for both direct care and Purchased/Referred Care (PRC) programs, and augmenting health services where deficiencies are highest. The IHCIA specifies that the IHS take into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances. The IHS received a total of $259 million in IHCIF resources from FY 2000 – FY 2018. Prior to the Omnibus Appropriations Act of 2018, which provided $72 million in a new IHCIF budget line, IHCIF increases were included in the Hospitals and Health Clinics budget line.

PROGRAM ACCOMPLISHMENTS

A formula to allocate appropriations for the IHCIF was initially developed through the work of a Tribal/IHS Workgroup in 2000. The formula, which later became known as the Federal Disparity Index (FDI), or synonymously, the Level of Need Funded (LNF), measured the LNF for IHS and Tribal facilities relative to a benchmark level of funding. The formula was revisited once in 2010, prompted by the reauthorization of the IHCIA, which included an update to the IHCIF provision, expanding the list of services that the IHCIF may support, establishing a reporting requirement, and reaffirming that IHS must consider services and resources provided by Federal programs, private insurance, and programs of State and local governments. While technical improvements were made to the data used in the calculation, the IHS did not to change the formula at that time.

In late 2017, in recognition of the considerable changes in the health care environment since the 2010 Tribal consultation on the IHCIF, in response to Tribal requests, and the funding increase for the IHCIF in the Consolidated Appropriations Act, 2018 (P.L. 115-141), IHS reconvened another IHCIF Tribal/IHS Workgroup (Workgroup) to review the existing formula and make recommendations for improvement.

The IHS updated the funding distribution formula based on the recommendations of the IHCIF workgroup, and allocated an additional $72 million in IHCIF resources to 40 sites across eight IHS Areas that were at or below a 34.84 percent Level of Need Funded.

FUNDING HISTORY

Fiscal Year	Amount*
2019	*$72,280,000*
2020	*$72,280,000*
2021 Final	*$72,280,000*
2022 Enacted	*$74,138,000*
2023 President's Budget/1	*$0*

1/ Resources in the Indian Health Care Improvement Fund are consolidated with historic funding amounts for this activity that were originally appropriated in Hospitals & Health Clinics. Fund for the Indian Health Care Improvement Fund is not eliminated.

BUDGET REQUEST

The FY 2023 Request proposes to consolidate funding for the Indian Health Care Improvement Fund into its original appropriations location, Hospitals and Health Clinics, through a budget-neutral realignment of the enacted base of $74 million. It also requests a General Program Increase of +$243 million within the Hospitals and Health Clinics funding line to provide additional direct health care services, and address resource disparities across the IHS.

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$179,144	$191,543	$208,310	+$16,767
FTE*	217	241	278	+37

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.

SUMMARY OF THE BUDGET REQUEST

The FY 2023 Indian Health Service (IHS) Budget submission for Preventive Services the budget includes a total of $208 million, which is +$17 million above the FY 2022 Enacted level.

This funding increase includes:

- Current Services - +$8 million
- Staffing of New and Replacement Facilities - +$6 million
- Community Health Representative Program Evaluation - +$3 million
- Hepatitis B and Haemophilus Immunization Programs (Alaska) - +$26,000

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

- **Public Health Nursing** (PHN) to support prevention-focused nursing care interventions for individuals, families, and community groups as well as improving health status by early detection through screening and disease case management. The PHN Program home visiting service provides primary, secondary, and tertiary prevention focused health interventions.

- **Health Education** to support the provision of community health, school health, worksite health promotion, and patient education. In order to prioritize health care services and staffing of newly constructed facilities, the Budget discontinues the Health Education program.

- **Community Health Representatives** (CHRs) to help to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained indigenous community members. In order to prioritize health care services and staffing of newly constructed facilities, the Budget discontinues the Community Health Representative program.

- **Hepatitis B and Haemophilus Immunization Programs (Alaska)** will support the provision of vaccines for preventable diseases, immunization consultation/ education, research, and liver disease treatment and management through direct patient care, surveillance, and education for Tribal facilities throughout Alaska. The Immunization Alaska Program budget supports these priorities through direct patient care, surveillance, and educating Alaska Native patients.

These **Preventive Health** services contribute widely to the performance measures that fall under the auspices of Hospitals & Health Clinics. PHN clinical services directly contribute to

community health and wellness through immunizations, case management, and patient education. CHRs are also community-based and contribute to follow up care and lay health education. Health Education activities permeate the Indian health system and are integral to the fulfillment of the performance screening measures. The Immunization Alaska Program plays a key role by tracking immunization rates through specific immunization registries throughout the State of Alaska, and such efforts contribute to the national immunization rates.

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$92,736	$102,466	$112,570	+$10,104
FTE*	197	221	253	+32

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

Allocation Method .....Direct Federal, P.L. 93-638 Tribal Contracts and & Compacts, Tribal Shares, Grants

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Public Health Nursing (PHN) Program is a community health nursing program that focuses on the goals of promoting health and quality of life, and preventing disease and disability. The PHN Program provides quality, culturally sensitive health promotion and disease prevention nursing care services through primary, secondary and tertiary prevention services to individuals, families, and community groups:

- *Primary prevention interventions* aim to prevent disease and include such services as health education/behavioral counseling for health promotion, risk reduction, and immunizations.
- *Secondary prevention interventions* detect and treat problems in their early stages. Examples include health screening of high-risk populations, screening for diabetes and hypertension, fall risk assessments, and school health assessments.
- *Tertiary prevention interventions* prevent or limit complications and disability in persons with an existing disease. The goal of tertiary prevention is to prevent the progression and complications associated with chronic and acute illness by providing optimal care for the patient. Examples include chronic disease case management, self-management education, medication management, and care coordination.

The PHN program aligns with the *IHS Strategic Plan FY 2019-2023 Goal 1 to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people by increasing access to quality health care services (Goal 1, objective 1.3).* The PHN Program funds provide critical support for direct health care services in the community which improve Americans' access to health care and expand choices of care and service options. *(Supports HHS Strategic Plan Goal 1:Protect and Strengthen Equitable Access to High Quality and Affordable Health Care, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while recognizing social determinants of health.)* PHNs support population-focused services to promote healthier communities through community based direct nursing services, community development, and health promotion and disease prevention activities. PHNs are licensed, professional nursing staff available to improve care transitions by providing patients with tools

and support that promote knowledge and self-management of their condition as they transition from the hospital to home. The PHN expertise in communicable disease assessment, outreach, investigation, and, surveillance helps to manage and prevent the spread of communicable diseases. PHNs contribute to several agency's primary prevention efforts such as providing community immunization clinics, administering immunizations to homebound AI/AN individuals, and through public health education, inspiring AI/AN people to engage in healthy lifestyles and ultimately live longer lives. PHNs conduct nurse home visiting services via referral for such activities as follows:

- Maternal and pediatric populations, including childhood obesity prevention through breastfeeding promotion, screening for early identification of developmental problems, and parenting education;
- Elder care services including safety and health maintenance care;
- Chronic disease care management; and
- Communicable disease investigation and treatment.

PHNs perform a community assessment to identify high-risk populations and implement evidenced based interventions to address identified areas of need. This activity targets fragmentation in patient care services and improves care continuums, including patient safety. Interventions are monitored with data collection and evaluated for outcome with an emphasis on producing a good return on investments in terms of service(s) provided.

PROGRAM ACCOMPLISHMENTS

As part of the Agency's Public Health Response to the pandemic emergency, in FY 2021 the PHN Program supported efforts to end the pandemic through vaccine administration and measures to slow the spread of the virus. The degree of mitigation activity commensurrated with staff shortages that challenged efforts to administer vaccines as well as activities for ongoing case investigation and monitoring individuals for adverse events. The PHN Program stressed compliance with CDC guidance that was reflected in protocols which were communicated to staff and supervisors. For example, the enforcement of protocols to prioritize home visits and patient contacts to provide services to the greatest need by use of a PHN Program Priority, Intensity and Timeliness of follow up policy. PHNs implemented strategies to reduce transmission of the virus within AI/AN communities by providing patient education to promote behaviors that prevented spread and shared best practices as part of the IHS Vaccine Taskforce sponsored IHS-wide webinars. Existing best practices such as collaborating with a team that includes a designated point of contact for each tribe, the Primary Care Physicians and utilization of an established PHN patient referral system and tribal programs for assistance in monitoring patients was key in planning for vaccination administration. Hosting weekly calls with tribes to provide information and updates regarding plans for vaccination efforts, sharing of high risk elder list established prior to the COVID pandemic, and planning to replicate prior PHN activity to high risk elders with influenza vaccines were used to define administration plans of the COVID vaccine. Other established PHN COVID vaccination efforts such as home visitation for home bound elders and drive through influenza vaccines continued. Prior to COVID, PHN's were already visiting elders and others in the home for safety and medication assessments. When influenza vaccines arrived PHN's began re-visiting known high risk elders and high risk patients with the help of the Community Health Representatives (CHR). The home visitations included providing up to date COVID information, safety COVID education, and COVID vaccination. During this time, the PHNs reported critical patient encounters for communicable disease, surveillance, contact tracing, testing, patient monitoring, and vaccination activities. These efforts resulted in an overall increase in the number of PHN activities reported to address the COVID-19 crisis.

During FY 2021, due to the pandemic crisis, PHN health promotion and disease prevention activities to improve the overall health prosperity of AI/AN communities resulted in decreased patient encounters for non-COVID related follow up. The PHN Program aligns with the Agency's priorities and contributes to patient care coordination activities and access to quality, culturally competent care that aims to promote health and quality of life through a community population focused nurse visiting program which serves the patient and family in the home and in the community *(IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.3)*. The PHN Program assesses the services provided in meeting the agency's priority Government Performance and Results Act (GPRA) measures and integrates the Department's Strategic Goal to strengthen social well-being, equity, and economic resilience. *(Supports HHS Strategic Plan Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3.Enhance promotion of healthy lifestyle choices to reduce occurrence and disparities in preventable injury, illness, and death.)* Using a variety of methods to educate the AI/AN population such as individual and group patient education sessions, screening activities and referring high-risk patients, and immunizing individuals to prevent illnesses, the PHN works to improve the overall wellness of Americans. Preventative health care informs populations, promotes healthy lifestyles and provides early treatment for illnesses. The PHN Data Mart report for FY 2021 reflects a decrease in PHN activity in GPRA screening documented activities which include the following encounter numbers:

- Tobacco Screening (2,811)
- Domestic Violence Screening (6,915)
- Depression Screening (6,071)
- Alcohol Screening (8,017)
- Adult Influenza Vaccines (36,324)

In 2021, the PHN Program continued efforts to meet the IHS's goal to decrease childhood obesity and prevent diabetes by supporting Baby Friendly re-designation by accomplishing the following activities: providing patient education, assessment and referral services for prenatal, postpartum and newborn clients during home visits, and utilizing a standardized PHN electronic health record template to document intervention *(IHS Strategic Plan FY 2019-2023, Goal 2 to promote excellence and quality through innovation of the Indian health system into an optimally performing organization, Objective 2.2: provide care to better meet the health care needs of AI/AN communities; and, supports HHS Strategic Plan Goal 2:Objective 2.3)* The PHN data mart provides a mechanism to evaluate how the PHN program delivers this evidence-based prevention service of promoting breastfeeding during the nurse patient encounter. For FY 2020, there were a total of 4,039 PHN patient encounters related to the Baby Friendly Hospital Initiative. These patient encounters included 10,670 documented patient education topics provided by the PHN during prenatal, postpartum and newborn encounters, which included the following topics: breastfeeding, child health for the newborn, immunizations, family planning, sudden infant death syndrome, tobacco use/prevention, postpartum depression, formula feeding, and child health. As part of this initiative, IHS is encouraging clinicians in Indian Country to support policies and practices that foster breastfeeding as the exclusive feeding choice for infants during their first six months of life. By doing so, clinicians will reduce current and future medical problems and decrease health care costs.

To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people by increasing access to quality health care services *(IHS Strategic Plan FY 2019-2023, Goal 1; and, supports HHS Strategic Plan, Goal 3: Strengthen Social Well-Being, Equity, and Economic Resilience, Objective 3.3: Expand access to high-quality services and resources for older adults and their caregivers to support increased independence and quality of life)*, the PHN Program continues to support caregivers of

individuals suffering from dementia. Caregivers supported by the PHN program includes screening for depression, the effect of depression on daily life, and caregiver burden and frustration. For FY 2021, there have been 1,859 PHN encounters to patients with dementia, and services provided at these PHN encounters include the following:

- Immunizations (2,646)
- Medications (673)
- Communicable disease prevention (401)
- Life adaptation (427)
- Safety and fall prevention (126)

In support of the Million Hearts campaign to prevent heart attacks and strokes, PHNs provided 13,438 patient encounters in FY2021 that encompassed patient education on tobacco cessation at 2,986, hypertension at 11,681, and sodium reduction at 727. Additional education provided during these PHN encounters include tobacco use, immunizations, diabetes, and medications.

PHNs provide services to enhance quality care and support patient safety during transitions of care settings by follow up on hospital discharges in an effort to decrease hospital readmissions. In FY 2021, PHNs documented patient encounters with patients who were discharged from the hospital and provided a total of 8,384 follow-up visits; some of these patients had multiple post discharge follow-up visits. Top patient education topics provided during these encounters include immunizations, community disease prevention, lifestyle adaptation and medication.

As a means of improving quality care and meeting the needs of the AI/AN population (*supports IHS Strategic Plan FY 2019-2023, Goal 2, Objective 2.2*) to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to the AI/AN people and to support staff retention and staff development, an evidenced based preceptorship program with proven training materials, preceptor development, and repository of training material was initiated in 2020. In March 2020, the PHN Program hosted the Vermont Nurses in Partnership for a week long training in Albuquerque, New Mexico to establish evidence-based transition programs, competence validation, and experiential learning for the PHNs. In FY 2022-23 planning for ongoing training to support this activity will continue.

In 2021, the PHN program continued interventions which targeted prevention of sexually transmitted infection (STI) to improve care. This activity can be monitored with the use of the PHN data mart tool as a performance measurement in support of practicing population based health management. The PHN data mart provides information on PHN activities such as the provision of patient education, surveillance and treatment of STIs. PHNs provided 30,098 patient encounters in FY2021 that encompassed 22,936 patient education codes documented for STI visits which included communicable disease, medications, contact with exposure, immunizations, and tobacco use. The PHN program will sponsor a grant program in FY2022 with a purpose to mitigate the prevalence of STIs within Indian Country. The emphasis is on raising awareness of STIs as a high-priority health issue among AI/AN communities and to support prevention and control activities of comorbid conditions.

In FY 2017, the current PHN grant program awarded 9 grants with a performance period of 5 years; these awards have a narrow and defined area of focus, seeking to improve specific behavioral health outcomes and to support the efforts of AI/AN communities toward achieving excellence in holistic behavioral health treatment, rehabilitation, and prevention services for individuals and their families (IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.2). Currently, there are 7 grant programs with goals to improve behavioral health outcomes through a PHN case management model. In addition to reducing the cost of health care, case management

has worth in terms of improving rehabilitation, improving quality of life, increasing client satisfaction and compliance by promoting client self-determination. The focus is on services for behavioral health and coexisting conditions such as chronic disease management, maternal child health care, and patient education services to improve health outcomes. The majority of the programs have established policies and procedures and nearly half are billing for PHN services to support sustainability. This grant program is ending in FY2022 and a new notice of funding opportunity will be awarded in 2023.

The FY 2021 target for the PHN Program measure was 330,000 encounters. The final FY 2021 result of 428,476 patient encounters exceeded the target by 98,476 encounters, a 29 percent increase. The PHN impact during the COVID-19 pandemic is reflected in the top ten patient encounters addressing communicable disease and surveillance. Historically, data exporting processes have impacted the overall PHN performance outcome as several tribal programs have migrated away from the IHS Patient Management System (RPMS) resulting in less visits being exported to the agency's National Data Warehouse database; however, in FY 2021 the pandemic crisis impacted the PHN workload with testing, patient monitoring and vaccine administration activities. The end result has been an increase in the number of PHN activities being reported in regards to services provided to address the pandemic crisis. In FY 2022, use of the PHN data mart to reflect the PHN activity in meeting Agency goals and to supplement the PHN program's accomplishments report will be emphasized. These reports provide an avenue to monitor the PHN program's support of the health care delivery services in the community, and provides available data to inform I/T/U decision-making *(IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.3; and, supports HHS Strategic Plan Draft, Goal 4, Restore Trust and Accelerate Advancements in Science and Research for All, Objective 4.4: Improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience*). In FY 2021, the updates to the PHN Documentation Manual was not completed due to heavy workload in responding to the pandemic. This will be a goal for FY 2022-23 and include information on the PHN data mart reports to improve reporting of outcome.

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount
2019	$86,354,000
2020	$91,984,000
2021 Final	$92,736,000
2022 Enacted	$102,466,000
2023 President's Budget	$112,570,000

TRIBAL SHARES

Public Health Nursing funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall Public Health Nursing budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2023 budget submission for Public Health Nursing $113 million, which is $10 million above the FY 2022 Enacted level.

FY 2022 Base Funding of $102 million – This funding will support the public health nursing services provided by IHS and Tribal programs, maintain the programs progress in raising the quality of and access to public health nursing care through continuing recruitment of nursing professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2023 Funding Increase of $10 million includes:

- Current Services: +$5 million for current services including:
    - Pay Costs +$3 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$290,000 – to fund inflationary costs of providing health care services.
    - Population Growth +$2 million – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.
- Staffing for New Facilities: +$6 million - to support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Naytahwaush Health Center (JV), Naytahwaush, MN	$845,000	5
NEACC (Salt River) Health Center, Scottsdale, AZ	$1,099,000	7

Ysleta Del Sur Health Center (JV), El Paso, TX	$302,000	2
Alternative Rural Health Center, Dilkon, AZ	$391,000	3
Rapid City Health Center, Rapid City, SD	$2,818,000	22
Grand Total:	**$5,455,000**	**39**

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
23 Public Health Nursing (PHN): Total number of IHS public health activities captured by the PHN data system; emphasis on primary, secondary and tertiary prevention activities to individuals, families and community groups. (Outcome)	FY 2021: 428,476 Target: 330,000 (Target Exceeded)	411,325	415,438	+4,113

GRANTS AWARDS

(whole dollars)	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget
Number of Awards	8	8	10
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

AREA ALLOCATION

Public Health Nursing

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2021 Final			FY 2022 Estimated			FY 2023 Estimated			FY '23 +/- FY '22
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$139	$12,640	$12,778	$153	13,963	$14,116	$168	$15,343	$15,511	$1,395
Albuquerque	1,934	1,912	3,846	2,137	2,112	4,249	2,348	2,321	4,669	$420
Bemidji	34	2,683	2,717	38	2,964	3,002	41	3,257	3,298	$297
Billings	1,799	3,076	4,875	1,987	3,398	5,385	2,184	3,733	5,917	$532
California	14	1,281	1,295	16	1,415	1,430	17	1,555	1,572	$141
Great Plains	5,065	5,598	10,663	5,596	6,184	11,780	6,149	6,795	12,944	$1,164
Nashville	441	1,948	2,389	487	2,152	2,639	535	2,365	2,900	$261
Navajo	9,125	8,662	17,787	10,080	9,569	19,649	11,076	10,515	21,591	$1,942
Oklahoma	3,750	14,230	17,980	4,143	15,720	19,863	4,552	17,273	21,826	$1,963
Phoenix	4,276	5,863	10,138	4,724	6,476	11,200	5,190	7,116	12,307	$1,107
Portland	656	2,889	3,545	725	3,191	3,916	797	3,507	4,303	$387
Tucson	18	1,260	1,277	19	1,392	1,411	21	1,529	1,550	$139
Headquarters	3,444	0	3,444	3,805		3,805	4,181		4,181	$376
Total, PHN	**$30,695**	**$62,041**	**$92,736**	**$33,909**	**$68,537**	**$102,446**	**$37,260**	**$75,310**	**$112,570**	**$10,124**

Note: FY 2022 and FY 2023 are estimates.

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$21,034	$23,250	$24,675	+$1,425
FTE*	15	15	19	+4

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Health Education Program has been in existence since 1955 to educate American Indian/Alaska Native (AI/AN) patients, school age children and communities about their health. The program focuses on the importance of educating patients in a manner that empowers them to make positive choices in their lifestyles and how they utilize health services. Accreditation requirements at IHS and tribal facilities specifically require the provision and documentation of patient education as evidence of the delivery of quality care.

In FY 2021, there was an increase of 16.15 percent or 462,205 patient visits from the previous year. In FY 2021, there was 2,917,182 patient education visit which exceeded FY 2020 patient education visits.

The Health Education funds provide critical support for direct health care services focused on strengthening the collaborative partnerships among direct care providers, patients, communities, and internal and external stakeholders. Funds are utilized to ensure IHS, Tribal, and Urban Indian health care programs have comprehensive, culturally appropriate services, available and accessible personnel, promotes excellence and quality through implemented quality improvement strategies, and strengthens the IHS program management and operations to address health disparities and raise the health status of AI/AN populations to the highest level possible (*IHS Strategic Plan FY 2019-2023, Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people; Goal 2, To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; & Goal 3, To strengthen IHS program management and operations*).

PROGRAM ACCOMPLISHMENTS

In response to the COVID-19 pandemic, the health education program provided patient education to mitigate risk of transmission, assisted with vaccination and contact tracing, and delivered

water/food supplies in the community. (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.2 Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines)*.

In addition, the Health Education Program targeted the following activities in FY 2021, which aligns with the *HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death.*

- The Health Promotion/Disease Prevention (HPDP)/HE Consultant continues to update the Physical Activity Kit (PAK) (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death*).
- Collaborated with the HP/DP program to provide Circle of Life, a cancer prevention virtual training to increase awareness of preventive screenings, risk, treatment, and care with 32 participants (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death)*.
- Collaborated with the HP/DP program to provide 16 virtual Basic Tobacco Intervention Skills Certification training with 139 participants and 4 Instructor trainings with 29 participants (*HHS Strategic Plan FY 2022-2026 Goal 1,* Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, *Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health*).
- Provided funding to Tribes and Service Units to address health disparities, including prevention of chronic diseases, and obesity though increased physical activity and diabetes prevention education *(HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death).*
- Collaborated with the HP/DP program to implement colorectal screening pilot projects in three sites *(HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health).*
- Purchased and distributed colorectal cancer and tobacco/vaping displays to (8) IHS Area Health Education programs to increase community awareness of cancer (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death*).
- Hosted a Positive Community Norm and Media Development training for 21 participants. Training delivered by the Montana Institute (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death)*.

- Maintained efforts to advance health literacy and plain language by developing culturally appropriate educational materials, posters, and infographics focusing on cancer and tobacco prevention. Presented on Keeping It Plain and Simple to Support Wellness for more than 70 participants (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death).*
- Continue to promote the IHS Introduction to Health Literacy training video posted at the HHS Learning Management System (*HHS Strategic Plan FY 2022-2026 Goal 2,* Safeguard and Improve National and Global Health Conditions and Outcomes, *Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death).*
- In FY 2021, the National Patient Education Committee continued to collaborate with the Office of Information Technology to update the RPMS/Electronic Health Record (EHR) coding, to streamline the patient education documentation process (*HHS Strategic Plan FY 2022-2026, Goal 4, Restore Trust and Accelerate Advancements in Science and Research for All, Objective 4.4 Improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience; & Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death).* The Health Education Program maintains data tracking of key program objectives. Tracked data includes educational encounters, the number of patients who received patient education services, provider credentials of who delivered the patient education, site location where patient education was provided, health information provided, amount of time spent providing patient health education, patient understanding, and behavior goals.

COVID-19

The COVID-19 pandemic has disproportionately affected AI/AN populations across the country. Data indicates AI/AN populations have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount
2019	$19,698,000
2020	$20,925,000
2021 Final	$21,034,000
2022 Enacted	$23,250,000
2023 President's Budget	$24,675,000

TRIBAL SHARES

Health Education funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating out the associated programs, functions, services, and activities. A portion of the overall Health Education budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2023 budget submission for Health Education of $25 million is $1 million above the FY 2022 Enacted level. This funding level will allow IHS to conduct an estimated 2,917,182 client interactions.

FY 2023 Funding Increase of $1 million includes:

- Current Services: +$1 million for current services including:
    - Pay Costs +$589,000 – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$63,000 – to fund inflationary costs of providing health care services.
    - Population Growth +$370,000 – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.
- Staffing for New Facilities: +$403,000 - to support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Rapid City Health Center, Rapid City, SD	$403,000	4
Grand Total:	**$403,000**	**4**

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2022 Target**	**FY 2023 Target**	**FY 2023 Target +/-FY 2022 Target**
HE-1 Number of visits with Health/Patient Education (Output)	FY 2021: 2,917,182 visits Target: 0 visits (Target Exceeded)	2,575,271 visits	2,688,583 visits	+113,312 visits

GRANT AWARDS – The Health Education budget does not fund grants.

AREA ALLOCATION

Health Education

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2021 Final			FY 2022 Estimated			FY 2023 Estimated			FY '23 +/- FY '22
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$35	$3,034	$3,069	$39	$3,353	$3,392	$41	$3,559	$3,600	$208
Albuquerque	299	1,025	1,325	331	1,133	1,464	351	1,203	1,554	$90
Bemidji	61	665	726	68	735	802	72	780	852	$49
Billings	242	1,120	1,363	268	1,238	1,506	284	1,314	1,598	$92
California	32	356	387	35	393	428	37	417	455	$26
Great Plains	348	1,871	2,219	385	2,068	2,452	408	2,194	2,603	$150
Nashville	171	716	887	190	791	981	201	840	1,041	$60
Navajo	38	3,332	3,371	42	3,683	3,726	45	3,909	3,954	$228
Oklahoma	784	2,446	3,230	867	2,703	3,570	920	2,869	3,789	$219
Phoenix	922	1,214	2,136	1,019	1,342	2,361	1,081	1,424	2,506	$145
Portland	106	979	1,084	117	1,082	1,198	124	1,148	1,272	$73
Tucson	4	260	265	5	288	292	5	305	310	$18
Headquarters	974		974	1,076		1,076	1,142		1,142	$66
Total, Hlth Ed	**$4,017**	**$17,017**	**$21,034**	**$4,440**	**$18,810**	**$23,250**	**$4,712**	**$19,963**	**$24,675**	**$1,425**

Note: FY 2022 and FY 2023 are estimates.

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$62,892	$63,679	$68,844	+$5,165
FTE*	5	5	6	+1

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Community Health Representative (CHR) Program is an IHS funded, tribally contracted program of well-trained and medically-guided community-based health workers. The CHR Program was established by the Congress in 1968 in response to the expressed needs of American Indian and Alaska Native (AI/AN) governments, organizations, and the IHS, for a health care program which would provide an outreach component to meet specific tribal health care needs.

The primary purpose of the CHR program is unique, distinct, and in line with broader Community Health Worker (CHW) workforce roles and competencies to include: (1) Relationship and trust-building – to identify specific needs of clients, (2) Communication – especially continuity and clarity, between provider and patient; and traditional knowledge and language, and (3) Focus on Social Determinants of Health – conditions in which people are born, grow, work, live, and age, including social connectedness, traditional knowledge, spirituality, relationship to the environment, and a shared history.

CHRs are trained in the skills of health care provision, disease control and prevention and help to eliminate health disparities by removing barriers to care in their communities (*IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce*). CHRs are the frontline workforce focusing on improving Social Determinants of Health (SDOH) for underserved populations to decrease health inequities across the country using a community-based approach. CHR activities impact SDOH with access to care and coverage, social/cultural cohesion, transportation, food access, environmental quality, social justice, housing and educational training opportunities (*Draft HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health*).

The CHR Program has made important contributions to Indian health in its efforts to provide community-oriented primary health care services serving as a way to bolster primary and preventive health (*HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care, and IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce*). CHRs are trusted members of the community and serve as a link between the Indian health system, including associated health programs, and AI/AN patients and communities. Importantly, this community-based delivery of care is provided in coordination with tribal health departments and programs.

PROGRAM ACCOMPLISHMENTS

As CHR programs have transitioned from IHS direct care services to local community control via Tribal contracting and compacting, IHS's role has transitioned to providing support for training CHRs and providing technical assistance to expand cohesion and greater understanding of the full potential of CHRs to improve health, support individual and community development, and access to systems of care.

During FY 2021, the Indian health care system modified health care delivery and adapted programming to address COVID-19. The CHR Program adapted accordingly to provide critical technical assistance and guidance for COVID-19 infection control, prevention and health education outreach to communities. This budget narrative includes examples of how services and programming was adapted to address COVID-19.

- The Community Health Representative Consultant participated in the Interdepartmental Health Equity Collaborative (IHEC) monthly operations and training meetings for Community Health Workers PATH Project. (*IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.2 Build, strengthen, and sustain collaborative relationships; Draft HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*).

- The Community Health Representative Consultant participated in the IHS CHAP Virtual Learning Series *Understanding the Role of the CHR & CHAP Workforce*, October 8, 2020. (*IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.2 Build, strengthen, and sustain collaborative relationships & Objective 1.3 Increase access to quality health care services; Draft HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*).

- During FY 21, IHS coordinated an IHS/UNM Community Health ECHO (Tele-ECHO) designed and implemented for the purpose of supporting CHRs and other IHS employees as they faced extraordinary professional and personal challenges during COVID-19 pandemic. This program held twenty 90-minute sessions from October 2020 through 2021 and hosted regional and national subject matter experts over the 10 months. Total participants attending were 1,142 with average attendance for a session of 57.1. (*IHS*

Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, Objective 1.2 Build, strengthen, and sustain collaborative relationships & Objective 1.3 Increase access to quality health care services; Draft HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care).

- In November 2020, the Community Health Representative Consultant presented in the NIH National Native American Heritage Month 'Effective Communication with American Indian and Alaska Native Communities' on November 10, 2020. (*IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.2 Build, strengthen, and sustain collaborative relationships, & Objective 1.3 Increase access to quality health care services; Draft HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care; Draft HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*).

- In January 2021, the IHS awarded the National Health Coaching Pilot contract to Legacy Holistic Health Institute. The pilot program (over 4 years) will train CHR/paraprofessionals and clinical educators in the coach approach using client-centered services for improving overall health and well-being. The national health coach training pilot includes four project areas: (1) CHR workforce development; (2) Inter-professional training; (3) National Board Health and Wellness (NBHWC) Certification; (4) Social Determinants of Health & Diversity Equity and Inclusion training. There were 484 applicants for 100 training slots, two cohorts of 50 each (*IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, & Objective 1.3 Increase access to quality health care services; Draft HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*).

- In March 2021, the IHS Community Health Representative Program provided 10 pre-training sessions for 27 Family Spirit virtual workshop attendees. The training provides maternal and child health information and skills training to CHR community educators on 63 lessons taught between pregnancy and the child's 3rd birthday for Tribal families. The Family Spirit Home Visiting Program addresses intergenerational behavioral health problems, applies local cultural assets, and overcomes deficits in the professional healthcare workforce in low-resourced communities. It is used in over 100 tribal communities across 16 states. (*IHS Strategic Plan FY 2019-2023 Goal 1 To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce; Draft HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*).

- In April 2021, the CHR Program in partnership with Northwest Portland Area Indian Health Board (NPAIHB) implemented an Indian Country ECHO for CHRs. The Community Health Representative Series Presentations *included Hepatitis C Virus, Substance Use Disorder, HIV, LGBTQ-2S, Sexually Transmitted Infections, and COVID-19 Vaccines.* This special webinar series was designed for non-clinical staff in key behavioral or community health positions. Total number of attendees for five webinars, 802. Funded through CARES Act. (*IHS Strategic Plan FY2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, & Objective 1.3 Increase access to quality health care services; Draft HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*).

- In July 2021, the IHS CHR Consultant was a keynote speaker at the National Association of Community Health Workers UNITY conference. Number of attendees, 642. (*IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, & Objective 1.2 Build, strengthen, and sustain collaborative relationships; Draft HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*).

- In July, the IHS in partnership with IHS/UNM Community Health Tele-ECHO conducted two teleECHO's in collaboration with Office of Urban Indian Health Programs (OUIHP) and National Council of Urban Indian Health (NCUIH) sharing community-level response to address COVID-19 of *enhancing health-related outreach and education activities to patients and families*. Number of attendees, 187. Funded through CARES Act. (*IHS Strategic Plan FY 2019-2023 Goal 3, To strengthen IHS program management and operations, Objective 3.1 Improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public; Draft HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care).*

- In August 2021, the IHS awarded Talance, Inc the contract for CHR Online Education Module training. This is a four-year contract to provide CHR online education on Basic and Refresher training. This will meet the need providing online core skills training for individuals and teams to bridge the gap between healthcare system and community (*IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, & Objective 1.3 Increase access to quality health care services; Draft HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*).

- In August 2021, the IHS in partnership with IHS/UNM Community Health Tele-ECHO conducted one teleECHO in collaboration with Health Resources and Services Administration (HRSA) on *promoting medical health centers, nursing education, pipeline programs and associated American Rescue Plan Act (ARPA) grants* specific in

addressing COVID-19. There were 45 attendees. Funded through CARES Act. (*IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, & Objective 1.3 Increase access to quality health care services; Draft HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care)*.

- In September 2021, the IHS CHR Consultant was a moderator for Johns Hopkins Center of American Indian Health *Emerging Topics in the COVID-19 Pandemic: The Latest in Science and Community-based Practices in Indian Country*. There were 131 attendees (IHS Strategic Plan FY 2019-2023 Goal 1, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, Objective 1.1 Recruit, develop, and retain a dedicated, competent, and caring workforce, & Objective 1.2 Build, strengthen, and sustain collaborative relationships; *Draft HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*).

COVID-19

The COVID-19 pandemic has disproportionately affected AI/AN populations across the country. Data indicates AI/AN populations have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2021, the National Association of Community Health Workers (NACHW) authored the report Community Champions and COVID-19 Vaccination: Concerns, Challenges and Contributions of Community Health Workers, Contact Tracers and Community Based Organizations during the First 60 Days of the COVID-19 Vaccine. This report provides a snapshot of respondent perspectives from individual, community, and system-levels, as well as challenges, bright spots and recommendations in vaccine distribution from 192 self-identified community health workers, contact tracers and community and organizational leaders. CHW respondents wrote about a variety of experiences with the COVID-19 vaccine, most of which fell into three categories: (1) Individual experiences with the vaccine and how they leveraged that experience in helping clients build confidence in getting vaccinated; (2) Community level mistrust and misinformation surrounding the COVID-19 vaccine and especially how social media has contributed to those barriers; and (3) Systemic barriers around vaccine access and lack of healthcare infrastructure which impeded on their community's ability to vaccinate their residents and adequately address the COVID-19 pandemic.

For additional information on the IHS COVID-19 response please refer to the Overview of Agency Performance for additional information.

FUNDING HISTORY

Fiscal Year	Amount
2019	$62,613,000
2020	$62,892,000
2021 Final	$62,892,000
2022 Enacted	$63.679,000
2023 President's Budget	$68,844,000

TRIBAL SHARES

Community Health Representatives funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall Community Health Representative's budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2023 budget submission for Community Health Representatives of $69 million is $5 million above the FY 2022 Enacted level.

FY 2023 Funding Increase of $5 million includes:

- Current Services: +$3 million for current services including:
    - Pay Costs +$1 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
    - Inflation +$252,000 – to fund inflationary costs of providing health care services.
    - Population Growth +$1 million – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.
- Program Evaluation: +$3 million for a national evaluation of the Community Health Representatives program.

  The Community Health Representative (CHR) program is over 90 percent directly operated by Tribes or Tribal organizations. As a result, evidence of performance and outcomes is often anecdotal. Lack of national data demonstrating the impact of CHRs in the communities they serve, and the critical role they place to facilitate access to health care services for American Indians and Alaska Natives has raised questions from stakeholders about the overall efficacy of the program.

  The CHRs play an invaluable part in the Indian health system by providing culturally competent outreach and facilitation services to members of the communities they serve – usually their own Tribal members. The CHRs have proven to be a critical asset in AI/AN communities' response to COVID-19 by providing much needed long-term contact tracing,

case management follow-ups, home visits, patient and community education on vaccine and public health measures, and transportation for tribal community members.

The CHRs serve as a vital link between the patient and the medical home by providing culturally appropriate care and supporting community health.

The requested resources will support a national evaluation, and related activities, to enhance outcome measures and data informed training and policymaking for the CHR program. It will also help the IHS to articulate the critical role this program plays in ensure access to health care services for American Indians and Alaska Natives.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
CHR-1 Number of patient contacts (Output)	FY 2021: 437,060 patient contacts Target: 0 patient contacts (Target Exceeded)	653,181 patient contacts	455,417 patient contacts	-197,764 patient contacts
CHR-2 CHR patient contacts for Chronic Disease Services (Output)	FY 2021: 151,201 patient contacts Target: 0 patient contacts (Target Exceeded)	254,418 patient contacts	157,551 patient contacts	-96,867 patient contacts
CHR-3 Number of CHRs Trained (Output)	FY 2021: 413 CHRs Target: 0 CHRs (Target Exceeded)	376 CHRs	376 CHRs	Maintain

AREA ALLOCATION

Community Health Representatives

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2021 Final			FY 2022 Estimated			FY 2023 Estimated			FY '23 +/- FY '22
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$51	$4,619	$4,670	$52	$4,677	$4,729	$56	$5,056	$5,112	$384
Albuquerque	40	3,632	3,672	41	3,677	3,718	44	3,976	4,020	$302
Bemidji	55	4,992	5,047	56	5,054	5,110	60	5,464	5,525	$414
Billings	51	4,620	4,671	52	4,677	4,729	56	5,057	5,113	$384
California	23	2,078	2,101	23	2,104	2,127	25	2,274	2,299	$173
Great Plains	262	7,199	7,461	265	7,289	7,554	286	7,880	8,167	$613
Nashville	278	3,297	3,576	281	3,339	3,620	304	3,610	3,914	$294
Navajo	79	7,145	7,224	80	7,234	7,314	86	7,821	7,908	$593
Oklahoma	104	9,415	9,519	105	9,532	9,638	114	10,306	10,419	$782
Phoenix	72	6,483	6,554	73	6,564	6,637	78	7,096	7,175	$538
Portland	54	4,857	4,911	55	4,917	4,972	59	5,316	5,375	$403
Tucson	23	2,040	2,063	23	2,066	2,089	25	2,233	2,258	$169
Headquarters	1,425	0	1,425	1,442		1,442	1,559		1,559	$117
Total, CHR	**$2,516**	**$60,376**	**$62,892**	**$2,547**	**$61,132**	**$63,679**	**$2,754**	**$66,090**	**$68,844**	**$5,165**

Note: FY 2022 and FY 2023 are estimates.

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

HEPATITIS B AND HAEMOPHILUS IMMUNIZATION PROGRAMS (ALASKA)

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$2,127	$2,148	$2,221	+$73
FTE*	0	0	0	0

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

Allocation Method.....Self-Governance Compact, Tribal Shares

PROGRAM DESCRIPTION

Hepatitis B Program – The Hepatitis B Program was initiated in 1983 because of the need to prevent and monitor hepatitis B infections among a large population of Alaska Natives with or susceptible to the disease. It continues to provide this service in addition to evaluation of vaccine effectiveness and the medical management of persons with hepatitis and liver disease.

Haemophilus Immunization (Hib) Program – The Hib Program started in 1989 with a targeted Haemophilus Influenzae type b prevention project in the Yukon Kuskokwim Delta and now focuses on maintaining high vaccine coverage in a continued effort to prevent communicable disease by providing resources, training, and coordination to Tribal facilities throughout Alaska. Alaska's geography necessitates innovation in program delivery and use of technology as many Tribal facilities are located in remote areas off any continuous road system. The Program maintains immunization practice procedures in partnership with Alaska's statewide Community Health Aide Program to ensure Health Aides working in both urban and remote Tribal facilities have the resources needed to provide high quality vaccination services where Alaska Native families live and play (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.3 *Increase access to quality health care services*; HHS Strategic Plan, Goal 1, Objective 1.3 *Expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while recognizing social determinants of health; HHS Strategic Plan Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes*). Through strong collaboration with local Tribal health partners and regional immunization coordinators, the State of Alaska Immunization Program and the IHS Area Immunization Program, the Hib Program offers clinical expertise in advancing vaccine reporting and data management capacity in an environment of evolving and expanding electronic health record systems (*HHS Strategic Plan, Goal 4, Objective 4.4 Improve data collection, use, and evaluation to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience*). In collaboration with statewide partners, the Hib Program advocates for continued access to affordable vaccine through public vaccine funding programs (HHS Strategic Plan Goal 1: Protect and Strengthen Equitable Access to High Quality

and Affordable Health Care). The Program works with Tribal public relations to address parental immunization hesitancy and highlight the importance of vaccines, utilizing locally developed culturally appropriate marketing materials and social media campaigns. In alignment with the HHS Strategic Plan Goal 4: Restore Trust and Accelerate Advancements in Science and Research for All, the Hib Program continues to focus on optimizing available information technology to advance capacity in maintaining high vaccine coverage rates, through refining electronic health record processes and expanding capacity for training, social marketing and consultation throughout Alaska statewide.

The Hepatitis B Program and the Hib Program of the Alaska Native Tribal Health Consortium, in collaboration with Alaska Tribal Health Care System partners, provides clinical expertise and consultation, trainings, research, evaluation and surveillance with the goal to reduce the occurrence of infectious disease and improve access to healthcare in the Alaska Native population. The programs support immunization, patient screening, development of electronic health record reminders and systems, providing an infrastructure to maintain high vaccine coverage, and high clinical management coverage of hepatitis B and C in Alaska Natives. The program also manages patients with autoimmune hepatitis (AIH), primary biliary cirrhosis (PBC), and nonalcoholic fatty liver disease (NAFLD). In patients with NAFLD that have nonalcoholic steatohepatitis (NASH) we have recently begun periodic screening and are included in these outcome measures. The Program promotes semi-annual screening of chronic hepatitis patients for both liver cancer and liver function (enzyme testing). The programs' activities support the IHS priorities on quality and partnerships as delineated in the IHS Strategic Plan.

Working with partners within the Alaska Tribal Health System to meet the HHS Strategic Plan the programs provide both direct and telehealth patient care and health provider education to not only increase access to quality care, but also expand the options available (HHS Strategic Plan, Goal 4, Restore Trust and Accelerate Advancements in Science and Research for All, and the HHS Strategic Plan, Goal 1 *Protect and Strengthen Equitable Access to High Quality and Affordable Health Care*). Both programs are actively engaged in preventing and treating communicable and chronic diseases (HHS Strategic Plan Goal 2Safeguard and Improve National and Global Health Conditions and Outcomes).

PROGRAM ACCOMPLISHMENTS

The Immunization Alaska Program comprised of both the Hepatitis B and Hib Programs has several performance measures to monitor progress in achieving the goal of high vaccine coverage for Alaska Native people as described below.

Hepatitis B Program

The Hepatitis B program continues to prevent and monitor hepatitis B infection among a large population of Alaska Natives with or susceptible to the disease. The program evaluates hepatitis A and hepatitis B vaccination coverage of Alaska Natives, and the total number of Alaska Native patients targeted for screening and the total number of patients screened for hepatitis B and hepatitis C as well as other causes of liver disease that disproportionately affect the Alaska Native population. Due to the opioids crisis, new hepatitis C virus (HCV) infections have increased 69 percent from 2015-2018 compared to the 2011-2014 time period. In response to this crisis, the Program is actively engaged in a statewide HCV elimination project. This involves recruiting patients for treatment through our local outpatient clinic, field clinics and video clinics (HHS Strategic Plan FY, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes*)* as well as performing provider in-person and webinar education seminars on treating

hepatitis C to build. The Program website provides online treatment documents and a treatment algorithm for Alaska Tribal healthcare providers. Also, Program staff conduct monthly Alaska HCV Extension for Community Healthcare Outcomes (ECHO) collaboratives providing remote assistance for hepatitis C case review and treatment recommendations. Since 2014, over 1,035 American Indian/Alaska Native persons have been treated for HCV through the Alaska Tribal Health System (HHS Strategic Plan Goal 2Safeguard and Improve National and Global Health Conditions and Outcomes*)*. The Program has two non-invasive elastography devices allows for the safe, non-invasive monitoring of liver disease progression without having to perform an invasive liver biopsy. One is a portable machine that is transported to field clinics thus reducing the need for patients to travel to Anchorage or alternative site for their care (HHS Strategic Plan Goal 1 Protect and Strengthen Equitable Access to High Quality and Affordable Health Care*)*.

With the onset of COVID-19 pandemic, the Program is monitoring persons with liver disease who test positive for COVID-19 to track their health outcomes and assess any complications related to their liver disease.

In FY 2021:

- Hepatitis A vaccination coverage did not achieve the target, and hepatitis B vaccination coverage exceeded the target. Hepatitis A vaccination coverage was 87 percent (90 percent target) and hepatitis B vaccination coverage was 95 percent (90 percent target).
- Overall, at least 73 percent of AI/ANs with either chronic hepatitis B (68 percent screened) or hepatitis C (76 percent screened) infection were screened for liver cancer and for liver aminotransferase (enzyme) levels.

Haemophilus Immunization (Hib) Program

The Hib program continues to provide resources, training and coordination to Tribes in Alaska to maintain high vaccine coverage among Alaska Native people. Vaccine coverage data is collected for each Tribal region and measured in collaboration with regional Tribal health immunization coordinators (HHS Strategic Plan, Goal 4, Restore Trust and Accelerate Advancements in Science and Research for All*)*. Technical consultation for the varying electronic health record (EHR) systems within each Tribal health organization is provided to support improved vaccine coverage for all Tribes. Statewide Alaska Native vaccine coverage rates (including influenza) are reported to IHS National Immunization Program for infants 3-27 months, 19-35 months, adolescents, adults. Flu vaccine coverage rates for healthcare personnel working at Tribal facilities are also reported to IHS National Immunization Program. Efforts pursuing information technology to advance capacity in maintaining high vaccine coverage rates include: participation as clinical experts on national EHR advisory workgroups regarding immunization-related product development; local advocacy for advancements in Alaska Tribal health electronic health record systems, such as reminder recall systems (i.e. patient reminders) and vaccination service delivery options (i.e. satellite or off-site clinics); providing clinical expertise in the implementation of a clinical decision support system (i.e. vaccine forecaster) in a prominent Alaska Tribal Health electronic health record system; and collaborations with State and Tribal partners in expanding coverage reporting capacity in available electronic health record systems (HHS Strategic Plan Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability*)*. Improvement in vaccine coverage relies on data capture and quality in electronic health record systems, facilitated by data interfaces, and in conjunction with clinical resources and training.

Routine immunizations have been disrupted by the COVID-19 pandemic. Childhood immunization coverage with 4:3:1:3*:3:1:4 series for Alaska Native children age 19-35 months

declined by 5 percent from March 31, 2020 (73 percent) to June 30, 2021 (68 percent). Leveraging the Healthy People 2030 measures, the Program will add two immunization performance measures to the Program for Alaska Native children age 19-35 months, 4 doses DTaP and 1 MMR.

In respond to this drop in non-COVID-19 vaccine coverage among Alaska Native children and in an effort to maintain routine vaccine coverage in all age groups, the Program is actively engaged in optimizing utilization of evidence-based strategies to improve vaccine coverage rates across the lifespan, in collaboration with statewide partners and Tribal public relations. Activities will include technical assistance in optimizing available information technology capacity for efficient accessible childhood, adolescent and adult vaccine coverage reporting within the Alaska Tribal Health Care system.

During FY 2021:

- Immunization Coverage for Alaska Natives age 19-35 months was 68 percent, for the 4:3:1:3*:3:1:4 series (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Var, 4 PCV).
  - 4 DTaP in this age group was 72 percent, the Healthy People 2030 vaccination objective IID-06 to increase the coverage level of 4 doses of DTaP vaccine in children by age two years has a target of 90 percent.
  - 1 MMR in this age group was 88 percent, the Healthy People 2030 vaccination objective IID-03 to maintain the coverage level of 1 dose of MMR in children by age 2 years has a target of 90.8 percent.
- Achieved 88 percent coverage with full series Haemophilus influenza type b (Hib) vaccine in children age 19-35 months, which is much higher than the US all-races 2018 rate of 75.3 percent.
- In FY 2020, achieved 60 percent Tdap vaccine coverage in all patients 19 years and older who had received Tdap within the past 10 years. Unable to measure in 2021.
- In FY 2020, achieved 82 percent pneumococcal vaccine coverage in patients 65 years and older who received pneumococcal vaccine in the past ever. Unable to measure in 2021.
- Assisted Tribal facilities using new electronic health record (EHR) systems or the IHS EHR immunization package in maintaining or establishing interface connection with the State of Alaska Immunization Information System (SIIS).
  - Provided technical assistance with two facilities that implemented new EHRs.
- Assisting Alaska Tribal Health electronic health record workgroup with gap analysis and providing associated consultation in preparation for transition to new clinical decision support system (i.e. vaccine forecaster).
- Assisted Tribal facilities in utilization of Alaska SIIS patient reminder system.
- Assisted Tribal facilities throughout Alaska to implement new policy and procedures associated with vaccine electronic inventory management, delivery systems and documentation for COVID-19 vaccine.
- Engaged in planning for COVID-19 vaccine and supported distribution, in collaboration with Alaska's State and Tribal stakeholders, and working with key participants critical for strategizing and plan implementation.

A summary of immunization[1] results is included below:

[1] IHS vaccination rates compare favorably with overall National vaccination rates. The CDC conducts National Immunizations Surveys which allows self-reporting of vaccines. https://www.cdc.gov/vaccines/vaxview/index.html

Immunization Measure	Age Group	Alaska Native coverage as of 6/30/2021	Alaska Native coverage as of 3/31/2020
4:3:1:3*:3:1:4	19-35 months	68%	73%
4:3:1:3:3:1	19-35 months	68%	74%
3 Hib vaccines doses		88%	90%
3 PCV (pneumococcal conjugate vaccine)	19-35 months	89%	92%
4 DTaP	19-35 months	72%	
1 MMR	19-35 months	88%	
1+ HPV	13-17 years female	82%	82%
Pneumococcal vaccine	65+ years	---	82%
Tdap	19 years and older	---	60%

The Hib program continues to collaborate with Centers for Disease Control and Prevention in networking with IHS, State, and Tribal agencies to provide technical assistance regarding EHRs. Challenges include the diversity of EHRs employed by Tribal organizations that may result in temporary loss or delay of Area-wide reporting of vaccine coverage. Regular reporting of immunization coverage is critical in assuring sufficient monitoring and follow-up with facilities experiencing vaccination administration issues. Technical assistance to sites will continue to be addressed through coordinated efforts by the Hib Program, IHS, State, and Tribes. Vaccine coverage is measured.

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount
2019	$2,127,000
2020	$2,127,000
2021 Final	$2,127,000
2022 Enacted	$2,148,000
2023 President's Budget	$2,221,000

TRIBAL SHARES

Alaska Immunization funds are paid out as tribal shares in their entirety.

BUDGET REQUEST

The FY 2023 budget submission for Alaska Immunization is $2 million, which is $73,000 above the FY 2022 Enacted level.

FY 2023 Funding Increase of $73,000 includes:

- Current Services: +$47,000 for current services including:
  - Inflation +$9,000 – to fund inflationary costs of providing health care services.
  - Population Growth +$38,000 – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2023 based on state births and deaths data.
- Alaska Immunization General Program Increase: +$26,000 will provide coordination of vaccine coverage reporting for Tribal facilities, training of Tribal immunization coordinators, and clinic staff in vaccine recommendations and documentation, consultation in the migration to alternate EHRs, and regular notification to hepatitis patients of the need to complete liver function screenings so that program clinicians can identify serious liver disease or liver cancer when it is at an early and treatable stage.

Hepatitis B Program – The program will conduct outpatient clinics five days a week at the Alaska Native Medical Center, travel to regional health centers to conduct outpatient clinics, and will continue its web-based application for video-conferencing that is accessible to the statewide Alaska Tribal Health System (ATHS) audience to provide relevant clinical information to assist in the care and management of hepatitis and liver disease patients. Continue AK HCV ECHO (Extension for Community Healthcare Outcomes) virtual field clinics where primary care physicians collaborate with program staff for the treatment of hepatitis C cases. Annual field clinics will be conducted across Alaska to provide direct patient care, clinical updates to ATHS staff, and to recruit and conduct follow-up on participants enrolled in the program's research studies. Hepatitis A and Hepatitis B vaccine coverage for Alaska Natives will be measured. In addition, the total number of Alaska Native patients targeted and screened will be measured for hepatitis B, hepatitis C, and other liver disease that affects Alaska Natives.

Haemophilus Immunization (Hib) Program – The budget request will allow staff to provide continued expertise and support to regional Tribal programs on-site and for many partner locations, including rural and isolated locations. Funding of these activities allows maintenance of current program support of Alaska Tribal immunization activities, statewide and national immunization advocacy and technical support, and Area reporting to IHS Headquarters. Activities include the maintenance of statewide Alaska Native vaccine coverage rate reporting to IHS Headquarters during current phase of evolving electronic health record systems and establishing capacity for vaccine coverage reporting where necessary. Expanding quality of services through provision of technical support for electronic clinical decision support systems (i.e. vaccine forecaster), coverage reporting and patient reminder systems. In addition, efficiency of consultations and trainings offered to Tribal facilities will improve through technology optimization such as utilization of widely available videoconferencing systems and local Distance Learning Network. Community outreach and patient education activities will continue to include limited print of media materials while also expanding to digital and electronic formats.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
AK-1 Chronic Hepatitis B Patients Screened/Targeted (Output) [2]	FY 2021: 636 Screened Target: 600 Screened (Target Exceeded)	600 Screened	600 Screened	Maintain
AK-2 Chronic Hepatitis C Patients Screened/Targeted (Output) [3]	FY 2021: 1394 Screened Target: 1300 Screened (Target Exceeded)	1300 Screened	1300 Screened	Maintain
AK-3 Other Liver Disease Patients Screened (Output) [4]	FY 2021: 374 Screened Target: 200 Screened (Target Exceeded)	200 Screened	300 Screened	+100 Screened
AK-4 Hepatitis A vaccination (Output) [5]	FY 2021: 87 % Target: 90 % (Target Not Met)	90 %	90 %	Maintain
AK-5 Hepatitis B vaccinations (Output) [6]	FY 2021: 95 % Target: 90 % (Target Exceeded)	90 %	90 %	Maintain

All data reported is from the Alaska Native Tribal Health Consortium.

GRANTS AWARDS -- The program does not award grants.

AREA ALLOCATION

Immunization Alaska

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2021 Final			FY 2022 Estimated			FY 2023 Estimated			FY '23 +/- FY '22
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$2,127	$2,127	$0	$2,148	$2,148	$0	$2,221	$2,221	$73
Total, Imm AK	**$0**	**$2,127**	**$2,127**	**$0**	**$2,148**	**$2,148**	**$0**	**$2,221**	**$2,221**	**$73**

Note: FY 2022 and FY 2023 are estimates.

[1] Hepatitis Program (Known Cases Screened) Sum of known hepatitis B cases FY 202010: 939 Decline in hepatitis B cases due to an aging cohort and their deaths; discovery of new cases is rare given hepatitis B vaccinations.

[2] Hepatitis Program (Known Cases Screened) Sum of known hepatitis C cases FY 2021: 1,826. New cases still increasing though the monthly rate decreased substantially for March and April because of the decrease in HCV screening due to COVID-19 and treatment of cases with no/mild fibrosis that no longer needed to be followed continued. Treated cases with advanced fibrosis/cirrhosis being followed indefinitely.

[3] Hepatitis Program (Known Cases Screened) Sum of known other liver disease cases FY 2021: 414. Other liver disease includes AIH and PBC (291 cases), plus the addition of NAFLD with NASH (123 cases).

[4] Hepatitis A/B Immunization rates for Alaska Native children who achieve Hepatitis A 1-dose completion and Hepatitis B 3-dose completion aged 19-35 months are compiled and reported throughout the Alaska Native Tribal Health System on a quarterly basis.

[5] The rates reported herein represent the most recent reporting period. Established target immunization rate for each vaccine is 90%.

[6] www.anthc.org/hep

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$62,684	$73,424	$112,513	+$39,089
FTE*	8	8	8	0

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

Allocation Method .....Formula Contracts and Competitive Formula Grants awarded to Urban Indian Organizations

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Office of Urban Indian Health Programs (OUIHP) was established in 1976 to make health care services more accessible to Urban American Indian/Alaska Native (AI/AN) people. The IHS OUIHP 2017-2021 Strategic Plan guides, supports, and improves access to high quality, culturally appropriate health care services for Urban AI/AN people. The OUIHP Strategic Plan aligns with the IHS Strategic Plan FY 2019-2023 to support health care solutions that fit the diverse circumstances of Urban AI/AN people and the tribal communities they serve. Urban Indian Organization Leaders provided input through the Urban Confer process to help inform the development of the IHS Strategic Plan. The IHS Strategic Plan will guide the work of OUIHP as we continue to strengthen our partnership with Urban Indian Organizations (UIOs) to address the three overarching goals of the IHS Strategic Plan to improve access to care, quality of care, and IHS management and operations.

The IHS enters into limited, competitive contracts and grants with 41 501(c)(3) non-profit organizations to provide health care and referral services for Urban AI/AN people in 22 states and 11 IHS Areas. These IHS contracts and grants with UIOs address the *IHS Strategic Plan Goal 1, to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people*. Awarding of these contracts and grants to UIOs also addresses *HHS Strategic Plan Draft Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes*. UIOs define their scope of work and services based upon the service population, health status, and unmet needs of the Urban AI/AN community they serve. Each Urban Indian Organization is governed by a Board of Directors that must include at least 51 percent Urban AI/ANs.

UIOs provide unique access to quality health care and culturally appropriate services for Urban AI/AN people. The 41 UIOs are an integral part of the Indian health care system and serve as resources to both tribal and Urban AI/AN communities, which addresses *IHS Strategic Plan Goal 2, to promote excellence and quality through innovation of the Indian health system into an optimally performing organization*. Urban AI/AN people are often invisible in the urban setting and face unique challenges when accessing health care. A large proportion of Urban AI/AN

people live in or near poverty and face multiple barriers such as the lack of quality and culturally relevant health care services in cities. UIOs are an important support to Urban AI/AN people seeking to maintain their tribal values and cultures and serve as a safety net for Urban AI/AN patients. Social determinants of health play a key role in health and wellness, and UIOs address a wide range of factors contributing to improved health outcomes. For example, Urban AI/AN people in need of substance use disorder treatment commonly exhibit co-occurring disorders, and UIOs integrate behavioral health into primary care to offer health services within a culturally appropriate framework. UIOs provide health care services that address *HHS Strategic Plan Goal 1, Protecting and Strengthening Equitable Access to High Quality and Affordable Healthcare.*

In Calendar Year 2020, UIOs provided 699,237 health care visits for 79,502 Urban AI/AN people who do not have access to the resources offered through IHS or tribally operated health care facilities because they do not live on or near a reservation[1]. UIOs vary in size and services – full ambulatory care, limited ambulatory care, outreach and referral, and residential and outpatient substance abuse treatment programs. UIOs are described as follows:

- Full Ambulatory Care: Programs providing direct medical care to the population served for 40 or more hours per week.
- Limited Ambulatory Care: Programs providing direct medical care to the population served for less than 40 hours per week.
- Outreach and Referral: Programs providing case management of behavioral health counseling and education services, health promotion/disease prevention education, and immunization counseling but not direct medical care services.
- Residential and Outpatient Substance Abuse Treatment: Programs providing residential and outpatient substance abuse treatment, recovery, and prevention services.

Included in the above 41 UIOs funded through contracts and grants, are the following:

- Oklahoma City Indian Clinic and Indian Health Care Resource Center of Tulsa: These two urban sites, initially demonstration projects, are now permanent programs within the IHS's direct care program and must continue to qualify as an Urban Indian Organization under the IHCIA definition, 25 U.S.C. § 1660b.
- Former National Institute on Alcohol Abuse and Alcoholism Programs: As of FY 2020, the Urban Indian Health Program includes five UIOs that previously received grants originally awarded by the National Institute on Alcohol Abuse and Alcoholism (former-NIAAA program) and later administered by the IHS Alcohol and Substance Abuse Program (ASAP). OUIHP confirmed each of these former-NIAAA programs is an Urban Indian Organization as defined by the IHCIA and fully implemented the administrative transfer from ASAP to OUIHP, as authorized by IHCIA at 25 U.S.C. § 1660c – Urban NIAAA transferred programs. Congress approved the transfer of this funding from the ASAP budget to the Urban Indian Health budget line for FY 2020. These Urban Indian Organization contract awards address *IHS Goal 1, to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.* These contract awards also align with *HHS Strategic Plan Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare*. The five UIOs provide high quality, culturally relevant prevention, early intervention, outpatient and residential substance abuse treatment services, and recovery support to meet the needs of Urban AI/AN communities they serve.

[1] UDS Summary Report Final - 2020 (ihs.gov)

The other major Urban Indian Health focus areas and activities are:

- 4-in-1 Grant Program: In FY 2021, the OUIHP awarded 4-in-1 grants to 33 UIOs. The grantees are awarded for a three-year funding cycle from April 1, 192019 - March 31, 2022. These grants provide funding to UIOs to support four health program areas: health promotion and disease prevention services; immunization services; alcohol and substance abuse related services; and mental health services. Grantees are required to participate in a national evaluation of the 4-in-1 grant program, which addresses *IHS Strategic Plan Goal 2, to promote excellence and quality through innovation of the Indian health system into an optimally performing organization*. The national evaluation includes reporting on the cultural interventions integrated into the 4-in-1 program activities, and practice based and evidence based approaches that are implemented to meet the needs of the Urban Indian service population. These grants *protect and strengthen equitable access to high quality and affordable health care, which meets HHS Strategic Plan Draft Goal 1 and enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death, which meets HHS Strategic Plan Goal 2, Objective 2.3.*
- Urban Indian Education and Research Organization Cooperative Agreement: Provides national education and research services for UIOs and OUIHP through a cooperative agreement. The cooperative agreement includes five project areas: (1) public policy; (2) research and data; (3) training and technical assistance; (4) education, public relations, and marketing; and (5) payment system reform/monitoring regulations. This cooperative agreement also addresses the unmet needs of 4-in-1 grantees under two of the focus areas, including research and data and training and technical assistance. This cooperative agreement meets *IHS Strategic Plan Goal 1, Objective 1.2, to build, strengthen, and sustain collaborative relationships.*
- Albuquerque Indian Dental Clinic: Provides dental services through the Albuquerque Area IHS Dental Program. These services address *the IHS Strategic Plan Goal 1, to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people.* The provision of dental services also addresses *HHS Strategic Plan Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare.*

UIOs are evaluated in accordance with the IHCIA requirements. The program is administered by OUIHP at IHS Headquarters. OUIHP integrates Enterprise Risk Management by annually reviewing Urban Indian Organization progress with set goals and objectives. The IHS Urban Indian Organization On-Site Review Manual is used by the IHS Areas to conduct annual onsite reviews of IHS funded UIOs to monitor compliance with Federal Acquisition Regulation contractual requirements established through legislation. The results are submitted to OUIHP for review and follow-up to ensure corrective action plans are successfully completed prior to continuation of funding. Requirements in the manual are based on best-practice standards for delivering safe and high quality health care and are similar to standards used by accrediting organizations.

Many UIOs are seeking or maintaining accreditation from several accreditation organizations such as the Joint Commission, Accreditation Association for Ambulatory Healthcare (AAAHC), and Commission on Accreditation of Rehabilitation Facilities. In FY 2021, through an IHS contract with AAAHC, accreditation services were provided to 19 out of the 41 UIOs to meet *IHS Strategic Plan Goal 2, Objective 2.1, to create quality improvement capability at all levels of the organization; and HHS Strategic Plan Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare.*

PROGRAM ACCOMPLISHMENTS

UIOs fulfill IHS data reporting requirements including the IHS Government Performance and Results Act (GPRA) report and the Diabetes Non-Clinical Audit report. UIOs currently participate in the IHS Improving Patient Care (IPC) Initiative and are now in the Quality and Innovation Learning Network (QILN) implementing what they have learned across a wider variety of clinical and administrative options.

From October 1, 2020, to September 30, 2021, the Urban Indian Organization FY 2021 GPRA cycle accomplishments included:

- 97 percent of the UIOs reported on 26 of the 26 performance measures (although not all have facility-specific data available due to inclusion in an IHS Service Unit);
- 59 percent of the UIOs reported through the Integrated Data Collection System Data Mart (IDCS DM);
- 13 (38 percent) have GPRA data specific to their health program available in IDCS DM;
- 7 UIOs reported through the Clinical Reporting System (2 of these programs reported both through IDCS DM and through CRS); and
- 13 UIOs reported manually using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records).

The IHS will proceed with plans to have all UIOs export data to the IHS National Data Warehouse (NDW). This includes working with UIOs utilizing commercial off the shelf systems to export data to the NDW. The OUIHP will continue to work with the IHS National Patient Information Reporting System (NPIRS) staff to improve the export and accuracy of data for UIOs. The OUIHP, with the assistance of the IHS Office of Information Technology, will continue to provide training and technical assistance to UIOs on accurate and uniform data collection, so as to achieve standardization throughout the system. This work aligns with *IHS Strategic Plan Goal 1, Objective 2.1.1, to improve the transparency and the quality of data collected regarding health care services and program outcomes.* It also aligns with *HHS Strategic Plan Draft Goal 5, Advance Strategic Management to Build Trust, Transparency, and Accountability*.

Design requirements for the IHS's IDCS DM, include an aggregate Urban report to provide the clinical measure results reported in the Outputs and Outcomes Table of the Urban program's budget narrative. IDCS DM data is only available at the service unit level and IHS is unable to view individual urban program data for some sites sending in data. An aggregate Urban report requires data from individual facility reports to produce national results. IHS will report data from aggregate Urban reports when available.

On December 27, 2020, the Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260) (hereinafter "the Act") was signed into law. The Act provided the IHS with a total FY 2021 appropriation of $6.4 billion. The Joint Explanatory Statement for Division G for the Act designated $1,000,000 to conduct an infrastructure study for facilities run by UIOs. The infrastructure study provides the first step towards creating a comprehensive action plan to focus on improving equity and reduce barriers to programs and services, which addresses *IHS Strategic Plan Goal 1, to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.* In FY 2021, the IHS initiated urban confer to seek input on developing and implementing the infrastructure study from UIOs. In FY 2022, the IHS awarded a contract to The Innova Group to conduct the infrastructure study to identify future facility needs of UIOs. The infrastructure comprehensive

action plan will address *HHS Strategic Draft Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare.*

In FY 2021, the OUIHP leveraged the IHS Office of Public Health Support's Indefinite Delivery Indefinite Quantity (IDIQ) contract to develop a new 5-year IHS OUIHP strategic plan. On December 3, 2021, the IHS initiated urban confer to seek input and recommendations on the new strategic plan to improve access to high quality, culturally competent health services for Urban Indians, which addresses *IHS Strategic Plan Goal 2, to promote excellence and quality through innovation of the Indian health system into an optimally performing organization*. In FY 2022, the expectation is to evaluate the existing OUIHP strategic plan and establish a new strategic plan, including goals, strategies, and performance measures based on recommendations from UIOs, partners, and external stakeholders. The new strategic plan addresses *HHS Strategic Draft Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare*. FY 2020 – FY 2021 COVID-19 accomplishments include:

- IHS held monthly Urban Indian Organization Leader Calls. The purpose of these calls was to provide Urban Indian Organization Leaders with COVID-19 updates in: 1) Prevention, Detection, Treatment, and Recovery; 2) Funding; and 3) National Supply Service Center. In FY 2020, the OUIHP held 15 conference calls scheduled as weekly to biweekly then monthly. There was an estimated total of 1,195 participants. In FY 2021, the OUHP held 18 conference calls scheduled monthly. There was an estimated total of 588 participants. Comments received included COVID-19 funding, testing, vaccines, medical supplies, telehealth, and data collection. These calls ended on June 1, 2021.
- In FY 2020, IHS conducted three urban confer sessions on March 25, April 1, and April 29 to seek input on COVID-19 funding decisions for resource distributions to UIOs. There were a total of 551 participants (187 participants from March 25, 252 participants from April 1, and 112 participants from April 29). In FY 2021, IHS conducted two urban confer sessions on January 4 and March 15 to seek input regarding the allocation of COVID-19 resources. There were a total of 199 participants (130 participants from January 4 and 69 participants from March 15). The urban confer satisfaction survey results indicated that participants were satisfied with information shared and topics discussed from sessions.
- On September 25, 2020, IHS initiated urban confer on COVID-19 vaccine planning. On October 8, 2020, IHS and the Centers for Disease Control (CDC) held a listening session on COVID-19 vaccine planning and distribution. On October 14, 2020, IHS requested input on the IHS COVID-19 Pandemic Vaccine Draft Plan from Urban Indian Organization Leaders.
- IHS distributed funding in the amount of $478 million to UIOs from the Families First Coronavirus Response Act; Coronavirus Aid, Relief, and Economic Security Act; Paycheck Protection Program and Healthcare Enhancement Act; Coronavirus Response and Relief Supplemental Appropriations Act; and American Rescue Plan Act for response and recovery to COVID-19.
- In FY 2020, OUIHP approved Urban Emergency Funds totaling $200,000 to address costs incurred during the COVID-19 crisis. The Indian Health Center of Santa Clara Valley received $172,205, Oklahoma City Area received $18,645, American Indian Health Service of Chicago received $4,150, and $5,000 was used to procure personal protective equipment for 41 UIOs. In FY 2021, the American Indian Health and Family Services in Detroit, Michigan, received $200,000 in Urban Emergency Funds.
- Across UIOs, more than 168,000 vaccine doses have been administered to patients, employees, and urban community members, while more than 112,000 have been tested.

- OUIHP coordinated two distributions of cloth masks totaling 78,500 to UIOs for critical infrastructure employees working in office settings to help slow the spread of COVID-19.
- Furthermore, OUIHP received approval to utilize IHS Headquarters Managed COVID-19 funding for a cooperative agreement supplement ($1 million per year for 2 years) to provide Public Health Support through education and services to 41 UIOs during the pandemic. The supplement was awarded on December 12, 2020, to the National Council of Urban Indian Health; and ends on June 14, 2022.

COVID-19

The COVID-19 pandemic has disproportionately affected AI/AN populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, UIOs, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19. This budget narrative may include examples of how care or programming was adapted to address COVID-19. Please refer to the Overview of Agency Performance for additional information about the IHS COVID-19 Response.

FUNDING HISTORY

Fiscal Year	Amount
2019	$50,533,000
2020	$57,684,000
2021 Final	$62,684,000
2022 Enacted	$73,424,000
2023 President's Budget	$112,514,000

BUDGET REQUEST

The FY 2023 budget submission for Urban Health is $113 million, which is $39 million above the FY 2022 Enacted level.

FY 2022 Base Funding of $73 million – The base funding provides for the following activities.

- Improving Urban AI/AN access to health care to improve health outcomes in urban centers.
- Strengthening programs that serve Urban AI/AN people throughout the United States.
- Enhancing Urban Indian Organization third party revenue, implementing payment reforms such as the transition to a new prospective payment system, and increasing quality improvement efforts.
- Increasing the number of accredited Urban Indian Organization programs and patient centered medical homes for Urban AI/AN individuals.
- Implementing and utilizing advanced health information technology.
- Expanding access to quality, culturally competent care for Urban AI/AN people through collaboration with other federal agencies.
- Implementing IHCIA authorities specific to UIOs.

FY 2023 Funding Increase of $39 million includes:

- Current Services: +$3 million for current services including:
  - Pay Costs +$2 million – to fund pay increases for federal and Tribal employees, of whom approximately 90 percent are working at the service unit level providing health care and related services.
  - Inflation +$403,000 – to fund inflationary costs of providing health care services.
  - Population Growth +$1 million – to fund the additional service needs arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.

- General Program Increase: +$27 million to expand access to health care for urban AI/AN through the following activities:
  - Improving Urban AI/AN access to health care and expanding services across each type of Urban Indian Organization (residential and outpatient substance abuse treatment center, outreach and referral, and limited and full ambulatory care).
  - Funding UIOs to provide culturally appropriate programming that meets the needs of their urban Indian patients.
  - Increasing funding to help UIOs recruit and retain medical and behavioral health providers, building internal capacity for expanding health services, facility improvements, and supporting training programs.
  - Enhancing third party revenue, implementing payment reforms such as the transition to a new prospective payment system; and supporting quality improvement efforts, research and data, training and technical assistance, and education, public relations, and marketing for UIOs.
  - Implementing and utilizing advanced health information technology; expanding and funding information technology infrastructure, staffing, and staff training; and telehealth.
  - Supporting ambulatory care UIOs to become certified patient-centered medical homes, which aligns with the triple aim of health care (improve the experience of care, improve the health of populations, and reduce costs).
  - Improving health care data, epidemiology, and population counts of AI/AN people residing in urban areas.
  - Expanding access to quality, culturally competent care for Urban AI/AN people through collaboration with local, state, and other federal agencies.
  - This funding increase could support an estimated 1,072,935 health care, outreach, and referral services to Urban Indian users in FY 2023.

- Partially Sustain ARPA Investments: +$9 million - to increase annual appropriations

to sustain the ARPA public health workforce, mental health, and alcohol and substance abuse investments, preventing a significant reduction in services.

The American Rescue Plan Act provided a historic investment in public health workforce activities, as well as mental health and substance abuse prevention and treatment services for American Indians and Alaska Natives. The IHS distributed these resources to all IHS, Tribal, and urban Indian Heath programs.

However, the ARPA appropriation provided one-time, non-recurring funding to support mental health and substance abuse prevention and treatment services. Ongoing resources are necessary to ensure that IHS, Tribal, and urban Indian health programs do not have to significantly reduce public health workforce activities and mental health and substance abuse treatment services as the one-time ARPA resources are expended.

- Realign Funding for Former National Institute on Alcohol Abuse and Alcoholism (NIAAA): +$31,061 - to realign remaining funding for former National Institute on Alcohol Abuse and Alcoholism (NIAAA) programs from the Alcohol & Substance Abuse line into the Urban Health line (see Difference column in the table below). This shift reduces administrative burden.

Recurring Funding for Former NIAAA Programs - Alcohol/Substance Abuse Funding

Former NIAAA Program	FY 2018	Difference	FY 2019
Juel Fairbanks Chemical Dependency Services	$104,685	$2,727	$107,412
American Indian Council on Alcoholism, Inc.	$278,816	$7,262	$286,078
Native Directions, Inc.	$364,037	$19,029	$383,066
Kansas City Indian Center (Heart of America)	$118,353	$2,043	$120,396
Native American Connections	$502,656	$0	$502,656
TOTAL	**$1,368,547**	**$31,061**	**$1,399,608**

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
UIHP-7 Number of AI/ANs served at Urban Indian clinics. (Outcome)	FY 2019: 76,760 Target: 54,525 (Target Exceeded)	TBD	TBD	Maintain
UIHP-8 Percentage of AI/AN patients with diagnosed diabetes served by urban health programs that achieve good blood	FY 2018: Result Expected December 31, 2022 Target: Set Baseline (Pending)	Discontinued	Discontinued	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
sugar control (Outcome)				
UIHP-9 Proportion of children, ages 2-5 years, with a BMI at or above the 95th percentile (Outcome)	FY 2018: Result Expected Dec 31, 2022 Target: Set Baseline (Pending)	Not Defined	Not Defined	Maintain
UIHP-10 Increase the number of diabetic AI/ANs that achieve blood pressure control (Outcome)	FY 2018: Result Expected Dec 31, 2022 Target: Set Baseline (Pending)	Not Defined	Not Defined	N/A
UIHP-11 Reduce the proportion of American Indians/Alaska Natives with diagnosed diabetes who have poor glycemic control (A1c >9%). (Outcome)	FY 2019: Result Expected Dec 31, 2022 Target: Set Baseline (Pending)	Not Defined	Not Defined	N/A

GRANTS AWARDS - Funding for UIOs for FY 2023 includes both grants and contracts awarded to the programs.

(whole dollars)	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget
Number of Awards	34	34	34
Average Award	$281,128	$281,128	$281,128
Range of Awards	$164,373 - $1,312,500	$164,373 - $1,050,000	$164,373 - $1,050,000

AREA ALLOCATION

Urban Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2021 Final			FY 2022 Estimated			FY 2023 Estimated			FY '21 +/- FY '20
	Federal	Urban	Total	Federal	Urban	Total	Federal	Urban	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$
Albuquerque	0	3,735	3,735	0	4,374	4,374	0	6,703	6,703	$2,329
Bemidji	0	5,647	5,647	0	6,615	6,615	0	10,136	10,136	$3,521
Billings	0	3,151	3,151	0	3,690	3,690	0	5,655	5,655	$1,965
California	0	8,629	8,629	0	10,108	10,108	0	15,489	15,489	$5,381
Great Plains	0	2,111	2,111	0	2,472	2,472	0	3,789	3,789	$1,316
Nashville	0	1,258	1,258	0	1,473	1,473	0	2,258	2,258	$784
Navajo	0	1,014	1,014	0	1,188	1,188	0	1,820	1,820	$632
Oklahoma	0	2,918	2,918	0	3,418	3,418	0	5,237	5,237	$1,819
Phoenix	0	3,470	3,470	0	4,064	4,064	0	6,228	6,228	$2,164
Portland	0	7,647	7,647	0	8,958	8,958	0	13,726	13,726	$4,769
Tucson	0	716	716	0	839	839	0	1,285	1,285	$446
Headquarters	0	22,389	22,389	0	26,225	26,225	0	40,187	40,187	$13,962
Total, Urban	**$0**	**$62,684**	**$62,684**	**$0**	**$73,424**	**$73,424**	**$0**	**$112,513**	**$112,513**	**$39,089**

Note: FY 2022 and FY 2023 are estimates.

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

INDIAN HEALTH PROFESSIONS

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$67,314	$73,039	$93,568	+$20,529
FTE*	14	16	16	--

*FTE numbers reflect only Federal staff and do not include increases for tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Indian Health Care Improvement Act (IHCIA) Public. Law 94-437, as amended, authorizes the Indian Health Service (IHS) Scholarship program, Loan Repayment program (LRP), health professions training related grants, and recruitment and retention activities. The IHS made its first scholarship program awards in 1978 when Congress appropriated funds for the Indian Health Professions (IHP) program.

The IHP programs work synergistically and directly supports *IHS' FY 2019-2023 Strategic Plan, Goal 1, Objective 1.1 through the recruitment and retention of health care professionals to provide high-quality primary care and clinical preventive services to American Indians and Alaska Natives (AI/AN). The IHP programs also directly support the IHS Strategic Plan Goal 1, Objective 1.2 through critical support in continuing to strengthen collaborations between the IHS, Tribes/Tribal organizations, Urban Indian organizations (I/T/U) and the Health Resources and Services Administration (HRSA)* to increase the number of sites eligible to participate as National Health Service Corps (NHSC) approved sites for the NHSC Scholarship program and LRP.

PROGRAM ACCOMPLISHMENTS

The IHP program has seen much success throughout the years including, but not limited to, the following:

- Recruiting well-qualified health care professionals through various sources: IHS Scholarship Recipients, US Public Health Service Commissioned Corps, Uniformed Services University of the Health Sciences (USUHS), various social media networking sites and through Career Fair events conducted virtually due to the pandemic.
- Conducting IHS Scholarship Program webinar-based general information session webinars for potential applicants.

- Conducting Loan Repayment Program general information session webinar and invited unfunded incomplete LRP applicants, Indians Into Medicine, Indians Into Nursing, and Indians into Psychology Grant program students. Enhancement and update of the Career Opportunities webpages on the IHS.gov website.
- Enabling AI/ANs to enter health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs.
- Serving as a catalyst in developing AI/AN communities by providing educational opportunities for AI/ANs to become health care professionals and return to their local communities to provide health care.
- Developing and maintaining American Indian psychology career recruitment programs as a means of encouraging AI/ANs to enter the mental health field.
- Assisting AI/AN health programs to recruit and retain qualified health professionals.
- Collaborating with the National Health Service Corps Loan Repayment Program that received an additional funding for loan repayment awards to clinicians working at IHS facilities, Tribally-operated 638 health programs, and Urban Indian programs to combat the nation's opioid crisis.
- Established COVID-19 FAQs on IHS LRP Web site which informs recipients of the flexibilities to support program participants directly impacted by COVID-19.
- Consulting annually with IHS Area Directors, Tribal health directors, and Urban Indian health directors regarding their health professions priorities eligible for Scholarship and Loan Repayment Program funding.

While the IHP programs have seen successes, IHP continues to strive to improve performance and identify areas of risk. Placement of new scholars within 90 days of completing their training continues to be a challenge. The use of outreach activities such as recruitment and placement webinars, direct emails to scholarship recipients, and the referral of graduates to area and site recruiters have all been used to facilitate the 90 day scholar placement. In FY 2019, 42 percent of scholars had a hire letter within 90 days (target was 78 percent). Failure to meet this goal was primarily due to scholars not completing their licensing boards and finding positions within the 90 day period. The Scholarship program continues to seek new ways to assist IHS scholars to meet this requirement. Assuring scholars and loan repayment recipients meet their service obligation is another critical component of the IHP programs. Annual employment verification through personnel rosters and certification by Tribal employers assist in this process. Scholarship program and LRP databases allow staff to identify when health professionals are expected to complete their service obligation and allow for timely follow-up.

Loan Repayment Program (Section 108): The LRP is an invaluable tool for recruiting and retaining healthcare professionals by offering them the opportunity to reduce their student loan debts through service to Indian health programs with critical staffing needs. Applicants agree to serve two years at an Indian health program in exchange for up to $20,000 per year in loan repayment funding and up to an additional $5,000 per year to offset tax liability. Loan repayment recipients can extend their initial two-year contract on an annual basis until their original approved educational loan debt is paid.

In FY 2021, a total of 1626 health professionals were receiving IHS loan repayment. This included 469 new two-year contracts, 642 one-year extension contracts and 515 health professionals starting the second year of their FY 2020 two-year contract.

Applicants who apply for but do not receive funding, are identified as either "matched unfunded" or "unmatched unfunded". The "matched unfunded" applicants are health professionals employed in an Indian health program. The "unmatched unfunded" applicants are health professionals that either decline a job offer because they did not receive loan repayment funding or those unable to find a suitable assignment meeting their personal or professional needs. In FY 2021, there were 38 "matched unfunded" applicants (including 10 nurses, 1 behavioral health providers, 3 dentists, 7 mid-level providers and 7 pharmacists, among others) and 314 "unmatched unfunded" health professionals (including 60 behavioral health providers, 10 dentists, 49 mid-level providers and 101 nurses among others). The inability to fund these 352 health professional applicants is a significant challenge for the recruitment efforts of the agency. A more detailed breakout of loan repayment awards in FY 2021 by discipline is included in a table at the end of the narrative.

Scholarship Program (Sections 103 and 104) – Section 103 scholarships include the preparatory and pre-graduate scholarship programs that prepare students for health professions training programs. Graduate students and junior- and senior-level undergraduate students are given priority for funding for programs under Section 103, unless the section specifies otherwise. Section 104 includes the Health Professions Scholarship program, which provides financial support consisting of tuition, fees and a monthly stipend for AI/AN students from federally recognized Tribes enrolled in health profession or allied health profession programs. Students accepting funding for programs under Section 104 incur a service obligation and payback requirement. In FY 2021, there were 618 new online scholarship applications submitted to the IHS Scholarship program. After evaluating the application for completeness and eligibility, a total of 134 of these new scholarship applications accepted the scholarship. The IHS Scholarship program also reviewed applications from previously awarded scholars that were continuing their education. A total of 121 extension awards were funded for FY 2021. A detailed breakout of scholarships awarded by discipline for FY 2021 is included in a table at the end of the narrative.

Extern Program (Section 105) - Section 105 of the IHCIA, is designed to give IHS scholars and other health professions students the opportunity to gain clinical experience with IHS and Tribal health professionals in their chosen discipline. This program is open to IHS scholars and non-scholars. Students are employed up to 120 days annually, with most students working during the summer months. In summer 2021, the Extern Program funded a total of 14 student externs. The pandemic situation affected many facilities from hiring the student externs. A breakout of extern awards by Area Offices is included in a table at the end of the narrative.

FUNDING HISTORY

Fiscal Year	Amount
2019	$56,363,000
2020	$65,314,000
2021 Final	$67,314,000
2022 Enacted	$73,039,000
2023 President's Budget	$93,568,000

BUDGET REQUEST

The FY 2023 budget submission for Indian Health Professions of $94 million is $21 million above the FY 2022 Enacted level.

FY 2022 Base Funding of $73 million – The base funding enables AI/ANs to enter the health care professions through a carefully designed system of preparatory, professional, and continuing

educational assistance programs; serve as a catalyst in developing AI/AN communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian self-determination in the delivery of health care; and assist Indian health programs to recruit and retain qualified health professionals.

FY 2023 Funding Increase of +$21 million includes:

- Current Services of +$529,000, including:
    - Pay Costs: +$6,000 – to fund pay increases for Federal and Tribal employees.
    - Inflation: +$523,000 to fund inflationary costs of providing health care services.
- Indian Health Professions Increase: +$20 million to support a variety of activities to improve recruitment and retention, including compensation and hiring initiatives, bolstering the personnel security program, and streamlining human resources information systems. Examples of key activities supported by these funds are:
    - Additional Scholarship and Loan Repayment Awards (+$10 million). These funds will support additional scholarship and loan repayment awards to improve recruitment and retention by bolstering two programs in high demand.
    - Compensation and Hiring Initiatives (+$1 million). Activities include the review and development of Title 38 Special Salary Rates for allied health professionals, and system enhancements to implement work schedules for health care providers that are currently available at VA and the private sector.
    - Personnel Security Program (+$2 million). This program is responsible for the proper vetting of incoming personnel, as well as continuous monitoring of personnel, to ensure eligibility to obtain and maintain a position of trust within the federal government.
        - IHS' vetting process is also extended to support the Indian Child Protection and Family Violence Prevention Act – Public Law 101-630, which is an additional check for all personnel occupying a position or performing work that involves regular contact with, or control over Indian children.
        - The IHS personnel security program directly supports the recruitment and retention of IHS personnel.
    - Human Resources Information Systems (+$2 million). Funds will streamline recruitment and retention activities, such as automating compensation and onboarding activities to expedite the hiring process.
    - Housing Subsidies for Health Care Professionals (+$1 million). The FY 2018 appropriation provided a new authority for the IHS to provide housing subsidies for health care professionals as a recruitment tool for IHS and Tribal Health Programs. The IHS did not receive funding to implement this new authority until the recruitment and retention funding increase in FY 2020. The IHS is in the process of implementing a pilot for this program to measure its success. Additional resources would make this a more

robust pilot, with results that are more appropriate for generalizing across the Indian health system, while filling critical vacancies.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
42 Scholarships: Proportion of Health Scholarship recipients placed in Indian health settings within 90 days of graduation. (Outcome)	FY 2021: 36 % Target: 78 % (Target Not Met)	50 %	40 %	-10%
IHP-1 Number of scholarship awards under section 103 (Output)	FY 2021: 35 Awards Target: 89 Awards (Target Not Met)	65 Awards	40 Awards	-25 Awards
IHP-2 Number of scholarship awards under section 104 (Output)	FY 2021: 220 Awards Target: 223 Awards (Target Not Met)	250 Awards	250 Awards	Maintain
IHP-3 Number of externs under section 105 (Output)	FY 2021: 0 Externs[1] Target: 135 Externs (Target Not Met)	100 Externs	35 Externs	-65 Externs
IHP-4 Number of new 2 year contract awarded loan repayments under section 108 (Output)	FY 2021: 469 contracts Target: 465 contracts (Target Exceeded)	570 contracts	570 contracts	Maintain
IHP-5 Number of continuing 1 year loan repayment contract extensions under section 108 (Output)	FY 2021: 642 Awards Target: 360 Awards (Target Exceeded)	680 Awards	680 Awards	Maintain
IHP-6 Total number of new awards funded in previous fiscal year under section 108 (Outcome)	FY 2021: 515 awards Target: 360 awards (Target Exceeded)	538 awards	570 award	-32 awards

* FY 2021 "Targets" include estimates based on complete FY 2020 funding cycle data.
** The "Number of Loan Repayments – Total" includes New Awards, Contract Extensions and Continuation Awards.
*** In FY 2021 a total of 260 awardees to date declined their award. The main reason for declinations is that the applicants also applied to the National Health Service Corps LRP and were accepted.

[1] Due to the COVID-19 pandemic, the Extern program was suspended in 2021.

GRANTS AWARDS

The IHP administers three grant programs which fund colleges and universities to train students for health professions: (1) American Indians into Nursing Program (Section 112), (2) Indians into Medicine Program (Section 114), and (3) American Indians into Psychology Program (Section 217). These programs provide support to students during their health career professional pathway and encourage students to practice in the Indian health system.

(whole dollars)	FY 2021 Final	FY 2022 CR	FY 2023 President's Budget
American Indians Into Nursing Program (Section 112) – CFDA No. 93.970			
Number of Awards	5	5	5
Average Award	$337,341	$337,341	$337,341
Range of Awards	$337,341	$337,341	$337,341
Indians Into Medicine Program (Section 114) – CFDA No. 93.970			
Number of Awards	4	4	4
Average Award	$321,250	$321,250	$321,250
Range of Awards	$195,000 - $700,000	$195,000 - $700,000	$195,000 - $700,000
American Indians Into Psychology Program (Section 217) – CFDA No. 93.970			
Number of Awards	3	3	3
Average Award	$240,791	$240,791	$240,791
Range of Awards	$240,791	$240,791	$240,791

Scholarship Program Awards –For FY 2021, the IHS Scholarship Program made awards to the following disciplines:

Section 103 Pre-professional 3 students				
Pre Nursing	3			
Section 103 Pre-graduate –32students				
Pre-Dentistry	9			
Pre-Medicine	23			
Section 104 Health Professions - 220 students				
Counseling Psychology	3		Pharmacy	20
Dentistry	17		Physical Therapy	23
Chiropractor	1		Physician Assistant	19
Clinical Psychology	7		Optometry	19
Nurse Practitioner	8		Physician, Allopathic	36
Nurse, Baccalaureate Degree	19		Physician, Osteopathic	34
			Podiatry	1
Nurse Midwife	2		Social Work	6
Nurse Anesthetist	5			

Loan Repayment Program Awards – In FY 2021, the IHS LRP made awards to the following disciplines:

Awards by Profession	Total Awards	New Awards	Contract Extensions	Matched Not Awarded
Behavioral Health	64	29	35	1
Dental*	93	24	69	3
Nurse	213	138	75	10
Optometrists	55	4	51	3
Pharmacists	240	100	140	7
Physician Assistants/ Advanced Practice Nurses	151	57	94	7
Physicians	135	42	93	4
Podiatrists	20	6	14	1
Rehabilitative Services	85	26	59	2
Other Professions	55	43	12	0
TOTAL	**1111**	**469**	**642**	**38**

* Includes Dentists and Dental Hygienists.

Other Professions	Total Awards	Matched Not Awarded	By Pay System	Awards
Acupuncturist	2	0	Tribal Employee	686
Chiropractors	6	0	Civil Service	332
Dietetics/Nutrition	15	0	Commissioned Corps	84
Engineering	5	0	Urban Health Employees	9
Medical Laboratory Scientist	10	0		
Medical Technology	1	0		
Radiology Technicians	12	0		
Sanitarian	2	0		
Respiratory Therapists	2	0		
TOTAL	**55**	**0**	**Total**	**1111**

Extern Program Awards – In summer 2021, the IHS Extern Program had a total of 14 student externs. The current pandemic situation affected many facilities in hiring student externs for the summer.

AREA OFFICES	NUMBER OF STUDENT EXTERNS
Albuquerque	1
California	1
Great Plains	5
Oklahoma	7

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

TRIBAL MANAGEMENT GRANT PROGRAM

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$2,465	$2,466	$4,486	+$2,020
FTE*	--	--	--	--

*Tribal Management Grant funds are not used to support FTEs.

Authorizing Legislation ..... 25 U.S.C. 450, Indian Self-Determination and Education Assistance Act, as amended 2010

FY 2023 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Tribal Management Grant (TMG) program was authorized in 1975 under Sections 103(b)(2) and 103(e) of Public Law (P.L.) 93-638, Indian Self-Determination and Education Assistance Act (ISDEAA), as amended. Under the authority of the ISDEAA, the program was established to assist all federally recognized Indian Tribes and tribally-sanctioned tribal organizations (T/TO) to plan, prepare, or decide to assume all or part of existing Indian Health Service (IHS) programs, functions, services, and activities (PFSA) and to further develop and enhance their health program management capability and capacity. (HHS Strategic Goals: 1.1 Increase choice, affordability, and enrollment in high-quality healthcare coverage; 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health; 1.4 Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families; 1.5 Bolster the health workforce to ensure delivery of quality services and care; 2.1 Improve capabilities to predict, prevent, prepare for, respond to, and recover from emergencies, disasters, and threats across the nation and globe; 2.2 Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines; 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death; 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion; 5.3 Uphold effective and innovative human capital resource management resulting in an engaged, diverse workforce with the skills and competencies to accomplish the HHS mission) The TMG program has provided discretionary competitive grants to T/TO, to establish goals and performance measures for current health programs, assess current management capacity to determine if new components are appropriate, analyze programs to determine if T/TO management is practicable, and develop and enhance infrastructure systems to manage or organize PFSA. The nature of the TMG program allowed T/TO the option to enter or not enter into ISDEAA contracts/compact agreements which are equal expressions of self-determination. (HHS Strategic Goals: 1.1 Increase choice, affordability, and enrollment in high-

quality healthcare coverage; 1.2 Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs; 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health; 1.4 Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families; 1.5 Bolster the health workforce to ensure delivery of quality services and care; 2.1 Improve capabilities to predict, prevent, prepare for, respond to, and recover from emergencies, disasters, and threats across the nation and globe; 2.2 Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines; 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death; 3.2 Strengthen early childhood development and expand opportunities to help children and youth thrive equitably within their families and communities; 3.3 Expand access to high-quality services and resources for older adults and people with disabilities, and their caregivers to support increased independence and quality of life; 3.4 Increase safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence; 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion; 4.2 Invest in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, healthcare, public health, and human services resulting in more effective interventions, treatments, and programs; 4.3 Strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions; 5.1 Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices; 5.4 Ensure the security and climate resiliency of HHS facilities, technology, data, and information, while advancing environment-friendly practices)

The IHS established four funding priorities for the TMG program:

- Tribes that receive federal recognition or restoration within the last five years with implementing or developing management and infrastructure systems for their organization
- T/TO that need to improve financial management systems to address audit material weaknesses
- Eligible Direct Service and Title I Federally recognized Indian Tribes or Tribal organizations submitting a competing continuation application or new application
- Eligible Title V Self Governance Federally recognized Indian Tribes or Tribal organizations submitting a competing continuation or new application.

The TMG program offered four project types with three different award amounts and project periods:

(1) Planning - fund up to $50,000 with project periods not to exceed 12 months. A Planning Project allows establishment of goals and performance measures for current health programs or to design their health programs and management systems.
(2) Evaluation - fund up to $50,000 with project periods not to exceed 12 months. An Evaluation Study Project determines the effectiveness and efficiency of a program or if new components are needed to assist the T/TO to improve its health care delivery system.
(3) Feasibility - fund up to $70,000 with project periods not to exceed 12 months. A Feasibility study analyzes programs to determine if T/TO management is practicable.

(4) Health Management Structure (HMS) grants are funded up to $300,000 with project periods not to exceed 36 months. HMS projects include the design and implementation of systems to manage PFSA, such as Electronic Health Records (EHR) systems or billing and accounting systems, management systems, health accreditation, as well as correction of audit material weaknesses.

The IHS Tribal Management Grants program supports the IHS Strategic Plan Goal 1 to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN by directly providing Tribes and Tribal organizations grant opportunities to develop systems, support financial management systems, and expand programs to increase access to preventive care services and quality health care.

PROGRAM ACCOMPLISHMENTS

Fiscal Year	New Funded Awards	*Cont: 2/3 Year	Total Award
FY 2017	16	3	$1,786,683
FY 2018	16	8	$2,235,271
FY 2019	11	15	$2,391,223
FY 2020	11	9	$1,802,826
FY 2021**	--	8	$637,734

* Grants which originally had two or three year project periods and were in their second or third year of funding.

** A delay in posting the Notification of Funding Opportunity (NOFO) resulted in new FY 2021 Awards not being issued. The FY 2021 funding will be used in the first FY 2022 Tribal Management awards, and the FY 2022 funding will be used for the second round of awards.

- In FY 2020 the amount of awards decreased due to the COVID-19 pandemic.
- Provided technical assistance to potential applicants and provided post award technical assistance to recipients – *HHS Strategic Goals: 1.1 Increase choice, affordability, and enrollment in high-quality healthcare coverage; 1.2 Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs; 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health; 1.4 Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families; 1.5 Bolster the health workforce to ensure delivery of quality services and care; 2.1 Improve capabilities to predict, prevent, prepare for, respond to, and recover from emergencies, disasters, and threats across the nation and globe; 2.2 Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines; 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death; 3.2 Strengthen early childhood development and expand opportunities to help children and youth thrive equitably within their families and communities; 3.3 Expand access to high-quality services and resources for older adults and people with disabilities, and their caregivers to support increased independence and quality of life; 3.4 Increase safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence; 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion; 4.2 Invest in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, healthcare, public health, and*

human services resulting in more effective interventions, treatments, and programs; 4.3 Strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions; 5.1 Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices; 5.4 Ensure the security and climate resiliency of HHS facilities, technology, data, and information, while advancing environment-friendly practices.

- Approximately one percent of TMG funding has been used for overall administration of the program; these funds provide TMG program requirements, training, and general technical assistance. – *HHS Strategic Goals: 1.1 Increase choice, affordability, and enrollment in high-quality healthcare coverage; 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health; 2.1 Improve capabilities to predict, prevent, prepare for, respond to, and recover from emergencies, disasters, and threats across the nation and globe; 5.1 Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices.*

FUNDING HISTORY

Fiscal Year	Amount
2019	$2,165,000
2020	$2,465,000
2021 Final	$2,465,000
2022 Enacted	$2,466,000
2023 President's Budget	$4,486,000

TRIBAL SHARES

Program funds are not subject to tribal shares since they are transferred through a federally-administered grant program.

BUDGET REQUEST

The FY 2023 budget submission for Tribal Management Grants of $5 million is $2 million above the FY 2022 Enacted level.

FY 2023 Funding Increase of +$2 million includes

- Current Services of +$20,000 including:
    - Inflation +$20,000 to fund inflationary costs of providing health care services.
- Tribal Management Grants Increase: +$2 million, for an additional 15-20 awards to Tribes to assess their capacity to directly operated health care services currently provided by the IHS.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
TMG-1 Planning Grants (Output)	FY 2020: 2 planning grants Target: 0 planning grants (Target Exceeded)	2 planning grants	2 planning grants	Maintain
TMG-2 Health Management Structure (HMS) grants (Output)	FY 2020: 9 HMS grants Target: 0 HMS grants (Target Exceeded)	9 HMS grants	10 HMS grants	+1 grant

GRANTS AWARDS

(whole dollars)	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget
Number of Awards	20 Total Awards: 11 Noncompeting Continuations and 9 New	20 Total Awards: 10 Noncompeting Continuations and 10 New [1]	20 Total Awards: 10 Noncompeting Continuations and 10 New [2]
Average Award	$105,135	$105,135	$105,135
Range of Awards	$50,000 - $150,000	$50,000 - $150,000	$50,000 - $150,000

[1] FY 2021 is an estimate will update when awarded.
[2] FY 2022 is an estimate will update when awarded.

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$82,456	$95,046	$115,378	+$20,332
FTE*	264	279	294	+15

*FTE numbers reflect only Federal staff and do not include increases for Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Direct Operations budget supports the Indian Health Service (IHS) provision of Agency-wide leadership, oversight, and executive direction for the comprehensive public and personal health care provided to American Indians and Alaska Natives (AI/AN). Funds are used to promote the efficient and effective administration and oversight of national functions such as: human resources (HR), financial management, acquisitions, internal control and risk management, health care and facilities planning, health information technology, Contract Disputes Act claims analysis, and other administrative support and systems accountability. These types of direct operations performed at the Headquarters and Area Office levels provide the foundation necessary to carry out the Agency mission.

The IHS Headquarters provides overall program direction, authorities, and oversight for the 12 IHS Areas and 170 Service Units; formulates policy and distributes resources; provides technical expertise to all components of the Indian health care system, which includes IHS direct, Tribally operated programs, and urban Indian organizations (I/T/U); maintains national statistics and public health surveillance; identifies trends; and projects future needs. The IHS Headquarters works in partnership with the Department of Health and Human Services (HHS) and sister agencies to formulate and implement national health care priorities, goals, and objectives for AI/ANs within the framework of its mission. The IHS Headquarters also works with HHS to formulate the annual budget and necessary legislative proposals, respond to congressional inquiries, and collaborate with other governmental entities to enhance and support health care services for AI/ANs.

By delegation from the IHS Director, the 12 Area Offices distribute resources, carry out policies and internal controls, monitor and evaluate the full range of comprehensive healthcare and community-oriented public health programs, and provide technical support to local Service Units and I/T/U staff. They ensure the delivery of quality health care through the 170 Service Units and participate in the development and demonstration of alternative means and improvement techniques of health services management and delivery to promote the optimal provision of health services to Indian people throughout the Indian health system.

Direct Operations funding supports all three goals of the IHS Strategic Plan. Recruitment, development, and retention of a dedicated, competent, and caring workforce (Goal 1, Access, Objective 1.1) is the foundation for improving quality (Goal 2) and strengthening management and operations (Goal 3). These funds are essential for sustaining a human resources program that can enhance and retain a workforce to carry out the agency's mission. The funds also support quality improvement capabilities (Goal 2, Quality, Objective 2.1) to ensure a quality healthcare program that promotes accountability, integrity, and stewardship. Woven through all of these components are the concerted efforts to continually strengthen IHS program management and operations through improved communication (Goal 3, Objective 3.1), secure and effective management of IHS's assets and resources (Goal 3, Objective 3.2), and modernization of information technology and systems to support data driven decisions (Goal 3, Objective 3.3).

PROGRAM ACCOMPLISHMENTS

The Direct Operations budget is critical for continued progress in assuring an accountable, quality, and high-performing Indian health system. Examples of significant agency activities made possible by Direct Operations funds are provided below.

The IHS is implementing activities to meet the strategies, objectives, and goals of the five-year (2019-2023) Strategic Plan which promotes a culture of accountability, quality, and patient safety across the agency, and serves as a roadmap for continual quality improvement. The Strategic Plan was published in February 2019 after extensive gathering of stakeholder input through Tribal Consultation, Urban Confer, and feedback from a IHS Federal-Tribal Strategic Planning Workgroup. To monitor implementation of the Strategic Plan, the IHS created a MS SharePoint site that allows for IHS Area and Headquarter (HQ) Offices reporting into a centralized location, the Strategic Plan Activity Repository (SPAR). Area and HQ Offices select high bar activities to include in the SPAR. These activities are updated quarterly (or more frequently as appropriate) and tied to a strategy. The IHS Strategic Plan has focused IHS programs and activities on improving quality, safety, and sustained compliance across the IHS healthcare system. As of December 2021, 342 total activities from Areas and HQ offices are currently tied to the IHS Strategic Plan, all 12 Areas and 12 HQ offices contribute activities and updates. This activity meets the draft HHS Strategic Plan Goal 5, Advance Strategic Management to Build Trust, Transparency, and Accountability.

The IHS is committed to improving the quality and safety of health care services. The Office of Quality (OQ), formally established in FY 2019, has made significant quality and patient safety improvements across the Agency. The OQ provides the structure to promote accountability and oversight with a focus on quality assurance to promote and sustain compliance with Centers for Medicare and Medicaid Services and accreditation organizations; quality improvement through innovation and implementation of quality improvement science; and improve patient safety and reduce all cause harm. Through the national leadership of the OQ in FY 2021, the IHS made substantial strides in addressing priority areas for quality improvement and patient safety including full implementation of the IHS Safety Tracking and Response system for tracking adverse events; coordinating infection control and prevention assessments in collaboration with the Centers for Disease Control and Prevention (CDC); and hiring an Associate Director for Quality Assurance and Patient Safety. This activity meets the draft HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.

The IHS is committed to making improvements and ultimately to being removed from the Government Accountability Office (GAO) High Risk list. Although the IHS is still on the list, significant progress has been made. The GAO cited 14 open recommendations in the High Risk Reports. Of those 14 recommendations cited in the High Risk Reports, GAO closed 12 recommendations. In August 2020, the IHS requested GAO to close another recommendation regarding Quality Care.

Like other rural healthcare providers, the IHS historically has difficulties recruiting and retaining healthcare providers. To address these challenges, IHS continues to maximize the use of available recruitment and retention tools such as recruitment, retention, and relocation incentives (3Rs); and use of Title 38 pay authorities. Most recently, the IHS increased its competitive stance in the healthcare labor market through the authorization of new Title 38 Special Salary Rate pay tables for IHS nurses. Additionally, the Office of Personnel Management granted IHS the authority to approve up to a 50% 3Rs rate as needed to recruit and retain specific Chief Executive Officers overseeing health facilities.

To strengthen human resources management, the IHS issued a Special General Memorandum 21-02, Personnel Security and Suitability Determinations that establishes agency policy on addressing unfavorably background investigations. In FY 2022, the IHS will pilot the USA Performance management system, which is an electronic performance management system developed by the Office of Personnel Management. This system will allow IHS to manage and track all performance plans in one system and will replace the paper performance plans. The use of an electronic system provides a streamlined and standardized performance management process. In FY 2023, USA Performance will roll-out IHS-wide.

In FY 2019, the IHS continued to expand the use of data analysis and visualization tools to enhance reporting and data-driven decisions. Building on the successful completion of the IHS 3rd Party Revenue Dashboard—a Qliksense based application developed to enhance reporting, trend analysis, and monitoring of third-party resources (e.g. Medicare and Medicaid) collected by federally-operated facilities—the IHS completed the "Follow the Money" Dashboard. This dashboard allows non-technical users to review funding status and spending data related to Purchased/Referred Care (PRC) instantly. Both applications democratize data previously held only in the proprietary accounting and reporting systems, Unified Financial Management System and Financial Business Intelligence System. Users are able to access data in a non-technical format that can be quickly sorted and compared by parameters such as type, Area, Service Unit, month, and fiscal year. This capability eliminates delays in accessing data through production financial systems, provides more financial information more widely, and reduces the requirement for a skilled financial analyst to produce labor intensive reports on demand, thereby freeing valuable time for value added analysis.

The IHS is committed to ensuring quality care for all patients and is actively working on deploying innovative strategies with a focus on achieving and sustaining improvements in quality of care, accountability and data-driven decision making, and recruiting and retaining a high performing workforce.

FUNDING HISTORY

Fiscal Year	Amount
2019	$70,788,000
2020	$71,538,000
2021 Final	$82,456,000
2022 Enacted	$95,046,000
2023 President's Budget	$115,378,000

TRIBAL SHARES

Direct Operations funds are subject to Tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall Direct Operations budget line is reserved for inherently federal functions and is therefore retained by the IHS.

BUDGET REQUEST

The FY 2023 budget submission for Direct Operations of $115 million is $20 million above the FY 2022 Enacted level.

FY 2022 Base Funding of $95 million – Funding provides for the direct operations of IHS's system-wide administrative, management, and oversight priorities at the discretion of the IHS Director that include:

- Continuing vital investments to enhance the IHS's capacity for providing comprehensive oversight and accountability in key administrative areas such as: human resources, property, acquisition, financial management, information technology, and program and personnel performance management.
- Improving responsiveness to external authorities such as Congress, the GAO, and the Office of Inspector General (OIG); and addressing Congressional oversight and reports issued by the GAO and the OIG to make improvements in management of IHS programs, such as the PRC program, quality oversight, and workforce.
- Addressing requirements for national initiatives associated with privacy requirements, facilities, and personnel security.
- Continuing analysis and settlement of tribal contracting and compacting Contract Support Costs (CSC) claims and maintaining policies and procedures to accurately determine CSC needs in the future.

- FY 2023 Funding Increase of $20 million includes:

- Current Services of +$3 million, including:

    - Pay Costs: +$3 million – to fund pay increases for Federal and Tribal employees.

    - Inflation +$156,000 to fund inflationary costs of providing health care services.

- Direct Operations: +$18 million in additional Direct Operations funding is essential for sustaining and bolstering core capacity to promote the efficient and effective administration and oversight of national functions like financial management, human resources, grants

management, acquisitions, ISDEAA contracting and compacting administration, contract support costs and tribal lease payment administration, performance management, and other administrative supports and systems. These resources would support critical hiring and systems needs at the national level, and within the IHS Area Offices. Current funding and staffing levels have led to delays in reporting, contracting, grant making, and hiring, and may lead to increased program risk. Increasing resources for these core management functions is vital for shoring up foundational capacity to support the IHS mission. Additional staff and resources are needed to maintain national and Area-level focus on fiscally responsible, accountable, and effective administration over inherently federal functions such as budget formulation and execution, policy management, workforce management and personnel security, acquisitions and grants management, Government Performance and Results Act and related performance management, and other key functions.

The IHS also faces increasing responsibilities associated with expansion of Indian Self-determination, through which Tribal Health Programs operate over 60 percent of the IHS's appropriated resources. The IHS must have the necessary resources to provide technical assistance to Tribes and Tribal Organizations, and effectively manage ISDEAA contracts and compacts. Investments in these critical programs can mitigate the potential for missed deadlines with potentially large and recurring financial penalties, facilitate consistency in ISDEAA contract and compact terms to reduce legal risk, and ensure well prepared and accurate reporting and negotiations. Similarly, the IHS is responsible for providing appropriate oversight and ensuring program integrity for Contract Support Costs and section 105(*l*) lease agreements, whose costs continue to increase over time.

In addition, these funds would also support a National Compliance Program. In January 2020, the IHS initiated the development of a national compliance program to address recommendations made by the HHS Office of Inspector General (https://oig.hhs.gov/oei/reports/oei-06-16-00390.asp. In 2010, the Office of Inspector General established a framework for compliance programs for health care providers. Seven key components of that framework guide the IHS national compliance program activities: designated compliance professionals, written policies and procedures, effective communication, effective training, enforcement of standards, internal auditing and monitoring, and prompt, responsive corrective action plans. The request would support:

- Compliance Oversight Reviews: Process development for annual Area-level reviews, and provide supports to Area Offices to resolve findings.

- High Risk Administrative Investigations: Acquire contracting support to perform internal investigations of high risk issues, and remediate findings.

- Enterprise Risk Management and OMB A-123 Activities: Implement a robust enterprise risk management plan for the Agency, and customize OMB A-123 audit activities for IHS needs.

- Additional FTE: Support inherently federal functions related to compliance and management of new activities.

AREA ALLOCATION

Direct Operations

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2021 Final			FY 2022 Estimated			FY 2023 Estimated			FY 2023 +/- FY 2022
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$41	$11,467	$11,509	$48	$13,218	$13,266	$58	$16,046	$16,104	$2,838
Albuquerque	1,006	756	1,762	1,160	871	2,031	1,408	1,058	2,466	$435
Bemidji	1,410	0	1,410	1,625		1,625	1,973		1,973	$348
Billings	2,225	80	2,305	2,564	92	2,657	3,113	112	3,225	$568
California	1,497	0	1,497	1,725		1,725	2,094		2,094	$369
Great Plains	2,462	0	2,462	2,838		2,838	3,446		3,446	$607
Nashville	1,036	1,918	2,955	1,194	2,211	3,406	1,450	2,684	4,134	$729
Navajo	3,094	0	3,094	3,566		3,566	4,329		4,329	$763
Oklahoma	1,834	4,337	6,171	2,114	5,000	7,114	2,566	6,069	8,635	$1,522
Phoenix	2,684	990	3,674	3,094	1,142	4,236	3,756	1,386	5,142	$906
Portland	1,932	1,641	3,573	2,227	1,892	4,119	2,703	2,297	5,000	$881
Tucson	689	0	689	794		794	964		964	$170
Headquarters	41,354	0	41,354	47,669		47,669	57,866		57,866	$10,197
Total, Direct Ops	**$61,265**	**$21,191**	**$82,456**	**$70,619**	**$24,426**	**$95,045**	**$85,726**	**$29,652**	**$115,378**	**$20,332**

Note: FY 2022 and FY 2023 are estimates.

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$5,806	$5,850	$6,174	+$324
FTE*	12	12	12	--

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

Authorizing Legislation ..... Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA), as amended 25 U.S.C. § 5381 et seq., 42 C.F.R. Part 137

FY 2023 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Office of Tribal Self-Governance (OTSG) is responsible for a wide range of Agency functions that are critical to the IHS's *efforts to expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health ps HHS Strategic Plan FY 2022-2026, Goal 1, Objective 1.3)* while sustaining collaborative relationships *with American Indian and Alaska Native (AI/AN) nations, Tribal organizations, and other AI/AN groups*. The OTSG serves as the primary liaison and advocate for Tribes and Tribal organization participating in the Tribal Self-Governance Program (TSGP) as authorized under Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA) (25 U.S.C. §5381 et. seq.) Through the TSGP, Tribes have the option to assume IHS program funds and manage them to best fit the needs of their Tribal communities. Tribes participating in the TSGP negotiate with the IHS and take on full funding, control, and accountability for those programs, services, functions, and activities (PSFAs), or portions thereof, that the Tribe chooses to assume.

The Self-Governance budget supports several OTSG activities and functions:

- Develops and oversees the implementation of Tribal self-governance legislation and authorities in the IHS *that expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health (HHS Strategic Plan FY 2022-2026, Goal 1, Objective 1.3) that improve quality of healthcare services (Strategic Goal 1, Objective 1.2) and increase choice, affordability, and enrollment in high-quality healthcare coverage (Strategic Goal 1, Objective 1.1).*
- Participates in nation-to-nation negotiations of ISDEAA Title V Compacts and Funding Agreements and provides oversight of the Agency Lead Negotiators *to expand equitable access to comprehensive, community-based, innovative, and*

culturally-competent healthcare services while addressing social determinants of health (Strategic Goal 1, Objective 1.3).

- Reviews eligibility requirements for Tribes to participate in the TSGP and receives Self-Governance Planning and Negotiation Cooperative Agreements that will help to bolster the health workforce to ensure delivery of quality services and care *(Strategic Goal 1, Objective 1.5) and to reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs (Strategic Goal 1, Objective 1.2).*
- Provides resources and technical assistance to Tribes and Tribal organizations *to expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health (HHS Strategic Plan FY 2022-2026, Goal 1, Objective 1.3)* for the implementation of Tribal self-governance.
- Provides TSGP training to Tribes, Tribal organizations, and Tribal groups *to expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health (HHS Strategic Plan FY 2022-2026, Goal 1, Objective 1.3) that increase choice, affordability, and enrollment in high-quality healthcare coverage (Strategic Plan, Goal 1, Objective 1.1*).
- Coordinates national Tribal self-governance meetings, including an annual consultation conference in partnership with the Department of the Interior, to promote the participation by all AI/AN Tribes in the IHS Tribal Self-Governance program *and expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health (Strategic Goal 1, Objective 1.3).*
- Develops, publishes, and presents information related to the IHS TSGP activities that will expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while addressing social determinants of health *(HHS Strategic Plan FY 2022-2026, Goal 1, Objective 1.3) with Tribes, Tribal organizations, state and local governmental agencies, and other interested parties to increase choice , affordability, and enrollment in high-quality healthcare coverage (Strategic Goal 1, Objective 1.1).*
- Coordinates self-governance Tribal Delegation Meetings for IHS Headquarters and Area Senior officials to expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health *(HHS Strategic Plan FY 2022-2026, Goal 1, Objective 1.3) that will reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs (Strategic Goal 1, Objective 1.2) and increase choice, affordability, and enrollment in high-quality healthcare coverage (Strategic Goal 1, Objective 1.1).*

PROGRAM ACCOMPLISHMENTS

The IHS TSGP has grown dramatically since the execution of the initial 14 compacts and funding agreements in 1994. In Fiscal Year (FY) 2020, IHS transferred approximately $2.6 billion of the total IHS budget appropriation to Tribes and Tribal organizations to support 105 ISDEAA self-governance compacts and 131 funding agreements.[1]

[1] For FY 2021, the IHS estimates an additional five Tribes will be entering into Title V ISDEAA compacts and funding agreements. This estimate corresponds to the number of Self-Governance Negotiation Cooperative Agreements available each fiscal year.

The Self-Governance budget brings health care quality expertise to the IHS, and Tribes, by:

- Providing support for projects that assist Tribally operated health programs *that build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2); improve the communication with Tribes (Strategic Goal 3, Objective 3.1)* and *provide care to better meet the health care needs of American Indian and Alaska Native Communities* (*Strategic Goal 2, Objective 2.2)*. For example, the IHS collaborated with Tribes and Tribal Organizations to coordinate the Virtual Fiscal Year 2021 Annual Self-Governance Tribal Conference which brings together Self-Governance Tribes, the Department of Interior, and other federal agencies to discuss key topics with Self-Governance Tribes to share and learn best practices, and to promote the participation of all American Indian and Alaska Native Tribes in IHS Tribal Self-Governance activities. In FY 2021-2022, the IHS also awarded four (4) Tribal Self-Governance Planning and Negotiation Cooperative Agreements to Tribes, which support Tribes and Tribal organizations with the planning and preparation necessary to assume responsibility for providing health care to their tribal members through the IHS TSGP.

- Collaborating on crosscutting issues and processes including, but not limited to: program management issues; self-determination issues; Tribal shares methodologies; and emergency preparedness, response and security *to secure and effectively manage the assets and resources (IHS Strategic Plan FY 2019-2023, Goal 3, Objective 3.2); improve communication with Tribes, Urban Programs, and other stakeholders, and modernize information technology and information systems to support data driven decisions (Strategic Goal 3, Objective 3.1 and 3.3).* In FY 2021-2022, the IHS coordinated with Tribes and Tribal Organizations three (3) virtual Tribal Self-Governance Advisory Committee and Joint Tribal-Federal Technical Workgroup meetings. This Committee advocates for Self-Governance Tribes and Tribal Organizations, suggests policy guidance on the implementation of the TSGP, and advises the IHS Director on issues of concern to all Self-Governance Tribes. Additionally, in FY 2021-2022, the IHS implemented Tribal Consultation, and reinstituted a Tribal Consultation Policy Workgroup of Tribal and Federal leaders, to update the IHS Tribal Consultation Policy and establish it as permanent policy in the Indian Health Manual.

- Providing technical assistance, disseminating communication, and supporting the disbursement of funds related to Coronavirus (COVID-19) activities to Self-Governance Tribes to *build, strengthen, and sustain collaborative relationships (IHS Strategic Plan FY 2019-2023, Goal 1, Objective 1.2)*. In 2021-2022, the IHS distributed five (5) COVID-related supplements to Self-Governance Tribes and Tribal Organizations.

These services are deployed in accordance with strategic planning, are data driven, and support program integrity *that create quality improvement capability at all levels of the organization (IHS Strategic Plan FY 2019-2023, Goal 2, Objective 2.1)* through adherence to reporting requirements. The Office of Tribal Self-Governance Funds Management Database supports the

Eligibility requirements for these agreements mirror the statutory requirements that Tribes must meet to participate in the IHS Tribal Self-Governance Program (25 U.S.C. §5383; 42 C.F.R. Part 137, Subpart C). For this pool, an average estimate of $5 million per Tribe is used to project estimates for Tribes entering into a Title V ISDEAA compacts and funding agreements, inclusive of both Tribal shares and Contract Support Costs.

delivery of services by improved access to data *through secure and effective management of assets and resources (Strategic Goal 3, Objective 3.2)* to evaluate performance and identify areas of process improvement *and modernize information technology and information systems to support data driven decisions (Strategic Goal 3, Objective 3.3).*

FUNDING HISTORY

Fiscal Year	Amount
2019	$4,806,000
2020	$5,806,000
2021 Final	$5,806,000
2022 Enacted	$5,850,000
2023 President's Budget	$6,174,000

TRIBAL SHARES

Program funds are not subject to tribal shares. However certain portion of the program funds support initial program transfers to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities. A portion of the overall program budget line is reserved for federally inherent functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

BUDGET REQUEST

The FY 2023 budget submission for Self-Governance of $6 million is $324,000 above the FY 2022 Enacted level.

FY 2022 Base Funding of $6 million: The base funding supports further implementation of the IHS Tribal Self-Governance program, continues funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to prepare and enter into the IHS Tribal Self-Governance program, and continues to fund performance projects and Tribal share needs in IHS Areas and Headquarters for any AI/AN Tribes that have decided to participate in the IHS Tribal Self-Governance program**.**

FY 2023 Funding Increase of +$324,000 includes:

- Current Services of +$184,000, including:
    - Pay Costs: +$162,000 – to fund pay increases for Federal and Tribal employees.
    - Inflation +$22,000 to fund inflationary costs of providing health care services.
- Tribal Self Governance General Increase +$140,000 – to continue funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to prepare and enter into the IHS Tribal Self-Governance program, and continues to fund performance projects and Tribal share needs in IHS Areas and Headquarters for any AI/AN Tribes that have decided to participate in the IHS Tribal Self-Governance program**.**

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
TOHP-SP Implement recommendations from Tribes annually to improve the Tribal consultation process and IHS operations. (Output)	FY 2021: 5 recommendations Target: 4 recommendations (Target Exceeded)	4 recommendations	5 recommendations	+1 recommendation

GRANT AWARDS

(whole dollars)	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget
Planning Cooperative Agreements			
Number of Awards	1	5	5
Award Amount	$91,721	$120,000	$120,000
Negotiation Cooperative Agreements			
Number of Awards	3	5	5
Award Amount	$48,000	$48,000	$48,000

AREA ALLOCATION

Self-Governance

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2021 Final			FY 2022 Estimated			FY 2023 Estimated			FY 2023 +/- FY 2022
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Albuquerque	0	0	0	0	0	0	0	0	0	$0
Bemidji	0	0	0	0	0	0	0	0	0	$0
Billings	0	0	0	0	0	0	0	0	0	$0
California	0	0	0	0	0	0	0	0	0	$0
Great Plains	0	0	0	0	0	0	0	0	0	$0
Nashville	0	0	0	0	0	0	0	0	0	$0
Navajo	0	0	0	0	0	0	0	0	0	$0
Oklahoma	0	0	0	0	0	0	0	0	0	$0
Phoenix	0	0	0	0	0	0	0	0	0	$0
Portland	0	0	0	0	0	0	0	0	0	$0
Tucson	0	0	0	0	0	0	0	0	0	$0
Headquarters	5,806	0	5,806	5,850	0	5,850	6,174	0	6,174	$324
Total, Self-Gov	**$5,806**	**0**	**$5,806**	**$5,850**	**0**	**$5,850**	**$6,174**	**0**	**$6,174**	**$324**

Note: FY 2022 and FY 2023 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
SPECIAL DIABETES PROGRAM FOR INDIANS

(Dollars in thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted 1/	President's Budget 1/	FY 2023 +/- FY 2022
BA	$150,000	$147,000	$147,000	+$0
FTE*	111	111	111	0

** FTE numbers reflect only Federal staff and do not include increases in tribal staff.*
/1 Reflects mandatory sequester of 2%.

Authorizing Legislation ..... 111 Stat. 574, 1997 Balanced Budget Act (P.L. 105-33), Consolidated Appropriation Act 2001 and amendment to Section 330C (c)(2)(c) Public Health Service Act through Senate Bill 2499 (passed the Senate 12/18/07) to extend funding through FY 2009, the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) Title III Special Diabetes Program for Indians (SDPI) to extend funding through FY 2011, the H.R. 4994 Medicare and Medicaid Extenders Act of 2010 to extend SDPI funding through FY 2013, the American Taxpayer Relief Act of 2012 (P.L. 112-240) to extend funding through FY 2014, the Protecting Access to Medicare Act of 2014 (P.L. 113-93; H.R. 4302) to extend funding through FY 2015. P.L. 114-10 – The Medicare Access and CHIP Reauthorization Act of 2015 authorized SDPI for FY 2016 and FY 2017, P.L. 115-63 — Disaster Tax Relief and Airport and Airway Extension Act authorized SDPI for the first quarter of FY 2018, and P.L. 115-96— Department of Homeland Security Blue Campaign Authorization Act of 2017 authorized SDPI for the second quarter of FY 2018, P.L. 115-123 – Bipartisan Budget Act of 2018 authorized SDPI for the rest of FY 2018 and all of FY 2019, the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (P.L. 116-59) authorized SDPI through November 21, 2019, the Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (P.L. 116-69) authorized SDPI through December 20, 2019. SDPI was authorized through May 22, 2020 through the Further Consolidated Appropriations Act, 2020 (P.L. 116-94). The Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-36) authorized SDPI through November 30, 2020. The Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. 116-159) authorized SDPI through December 11, 2020. The Further Continuing Appropriations Act, 2021, and Other Extensions Act (P.L. 116-215) authorized SDPI through December 18, 2020. The Consolidated Appropriations Act, 2021 (P.L. 116-260) authorized SDPI until September 30, 2023.

FY 2023 Authorization..... Expires September 30, 2023

Allocation Method ..... Grants and Contracts

PROGRAM DESCRIPTION

The Special Diabetes Program for Indians (SDPI) grant program provides funding for diabetes treatment and prevention to approximately 301 Indian Health Service (IHS), Tribal, and Urban (I/T/U) Indian health grant programs. Funds for SDPI were first authorized in FY 1998; as such, FY 2023 would be the 26th year of the SDPI. SDPI is currently authorized through September 30, 2023. The IHS Office of Clinical and Preventive Services (OCPS) Division of Diabetes Treatment and Prevention (DDTP) provides leadership, programmatic, administrative, and technical oversight to the SDPI grant program.

The mission of the DDTP is to develop, document, and sustain public health efforts to prevent and control diabetes in American Indians and Alaska Natives (AI/ANs) by promoting collaborative strategies through its extensive diabetes network. This mission aligns with *Goal 1 of the IHS Strategic Plan, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people and Objective 2.2 of the HHS Strategic Plan, Provide care to better meet the health care needs of American Indian and Alaska Native communities*. The diabetes network consists of a national program office, Area Diabetes Consultants in each of the 12 IHS Areas, and approximately 301 SDPI grants and sub-grants at I/T/U sites across the country.

Target Population: American Indians and Alaska Natives

Diabetes and its complications are major contributors to death and disability in nearly every Tribal community. AI/AN adults have the highest age-adjusted rate of diagnosed diabetes (14.5 percent) among all racial and ethnic groups in the United States, more than twice the rate of the non-Hispanic white population (7.4 percent).[1] In some AI/AN communities, more than half of adults 45 to 74 years of age have diagnosed diabetes, with prevalence rates reaching as high as 60 percent.[2]

Allocation Method

In the Balanced Budget Act of 1997, Congress instructed the IHS to use SDPI funds to "establish grants for the prevention and treatment of diabetes" to address the growing problem of diabetes among AI/AN people. The entities eligible to receive these grants were I/T/Us. The IHS distributes this funding to approximately 301 I/T/U sites annually through a process that includes Tribal Consultation/Urban Confer, development of a formula for distribution of funds, and a formal grant application and administrative process. *This process is consistent with IHS Strategic Plan Objective 1.2 to "build, strengthen, and sustain collaborative relationships*" *and also supports Objective 5.1 of the HHS Strategic Plan to ensure responsible financial management.*

Strategy

The SDPI brings Tribes together to work toward a common purpose and share information and lessons learned. The Tribal Leaders Diabetes Committee, established in 1998, reviews information on the SDPI progress and provides recommendations on diabetes-related issues to the IHS Director. Through partnerships with federal agencies, private organizations, and an extensive I/T/U network, DDTP undertook one of the most strategic diabetes treatment and prevention efforts ever attempted in AI/AN communities and demonstrated the ability to design, manage, and measure a complex, long-term project to address this chronic condition. Because of the significant costs associated with treating diabetes, I/T/Us have used best and promising practices for their local SDPI funding to address the primary, secondary, and tertiary prevention of diabetes and its complications. *These efforts increase the availability and accessibility of*

[1] Centers for Disease Control and Prevention. National Diabetes Statistics Report website. https://www.cdc.gov/diabetes/data/statistics-report/index.html. Accessed 3/17/2022.
[2] Lee ET, Howard BV, Savage PJ, et al. Diabetes and impaired glucose tolerance in three American Indian populations aged 45-74 years: the Strong Heart Study. *Diabetes Care*. 1995;18:599-610.

comprehensive, culturally appropriate personal and public health services to AI/AN people, which supports Goal 1 of the IHS Strategic Plan and Objective 1.3 of the HHS Strategic Plan.

This collaborative approach supports the strategic planning process necessary to identify the goals and objectives needed to achieve the intended SDPI outcomes. As in *Objectives 1.2, 1.3, and 3.1 of the IHS Strategic Plan, the SDPI promotes collaboration and communication with Tribes and Urban Indian Organizations in the development of quality community-based diabetes prevention and treatment programs.*

PROGRAM ACCOMPLISHMENTS

SDPI: Two Major Components

As directed by Congress and Tribal consultation, the SDPI consists of two major components: (1) SDPI Grant Program; and (2) Diabetes data and program delivery infrastructure.

1. SDPI Grant Program

The SDPI grant program (formerly called the SDPI Community-Directed grant program) provides $138.7 million per year in grants and technical assistance for local diabetes treatment and prevention services at I/T/U health programs in 35 states. Each of the communities served by the SDPI grant program is unique in that its diabetes treatment and prevention needs and priorities are defined locally. Based on these local needs and priorities, the SDPI grant programs implement interventions to address the diabetes epidemic.

The Consolidated Appropriations Act of 2001 established statutory authority for SDPI to implement a best practices approach to diabetes treatment and prevention. As such, the SDPI has incorporated Indian Health Diabetes Best Practices into the SDPI grant application process used throughout AI/AN communities. *This effort is used to promote excellence and quality within the SDPI programs, which aligns with the IHS Strategic Plan Goal 2.* Grant programs are required to document the use of one SDPI Diabetes Best Practice,[3] corresponding evaluation measures, and progress in achieving program objectives in order to enhance accountability. Grantees receive training on how to collect, evaluate, and improve their data collection and use it to improve their outcome results.

Impact of the SDPI Grant Programs

SDPI funding has enabled staff and programs at the local and national levels to increase access to diabetes treatment and prevention services throughout the Indian health system. The following table demonstrates substantial increases in access to many activities and services:

[3] *Available at* https://www.ihs.gov/sdpi/sdpi-community-directed/diabetes-best-practices/

Diabetes treatment and prevention services available to AI/AN individuals	Access in 1997	Access in 2019	Absolute Percentage increase
Diabetes clinical teams	30%	95%	+65%
Diabetes patient registries	34%	96%	+62%
Nutrition services for adults	39%	94%	+55%
Access to registered dieticians	37%	85%	+48%
Culturally tailored diabetes education materials	36%	96%	+60%
Access to physical activity specialists	8%	84%	+76%
Adult weight management services	19%	76%	+57%

Clinical Diabetes Outcomes during SDPI

At the same time that access to these diabetes services increased, key outcome measures for AI/ANs with diabetes showed improvement or maintenance at or near national targets. These results have been sustained throughout the inception of SDPI. Examples include:

- *Improving Blood Sugar Control*
  Blood sugar control among AI/ANs with diabetes served by the IHS has improved over time. The average blood sugar level (as measured by the A1C test) decreased from 9.0 percent in 1996 to 8.2 percent in 2021, nearing the A1C goal for most patients of less than 8 percent.
- *Improving Blood Lipid Levels*
  Average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 88 mg/dL in 2021, surpassing the goal of less than 100 mg/dL.
- *Reducing Kidney Failure*
  The rate of new cases of kidney failure due to diabetes leading to dialysis declined by more than half (54 percent) in AI/AN people from 1996 to 2013. This is a much larger decline than in any other racial group in the US.[4]

2. Diabetes Data and Program Delivery Infrastructure

The IHS has used funding from the SDPI to strengthen the diabetes data infrastructure of the Indian health system by improving diabetes surveillance and evaluation capabilities. The SDPI supports the development and implementation of the IHS Electronic Health Record, and the IHS Diabetes Management System in all 12 IHS Areas, *which supports Objective 3.3 of the IHS Strategic Plan.*

Facilities associated with SDPI programs participate in the annual IHS Diabetes Care and Outcomes Audit. The Diabetes Audit is the cornerstone of the IHS DDTP diabetes care surveillance system, tracking annual performance on diabetes care and health outcome measures. Data collection for the Diabetes Audit follows a standardized protocol to ensure statistical integrity and comparability of measures over time. The 2021 Diabetes Audit included a review of 126,550 patient charts at 323 I/T/U health facilities. The Diabetes Audit enables IHS and the SDPI programs to monitor and evaluate yearly performance at the local, regional, and national

[4] Bullock A, Burrows NR, Narva AS, et al. Vital Signs: Decrease in Incidence of Diabetes-Related End-Stage Renal Disease among American Indians/Alaska Natives — United States, 1996–2013. MMWR Morb Mortal Wkly Rep 2017;66:26-32. DOI: http://dx.doi.org/10.15585/mmwr.mm6601e1.

levels, as well as enhance quality improvement capabilities across AI/AN communities. *These innovative efforts align with Objective 2.1 of the IHS Strategic Plan.* DDTP provides Diabetes Audit training through online and webinar formats. DDTP receives evaluations on all trainings provided to guide improvements for future sessions.

Key Performance/Accomplishments

Annual SDPI assessments have shown significant improvements in the availability of diabetes clinical care and community services provided over time when compared to the baseline SDPI assessment in 1997 (see table above titled "Diabetes treatment and prevention services available to AI/AN individuals").

Ongoing efforts to improve blood glucose, blood pressure, and cholesterol values will continue to reduce the risk for microvascular, as well as macrovascular complications (see "Outputs/Outcomes" table below).

Reporting

In addition to internal monitoring of the SDPI Grant Program, the DDTP has completed six SDPI Reports to Congress to document the progress made since 1997. The SDPI Reports to Congress are as follows:

- January 2000 Interim Report to Congress on SDPI;
- December 2004 Interim Report to Congress on SDPI;
- 2007 SDPI Report to Congress: On the Path To A Healthier Future;
- 2011 SDPI Report to Congress: Making Progress Toward A Healthier Future;
- 2014 SDPI Report to Congress: Changing the Course of Diabetes: Turning Hope into Reality; and
- 2020 SDPI Report to Congress: Changing the Course of Diabetes: Charting Remarkable Progress.

Following Tribal consultation, beginning in FY 2016, SDPI funding has been distributed as follows:

Special Diabetes Program for Indians – Total Yearly Costs

CATEGORY	Percentage of the total	(Dollars in Millions)
SDPI Grant Programs (272 Tribal and IHS grants, sub-grants, and technical assistance in FY 2020).	**88.6%**	**$130.2**
Administration of SDPI grants (includes program support funds to IHS Areas, Tribal Leaders Diabetes Committee, DDTP, Grants Management, evaluation support contracts, etc.)	**2.1%**	**$3.1**
Urban Indian Health Program SDPI Grant Programs ($8.5M allocated to 29 grants and technical assistance in FY 2020)	**5.8%**	**$8.5**
Funds to strengthen the Data Infrastructure of IHS	**3.5%**	**$5.2**
TOTAL:	**100%**	**$147.0**

BUDGET REQUEST

The SDPI is currently authorized at $150 million annually through September 30, 2023, under the Consolidated Appropriations Act, 2021. The FY 2023 funding level of $147 million reflects mandatory sequester of two percent. The distribution of funding is shown in the grant tables that follow. Please note that the numbers provided for FY 2023 are likely to change due to the start of the new SDPI grant cycle.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
53 Controlled BP <140/90 (Outcome)	FY 2021: 48.1 % Target: 59.1 % (Target Not Met) FY 2020: 52.7 % Target: 60.5% (Target Not Met)	57%	52.4%	-4.6%
54 Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes (Intermediate Outcome)	FY 2021: 50.1 % Target: 49 % (Target Exceeded) FY 2020: 50.2%Target: 51.6 % (Target Not Met)	56.8%	54.3%	-2.5%
86 Reduce the proportion of American Indians/Alaska Natives with diagnosed diabetes who have poor glycemic control (A1c >9%). (Outcome)	FY 2021: 15.8 % Target: 16.8 % (Target Exceeded) FY 2020: 16.4 % Target: 17.4 % (Target Exceeded)	15.6%	14.5%	-1.1%

GRANTS AWARDS

The SDPI provides grants for diabetes treatment and prevention services to I/T/U health programs in 35 states. The SDPI grant programs provide local diabetes treatment and prevention services based on community needs.

(whole dollars)	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget
Number of Awards	301 (includes sub-grants)	301 (includes sub-grants)	301 (includes sub-grants)
Average Award	$452,011	$452,011	$452,011

Range of Awards	$25,000 - $7,553,570	$25,000 - $7,553,570	$25,000 - $7,553,570

FY 2023 State/Formula Grants

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs
by State and FY 2023 Annual Financial Assistance Awards

State	State Name	FY 20 Total # Grant Programs	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget
AK	Alaska	20	10,191,326	$10,191,326	$10,191,326
AL	Alabama	1	279,211	279,211	279,211
AZ	Arizona	28	28,915,564	28,915,564	28,915,564
CA	California	38	9,720,825	9,720,825	9,720,825
CO	Colorado	3	903,625	903,625	903,625
CT	Connecticut	2	232,777	232,777	232,777
FL	Florida	2	486,980	486,980	486,980
IA	Iowa	1	304,592	304,592	304,592
ID	Idaho	4	935,841	935,841	935,841
IL	Illinois	1	281,832	281,832	281,832
KS	Kansas	5	937,919	937,919	937,919
LA	Louisiana	4	364,530	364,530	364,530
MA	Massachusetts	2	168,316	168,316	168,316
ME	Maine	5	543,580	543,580	543,580
MI	Michigan	12	2,363,824	2,363,824	2,363,824
MN	Minnesota	8	3,274,552	3,274,552	3,274,552
MS	Mississippi	1	1,256,112	1,256,112	1,256,112
MT	Montana	10	5,564,865	5,564,865	5,564,865
NE	Nebraska	5	1,931,172	1,931,172	1,931,172
NV	Nevada	14	5,203,730	5,203,730	5,203,730
NM	New Mexico	28	12,613,849	12,613,849	12,613,849
NY	New York	3	1,264,077	1,264,077	1,264,077
NC	North Carolina	1	1,351,228	1,351,228	1,351,228
ND	North Dakota	5	3,168,173	3,168,173	3,168,173
OK	Oklahoma	27	23,460,585	23,460,585	23,460,585
OR	Oregon	9	1,832,727	1,832,727	1,832,727
RI	Rhode Island	1	113,475	113,475	113,475
SC	South Carolina	1	163,399	163,399	163,399
SD	South Dakota	9	6,014,743	6,014,743	6,014,743
TN	Tennessee	1	130,001	130,001	130,001
TX	Texas	4	784,901	784,901	784,901
UT	Utah	5	2,051,292	2,051,292	2,051,292
WA	Washington	27	4,792,337	4,792,337	4,792,337
WI	Wisconsin	12	3,421,213	3,421,213	3,421,213

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2023 Annual Financial Assistance Awards					
State	State Name	FY 20 Total # Grant Programs	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget
WY	Wyoming	2	1,032,196	1,032,196	1,032,196
	Total States	**301**	$136,055,369	$136,055,369	$136,055,369
	Indian Tribes*	**255**	$113,985,031	$113,985,031	$113,985,031

*This is the number of tribes that are primary grantees or sub-grantees.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2023 Performance Budget Submission to Congress

TABLE OF CONTENTS

Facilities

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
BA	$917,888	$940,328	$1,567,343	+$627,015
FTE*	1,163	1,185	1,211	+26

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

SUMMARY OF THE FACILITIES BUDGET

The Indian Health Facilities Appropriation includes facility projects, program support, medical equipment, and personnel quarters activities. Project activities include Maintenance and Improvement (M&I), Sanitation Facilities Construction (SFC), and Health Care Facilities Construction (HCFC). The program support activity is Facilities and Environmental Health Support (FEHS). Equipment and Personnel Quarters collections are also separate activities.

The Facilities Appropriation continues funding for health facility support, public health and preventive services where staff are funded through the Facilities Appropriation to work in healthcare facilities and in the AI/AN communities across Indian country. Starting in FY 2024, the Budget proposes to reduce or eliminate existing facilities backlogs.

BUDGET AUTHORITY

The FY 2023 budget submission for Facilities is $1,567 billion and is $627 million above the FY 2022 Enacted Level.

Maintenance & Improvement –The FY 2023 budget submission for Maintenance and Improvement is $346 million, which is $176 million above the FY 2022 Enacted Level. These funds are the primary source for providing maintenance, repair, and improvement of health care facilities. Specific objectives and program priorities to address the condition of facilities include:

- Providing routine maintenance and repairs to upkeep facilities at their current conditions;
- Achieving compliance with buildings and grounds accreditation standards of the Joint Commission or other applicable accreditation bodies;
- Providing improvements to facilities for enhanced patient access and care through larger M&I projects to reduce the Backlog of Essential Maintenance, Alteration and Repair (BEMAR), which is estimated at $1.022 billion for all IHS and reporting Tribal facilities;
- Ensuring that health care facilities meet building codes and standards;
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., sustainability, energy conservation, seismic, environmental, handicapped accessibility, and security; and
- Demolishing facilities when excess to the needs of the Service and/or a liability to health and safety.

Sanitation Facilities Construction –The FY 2023 budget submission for Sanitation Facilities Construction is $203 million, which is $5 million above the FY 2022 Enacted Level.

These funds provide for water supply, sewage disposal, and solid waste disposal facilities, including:

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

Health Care Facilities Construction – The FY 2023 budget submission for Health Care Facilities Construction is $546 million, which is $287 million above the FY 2022 Enacted Level.

This funding level for the construction of new and replacement healthcare facilities will allow IHS to continue/complete the following projects:

- Phoenix Indian Medical Center, Phoenix, AZ
- Whiteriver Hospital, Whiteriver, AZ
- Gallup Indian Medical Center, Gallup, NM
- Bodaway Gap Health Center, The Gap, AZ
- Albuquerque West Health Center, Albuquerque, NM
- Sells Health Center, Sells, AZ
- New and Replacement Staff Quarters
- Small Ambulatory
- Green Infrastructure
- Mid-Sized Ambulatory Demonstration Projects

Facilities and Environmental Health Support (FEHS) – The FY 2023 budget submission for Facilities and Environmental Health Support is $371 million, which is $88 million above the FY 2022 Enacted Level.

This total includes funding for leadership and staffing to manage and implement all aspects of the Facilities Appropriation and shared operating costs at existing, new and replacement health care facilities.

FEHS funds provide for:

- Personnel who provide facilities and environmental health services and for operating costs associated with provision of those services and activities.

Equipment –The FY 2023 budget submission for Equipment is $102 million, which is $72 million above the FY 2022 Enacted Level.

These funds provide for:

- Routine replacement of medical equipment to over 1,500 federally and tribally-operated health care facilities allocated on workload using a standard formula;
- New medical equipment in tribally-constructed health care facilities; and
- TRANSAM, a program under which IHS acquires and distributes surplus Department of Defense medical equipment.

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$168,952	$169,664	$345,565	+$175,901
FTE*	--	--	--	--

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

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

PROGRAM DESCRIPTION

Maintenance and Improvement (M&I) funds are the primary source of funding to maintain, repair, and improve existing Indian Health Service (IHS) and Tribal health care facilities, which are used to deliver and support health care services. M&I funding supports federal, government owned buildings and tribally-owned space where health care services are provided pursuant to contracts or compacts executed under the provisions of the Indian Self-Determination and Education Assistance Act (P.L. 93-638). M&I funds are necessary to achieve and maintain accreditation, to meet building codes and standards, to maintain and repair the physical condition of health care facilities, to modernize existing health care facilities to meet changing health care delivery needs, and to implement mandated requirements (e.g., energy conservation, seismic, environmental, handicapped accessibility, security, etc.). Efficient and effective buildings and infrastructure are vital to delivering health care in direct support of the IHS mission and priorities.

Maintaining reliable and efficient buildings is an increasing challenge as existing health care facilities age and additional space is added into the real property inventory. The average age for IHS-owned health care facilities is approximately 35 years, whereas the average age, including recapitalization of private-sector hospital plants, is 9 to 10 years.[1] Many IHS and Tribal health care facilities are operating at or beyond capacity, and their designs are not efficient in the context of modern health care delivery. In addition, as existing health care facilities continue to age, the operational and maintenance costs increase. (The 'average age of hospital plant' measures the average age of the facility including capital improvements, replacement of built-in equipment and modernization.)

[1] *Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings,* The National Academies Press (1990), *available at* http://www.nap.edu/catalog

IHS hospital administrators have reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance with the Medicare Hospital Conditions of Participation. Further, the administrators reported that maintaining aging buildings and equipment is a major challenge. Over one third of all IHS hospital deficiencies have been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors.

The physical condition of IHS-owned and many tribally owned healthcare facilities is evaluated through routine observations by facilities personnel and by in-depth condition surveys. These observations and surveys identify facility, fire-life-safety, and program deficiencies, and are used to develop IHS' estimate of the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). The BEMAR is a measure of the condition of health care facilities in the Indian health system and establishes priorities for larger M&I projects. The FY 2021 BEMAR for all IHS and reporting Tribal health care facilities as of October 1, 2021, is $1,022 million. When IHS replaces an older, obsolete hospital or clinic with a new facility, all deficiencies associated with the old facility are removed from the backlog

M&I Funds Allocation Method

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

1. *Routine Maintenance Funds* – These funds support activities that are generally classified as those needed for maintenance and minor repair to keep the health care facility in its current condition. Funding allocation is formula based. The Building Research Board of the National Academy of Sciences has determined that approximately two to four percent of current replacement value of supported buildings is required to maintain (i.e., 'sustain') facilities in their current condition.[2]

2. *M&I Project Funds* – These funds are used for major projects to reduce the Backlog of Essential Maintenance, Alteration and Repair (BEMAR) and make improvements necessary to support health care delivery. This funding will provide improvements to facilities for enhanced patient access and care and facilitate larger M&I projects to reduce the (BEMAR) within a five year period. Funding allocation is formula based.

3. *Environmental Compliance Funds* – These funds are used to address findings and recommendations from environmental audits, to improve energy efficiency and water efficiency, to increase renewable energy usage, to reduce consumption of fossil-fuel generated electricity, and to implement other sustainability initiatives. These funds are available to Federal and Tribal health care facilities on a national basis.

4. *Demolition Funds* – The IHS has a number of Federally owned buildings that are vacant, excess, or obsolete. Demolition funds are used to dispose of these excess assets. These funds may be augmented with Environmental Compliance Funds as available for demolition and disposal to the extent that the proposed action reduces hazards, environmental concerns, or liability to IHS. Based upon recent interpretation of the Administrative Provision related to Demolition of hazardous, obsolete federal buildings, the inventory of this federal inventory continues to grow as does the potential liability.

[2] *Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings,* The National Academies Press (1990), *available at* http://www.nap.edu/catalog.

IHS Strategic Plan and how the Facilities programs are implementing: In consultation with Tribes and the Federal healthcare sites, IHS is allocating funding to the IHS Area Offices to complete BEMAR projects to make renovations and improvements necessary to support health care delivery in the health care facilities and to modernize the health care facilities and staff quarters to expand access to quality health care services.

FUNDING HISTORY

Fiscal Year	Amount
2019	$167,527,000
2020	$168,952,000
2021 Final	$168,952,000
2022 Enacted	$169,664,000
2023 President's Budget	$345,565,000

TRIBAL SHARES

There are no Tribal Shares allocated from Maintenance & Improvement funds. Rather, Tribal shares associated with the Facilities Program may be transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities at a Federal or Tribal healthcare site. Tribes may also contract or compact to perform individual Maintenance & Improvement projects that are awarded to federally owned sites.

BUDGET REQUEST

The FY 2023 budget submission for Maintenance & Improvement of $346 million is $176 million above the FY 2022 Enacted level.

FY 2022 Base Funding of $170 million – Supports maintenance, repair, and improvements for existing IHS and Tribal facilities.

FY 2023 Funding Increase of +$176 million includes:

- Current Services of +$4 million, including:
    - Inflation +$931,000 to fund inflationary costs of providing health care services.
    - Population Growth +$3 million – to address the impact of the additional services need arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.

Maintenance and Improvement: +$172 million would provide resources to the fund critical Backlog of Essential Maintenance and Repair (BEMAR). Facility deficiencies/BEMAR and medical equipment are complex and involve many variables such as accreditation standards, healthcare patient satisfaction, changing healthcare delivery standards, building codes, old building equipment/system, and medical devices/equipment plus telemedicine used by healthcare professionals.

The total $346 million funding request for FY 2023 would support:

- Approximately $105 million is the projected amount for routine maintenance and repair to sustain the condition of federal and Tribal healthcare facilities buildings. These funds will support facilities activities that are generally classified as those needed for 'sustainment' of existing facilities and provided to the IHS Area Offices and to Tribes for daily maintenance activities and local projects to maintain the current state of health care facilities. These *Routine Maintenance Funds* may be used for Area and Tribal M&I projects to fund smaller elements of the backlog of work to address the old and antiquated facilities plant infrastructure (e.g., mechanical and electrical BEMAR) and program enhancements.

- Approximately $238 million would be available for major Area and Tribal M&I projects to reduce the BEMAR deficiencies and to improve healthcare facilities to meet changing healthcare delivery needs. The FY 2023 Budget Request continues funding critical projects to address the old and antiquated facilities plant infrastructure (e.g., mechanical and electrical BEMAR), accreditation standards, and program enhancements, all of which is essential to support health delivery.

- Approximately $3 million would be available for environmental compliance projects. The IHS places a high priority on meeting Federal, State, and local legal/regulatory environmental requirements, including allocating funding to address findings and recommendations from environmental audits. The IHS has currently identified approximately $7 million in environmental compliance tasks and included them in the BEMAR database.

- M&I funds, a portion from above categories retained by Headquarters, also provide resources for the demolition of IHS facilities that are no longer needed. The IHS has approximately 100 Federally owned buildings that are vacant, excess, or obsolete. Many of these buildings are safety and security hazards. IHS plans for orderly demolition of some of these buildings, in concert with transferring others, reducing hazards and liability. Demolition Funds may be used in concert with environmental compliance funds as available for demolition of the Federal buildings to the extent that the proposed action reduces hazards, environmental concerns, or liability to the Indian Health Service. Since FY 2000 when funds were first set aside for the demolition of Federal buildings, associated demolition costs have risen significantly due to inflation, environmental regulations, recycling and landfill diversion requirements, abatement of hazardous material, etc. For example, many IHS locations are very remote which significantly increases the cost to haul the demolition waste off the reservation to approved landfills and recycling facilities.

OUTPUTS / OUTCOMES

The Outcomes for this program are measured through BEMAR, i.e., progress in addressing maintenance needs and facility deficiencies. Maintaining effective and efficient healthcare buildings improve the ease and access to care, facilitate successful behavioral health services, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment to deliver services.

IHS targets the M&I funding, and supplements these funds with collections where available, towards major projects to reduce the BEMAR and improve the condition of existing Federal and Tribal healthcare sites. A few examples of these projects include: renovating/expanding pharmacy space, improvements to dental clinics to serve more users, remodeling reception/waiting areas, construction of CT suite and new digital radiology rooms, repaving parking lots, emergency department renovations, new heating-ventilation-air conditions systems, sustainability projects to

reduce utility costs, etc. Continued investment in the BEMAR which is currently at $1 billion, will enable IHS and the Tribes to maintain accreditation standards and delivery quality health care services.

GRANT AWARDS – This program has no grant awards.

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$196,577	$197,783	$202,651	+$4,868
FTE*	119	119	119	--

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

Authorizing Legislation.....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; 42 U.S .C 2004a, Indian Sanitation Facilities Act; 25 U.S.C. 1632, Indian Health Care Improvement Act, as amended 2010

FY 2023 Authorization.....Permanent

Allocation Method.....Needs-based priority system for construction project fund allocation and implemented through P.L. 86-121 Memorandum of Agreements, P.L. 93-638 Self-Determination Contracts and Self-Governance Construction Project Agreements.

PROGRAM DESCRIPTION

The Indian Health Care Improvement Act (IHCIA) requires the Indian Health Service (IHS) to identify the universe of sanitation facilities needs for existing American Indian and Alaska Native (AI/AN) homes by documenting deficiencies and proposing projects to address their needs. These projects prevent communicable diseases by providing new and existing homes with services such as water wells, onsite wastewater disposal systems, or connections to community water supply and wastewater disposal systems. These projects can also include provision of new or upgraded water supply or waste disposal systems. These outcomes support both the HHS and IHS Strategic Plans. (IHS Strategic Plan FY 2019-2023, Objective 1.3: *Increase access to quality health care services*. Strategy 14, "*Develop and coordinate environmental engineering, environmental health, and health facilities engineering services to provide effective and efficient public health services…*").

The four types of sanitation facilities projects funded through IHS are: (1) projects to serve existing housing; (2) projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the Bureau of Indian Affairs (BIA)-Home Improvement Program, Tribes, individual homeowners, or other nonprofit organizations; (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 provide sanitation facilities to existing homes are selected for funding in priority order each year from the Sanitation Deficiency System (SDS). The SDS is an inventory of the sanitation deficiencies of federally recognized AI/AN eligible homes and communities; the sanitation deficiencies include needed water, sewer, and solid waste facilities for existing AI/AN homes. These actions support Strategy 1, "*Improve the transparency and quality of data collected regarding health care service and program outcomes*" (IHS Strategic Plan FY 2019-2023, Objective 2.1: *Create quality improvement capability at all levels of the organization*). Project selection is driven by

objective evaluation criteria including health impact, existing deficiency level, adequacy of previous service, capital cost, local Tribal priority, operations and maintenance capacity of the receiving entity, availability of contributions from non-IHS sources, and other conditions that are locally determined. The SDS priority position of each unfunded project is reevaluated with the Tribes in each Area annually.

Sanitation Facilities Construction (SFC) projects can be managed by IHS directly or by Tribes that elect to use the Title I or Title V authorization under P.L. 93-638, the Indian Self-Determination and Education Assistance Act. Sanitation facilities projects are carried out cooperatively with the Tribes that will be served, and construction is performed by either the IHS or the Tribes (IHS Strategic Plan FY 2019 – 2023, Objective 1.2: *Build, strengthen, and sustain collaborative relationships*). Projects start with a Tribal project proposal and are funded and implemented through execution of an agreement between a Tribe and IHS. In these agreements, the Tribes also assume ownership responsibilities, including operation and maintenance. The overall SFC goals, reporting requirements, eligibility criteria, project planning, and funding priorities remain the same, regardless of the delivery methods chosen by a Tribe.

The SFC Program leverages its capabilities in partnering with Tribes by also partnering with other Federal agencies in constructing or financing construction of water supply, wastewater and solid waste disposal projects addressing sanitation deficiencies faced by Tribes. One way in which the SFC Program engages in such partnerships is through the Infrastructure Task Force (ITF), a partnership of Federal agencies focused on finding ways to better serve Tribes through cooperative efforts (IHS Strategic Plan FY 2019 – 2023, Objective 1.2: *Build, strengthen, and sustain collaborative relationships*).

PROGRAM ACCOMPLISHMENTS

The SFC Program is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated to provide water and waste disposal facilities for eligible AI/AN homes and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have declined. Research supported by the Centers for Disease Control and Prevention states populations in regions with a lower proportion of homes with water service, reflect significantly higher hospitalization rates for pneumonia, influenza, and respiratory syncytial virus.[1] Researchers associated the increasing illnesses with the restricted access to clean water for hand washing and hygiene. The SFC Program works collaboratively with Tribes to assure all AI/AN homes and communities are provided with safe and adequate water supply and waste disposal facilities as soon as possible.

In FY2021, IHS funded projects to provide service to 48,816 AI/AN homes. IHS also completed construction on 250 projects with an average project duration of 3.6years. However, at the end of FY 2021about 7,228, or 1.9 percent of all AI/AN homes tracked by IHS lacked water supply or wastewater disposal facilities; and, about 108,459 or approximately 29percent of AI/AN homes tracked by IHS were in need of some form of sanitation facilities improvements. The individuals who live in homes without adequate sanitation facilities are at a higher risk for gastrointestinal disease, respiratory disease and other chronic diseases.[2] Many of these homes without service are very remote and may have limited access to health care which increases the importance of improving environmental conditions.

[1] Thomas W. Hennessy, Troy Ritter, Robert C. Holman, Dana L. Bruden, Krista L. Yorita, Lisa Bulkow, James E. Cheek, Rosalyn J. Singleton, and Jeff Smith. The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives. American Journal of Public Health: November 2008, Vol. 98, No. 11, pp. 2072-2078.

The total sanitation facility need reported through SDS has increased approximately $0.27 billion or 8.7 percent from $3.09 billion to $3.36 billion from FY 2020 to FY2021. In FY 2020, the IHS was appropriated $0.20 billion to address sanitation deficiencies and support provision of sanitation facilities to eligible AI/AN homes and communities. The magnitude of the sanitation facility needs increase is due to the underlying challenges of construction cost inflation, population growth, an increasing number of regulations, and failing infrastructure. Failing infrastructure is presumably the largest factor, which is a result of the infrastructure age and inadequate operation and maintenance. Under the IHCIA, the IHS is authorized to provide operation and maintenance assistance for, and emergency repairs to, Tribal sanitation facilities, when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities, however resources have not been appropriated specifically for this purpose.

During FY 2021, 390 construction projects to address water supply and wastewater disposal needs were funded with a construction cost of $220 million using IHS and contributed funds. Once constructed, these sanitation facilities will benefit an estimated 188,000 AI/AN people and help avoid over 379,600 inpatient and outpatient visits related to respiratory, skin and soft tissue, and gastro enteric disease over 30 years. The health care cost savings for these visits alone is estimated to be over $403 million. Every $1 spent on water and sewer infrastructure will save $1.23 in avoided direct healthcare cost. These outcomes support Strategy 14, "Develop and coordinate environmental engineering, environmental health, and health facilities engineering services to provide effective and efficient public health services…". (IHS Strategic Plan FY 2019- 2023, Objective 1.3: *Increase access to quality health care services).*

In FY 2023, the SFC Program will continue to focus on improving quality of data reported through the SDS on the sanitation facility needs supporting AI/AN homes and communities (IHS Strategic Plan FY 2019-2023, Objective 2.1: *Create quality improvement capability at all levels of the organization*). These efforts will ensure the sanitation facilities needs included in SDS are:

- Associated with timely completion of design and construction activities on funded sanitation facilities projects;
- Adequately documented;
- Reflect an update of current needs; and
- Include only sanitation facilities fundable by the SFC program for AI/AN eligible homes and communities and consistent with the prescribed Deficiency Levels referenced in the IHCIA.

Additionally, in FY 2023, the SFC Program will continue to focus on maintaining average construction project duration of 4.0 years. In order to achieve this outcome, the FY 2023 President's Budget includes a corresponding request for +$49 million in the Facilities and Environmental Health Support budget line to support additional hiring for IHS SFC projects, and to provide program support funding to Tribes that choose to implement their own projects. Consistent with existing practice, funds will only be obligated to projects that have been certified by the SFC Program Areas as "ready to fund"; this means they have a well-defined scope, a detailed cost estimate, a completed preliminary design and that known potential risks to project construction, operation and maintenance have been considered and mitigated.

FUNDING HISTORY

Fiscal Year	Amount
2019	$192,033,000
2020	$193,577,000
2021 Final	$196,577,000
2022 Enacted	$197,783,000
2023 President's Budget	$202,651,000

BUDGET REQUEST

The FY 2023 budget submission for Sanitation Facilities Construction of $203 million is $5 million above the FY 2022 Enacted level.

FY 2022 Base Funding of $198 million including:

- Up to $80 million will be used to serve new and like-new homes, which are non-Department of Housing and Urban Development (HUD) homes (HUD homes are served under HUD authorities and appropriations). Some of these funds may also be used for sanitation facilities for individual homes of the disabled or sick, with a physician referral, indicating an immediate medical need for adequate sanitation facilities in their home.[3] As needed, amounts to serve new and like-new homes will be established by Headquarters after reviewing Area proposals. Priority will be given to projects under the BIA Housing Improvement Program (HIP) to serve new and like-new homes with the exception of "Category A" BIA HIP homes which are considered existing homes and will be served with the funds described in this section. The IHS appropriated funds for sanitation facilities construction are prohibited by law from being used to provide sanitation facilities for new homes funded with grants by the housing programs of HUD. These HUD housing grant programs for new homes should continue to incorporate funding for the sanitation facilities necessary for those homes.

- Up to $55 million[4] will be used to cover cost increases due to inflation on projects funded during the pandemic with pre-pandemic cost estimates serving AI/AN homes and communities.

- Up to $55 million may be distributed to the Areas for prioritized projects identified in the IHS data system as Tier 1 Ready to Fund serving 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 sanitation facilities that are in need of some form of improvement. Another element of the distribution formula is a weight factor that favors Areas with larger numbers of AI/AN homes without water supply or sewer facilities, or without both. If there are insufficient Tier 1 projects then these funds will be used to support project planning, design, and construction administration to address existing sanitation deficiencies impacting AI/AN homes are fully designed and construction ready in FY2024. These funds will be used in conjunction with the FY 2023 Infrastructure Investment and Jobs Act.

- Up to $6 million will be reserved at IHS Headquarters for special projects to include up to $4 million for data migration of available water and wastewater system data from tribally owned and operated systems serving AI/AN homes and communities from electronic or paper file formats. This data is currently located in electronic or paper files within the IHS Areas and will be migrated

[3] Indian Health Service. Chapter 5 Eligibility for IHS SFC Program Services and IHS-Funded Projects. Criteria for the Sanitation Facility Construction Program June 1999 ver. 1.02, 3/13/03.

[4] Assumed 8% inflation associated with $675.5M in project funding from FY2023 IIJA.

under this initiative into the SFC Program Geographic Information System (GIS) portal. This data is used by the SFC Program to assist in needs identification, planning, and designing facilities to serve tribal homes and communities. An amount up to $1 million will be used to maintain and enhance the SFC Program data and reporting systems. The remaining special project funds will be used to pay for Area requested research studies, training, or other needs related to sanitation facilities construction, but which are not eligible for construction funds.

- Up to $2 million will be reserved at IHS Headquarters for emergency projects as requested by Areas to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situation that require immediate attention to avoid a health hazard or to protect the Federal investment in sanitation facilities. Any emergency funds unused by the end of the fiscal year may be distributed to address the SDS projects in the Areas.

FY 2023 Funding Increase of +$5 million includes

- Current Services of +$5 million, including:
  - Pay Costs: +$2,000 to fund pay increases for Federal and Tribal employees.
  - Inflation +$1 million to fund inflationary costs of providing health care services.
  - Population Growth +$4 million – to address the impact of the additional services need arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
35 Number of new or like-new and existing AI/AN homes provided with sanitation facilities. (Outcome)	FY 2021: 48,816 Target: 40,400 (Target Exceeded)	44,000	54,000[1]	+10,000
SFC-E Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. (Outcome)	FY 2021: 3.6 yrs Target: 4 yrs (Target Exceeded)	4 yrs	4 yrs	Maintain

[1]Target based on funding from both FY 2023 President's Budget and $675.5 million from the Infrastructure Investment and Jobs Act (IIJA).

GRANT AWARDS – This Program has no grant awards.

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$259,290	$259,293	$545,784	+$286,491
FTE*	--	--	--	--

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Health Care Facilities Construction (HCFC) funds provide optimum availability of functional, modern IHS and tribally operated health care facilities and where required staff quarters. The IHS is authorized to construct health care facilities and staff quarters, support Tribal construction of facilities under the Joint Venture Construction Program (JVCP), provide construction funding for Tribal projects Under the Small Ambulatory Program (SAP), and provide funding to construct new and replacement dental units.

The construction and modernization of IHS infrastructure through the health care facilities construction program helps ensure the IHS commitment to the Department of Health and Human Services Strategic Objectives 1.2: Expand safe, high-quality healthcare options, and encourage innovation and competition; and 1.3: Improve Americans' access to healthcare and expand choice of care and service options. The health care facilities constructed by the IHS ensure access to quality, culturally competent health care for one of the lowest income populations in the United States, American Indians and Alaska Natives (AI/AN). The focus of the IHS health care service programs provided in these facilities is on prevention and delivery of comprehensive primary care in a community setting.

The HCFC program is funded based on an IHS-wide list of priorities for construction projects. During FY 1990, at the direction of Congress, the IHS established the 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 health care facility, if any, degree of isolation of the population to be served in the proposed health care facility, and availability of alternate health care resources. The remaining health care facilities projects on the HFCPS list, including those partially funded, total approximately $2.00 billion as of January 2021. The reauthorization of the Indian Health Care Improvement Act (IHCIA) includes a provision, "any project established under the construction priority system in effect on the date of enactment of the Act of 2009 shall not be affected by any change in the construction priority system taking place after that date…" Total need for the HCFC Program is approximately

$15 billion for expanded and active authority facility types according to *The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*.

The Joint Venture Construction Program (JVCP) authorizes IHS to enter into agreements with Tribes that construct their own health care facilities. The Tribe provides the resources, whether from its own funds, through financing, grants, contributions, or a combination thereof, for the construction of its health care facility. IHS health care facility construction appropriations are not used for construction of facilities in the JVCP but may be used to equip the health care facility. Tribes apply for the JVCP during a competitive process and the approved projects are entered into agreements with IHS. Based on the date of projected completion of construction by the respective Tribe, the IHS agrees to request a funding increase from Congress for additional staffing and operations consistent with a fully executed beneficial occupancy of the health care facility.

The Small Ambulatory Program (SAP) provides funding for small Tribal health care facilities. The SAP is authorized by Section 306 of the Indian Health Care Improvement Act, Public Law 94-437, and projects are competitively selected for funding as funds are appropriated. The SAP program is available for AI/AN Tribes or Tribal organizations to competitively obtain funding for the construction, expansion or modernization of tribally owned small ambulatory health care facilities. The selected projects will not be a part of the IHS HFCPS.

These three programs implement the IHS Strategic Plan Goal 1 by increasing access to culturally appropriate health care services for American Indian and Alaska Native people. IHS Strategic Plan Goal 2 is supported when a new facility is completed. A new facility is designed to meet the demand for health services from a growing population by providing more healthcare providers and exam rooms, dentists and dental chairs, improved imaging systems, and expanded services such as eye care and audiology. Each new facility includes a component to address behavioral health issues. Administration staff is increased to strengthen management, collections and bring health care quality expertise to the replacement facility. Each facility also incorporates additional space for Tribal health programs which complements IHS programs and how the HCFC programs are implementing.

PROGRAM ACCOMPLISHMENTS

Each healthcare facility project that is completed increases access to much needed health care services. Each completed replacement facility is typically larger to meet the increased demand for health services from a growing population. Tribes typically provide land, at no cost to the Federal Government, for the new or replacement health care facility.

The FY 2021 appropriation contributed to the Phoenix Indian Medical Center, Phoenix, AZ, the Whiteriver Hospital, Whiteriver, AZ; Gallup Indian Medical Center, Gallup NM; Bodaway Gap Health Center, The Gap, AZ; Albuquerque West Health Center, Albuquerque, NM; Albuquerque Central Health Center, Albuquerque, NM and Sells Alternative Rural Hospital, Sells, AZ projects.

The FY 2021 appropriation also contributed $25 million to the IHS SAP, $10 million to the Staff Quarters Program and $5 million to the Green Infrastructure Program. The selection and agreements to award the funds for staff quarters and the Green Infrastructure has occurred and the SAP applications are due from Tribes by July 1, 2022.

The FY 2022 appropriation will fund the Rapid City Health Center, Rapid City, SD; Alamo Health Center, Alamo, NM; Pueblo Pintado Health Center, Pueblo Pintado, AZ; Phoenix Indian Medical Center, Phoenix, AZ, Whiteriver Hospital, Whiteriver, AZ; Gallup Indian Medical Center, Gallup, NM; and Sells Alternative Rural Hospital, Sells, AZ projects.

The FY 2022 appropriation will also contribute $25 million to the IHS SAP, $10 million to the Staff Quarters Program and $5 million to the Green Infrastructure Program. The selection and agreements to award the funds is beginning in late FY 2022.

The JVCP has saved the Federal Government over $1 billion dollars in capital expenses since its inception. The outcome of the JVCP provides the same accomplishments as described above.

The federal construction and the Joint Venture programs bring new and increased health care capacity to AI/AN communities where there is a great need. These activities increase the access to quality healthcare in these underserved communities.

FUNDING HISTORY

Fiscal Year	Amount
2019	$243,480,000
2020	$259,290,000
2021 Final	$259,290,000
2022 Enacted	$259,293,000
2023 President's Budget	$545,784,000

BUDGET REQUEST

The FY 2023 budget submission for Health Care Facilities Construction of $546 million is $276 million above the FY 2022 Enacted level.

FY 2022 Base Funding of $259 million – Supports Health Care Facilities Construction for new and replacement IHS and Tribal health care facilities.

FY 2023 Funding Increase of +$276 million includes

- Current Services of +$603,000, including:
    - Inflation +$603,000 to fund inflationary costs of providing health care services.

Health Care Facilities Construction: +$276 million- to continue to fund the projects on the 1993 IHS Health Care Facilities Construction Priority List and support other targeted facilities programs including a new mid-sized ambulatory demonstration program. These health care facilities will improve access to direct health care services in the communities they serve.

The total $546 million requested for FY 2023 would support:

Phoenix Indian Medical Center, Phoenix, AZ $48.5 million
These funds will be used to plan, purchase land, and design the facility. The new Phoenix Indian Medical Center Health Care System is planned to decentralize a substantial portion of the primary care services workload to three new satellite facilities. The three satellite facilities

are located in the southwest valley, the southeast valley, and in the northeast valley. The satellite facilities are located closer to the user's communities to provide more access to care. A new Central facility will be a major resource to the satellite facilities. The Central facility will be designed and equipped with full telemedicine support and visiting professionals to provide specialty care services, and will continue to serve as a referral hospital for specialty consultation and procedures.

Whiteriver Hospital, Whiteriver, AZ $100 million

These funds will be used to begin construction of the replacement hospital. It will serve a projected user population of 36,113 providing 67,000 primary care provider visits and 101,200outpatient visits annually. This project also includes an estimated 144 staff quarters for health care professionals serving at the facility.

Gallup Indian Medical Center, Gallup, NM $48.5 million

These funds will be used to plan, purchase land, and design the facility. The proposed replacement Gallup Indian Medical Center will provide comprehensive inpatient, ambulatory, behavioral, and preventive health services for the Gallup Service Unit. The projects will also provide specialty care and inpatient care services to support other Navajo Area service units.

Bodaway Gap Health Center, The Gap, AZ $118 million

These funds will be used to complete construction of the health center and 82 staff quarters located in The Gap, AZ. The Health Center will serve a projected user population of 4,646 generating 18,458 primary care provider visits annually. The facility will provide an expanded outpatient and community health department, and a full array of ancillary and support services.

Albuquerque West Health Center, Albuquerque, NM $40 million

These funds will be used to complete the construction of the health center located in the west side of Albuquerque, NM.The land donated for the Albuquerque West Health Center was evaluated and was found not sutable, therefore IHS to purchase land for the facility in the Albuquerque area. These funds will be use to purchase land.

Sells Health Center, Sells, AZ $121 million

These funds will complete the construction of the health center and staff quarters in the Sells, AZ. The Sells Health Center will consist of approximately 210,000 GSF of space. The Health Center will serve a projected user population of 21,400 generating 38,200 primary care provider visits annually. The facility will provide an expanded outpatient and community health department, and a full array of ancillary and support services.

New and Replacement Staff Quarters $25 million

Many of the 2,700 quarters across the IHS health delivery system are more than 40 years old and in need of major renovation or total replacement. Additionally, in a number of locations the amount of housing units is insufficient. The identified unmet need, of housing units in isolated, remote locations is a significant barrier to the recruitment and retention of quality healthcare professionals across Indian Country. This funding level would fully-fund the current need for 990 new or replacement staff quarters. The amount distributed to each Area will be based on each Area's internal priority list.

Small Ambulatory $30 million

These resources would support up to 10 small ambulatory facilities in American Indian and Alaska Native communities. Consistent with prior years, the IHS will request applications from interested Tribes. Funds will support for construction, expansion or modernization of non-IHS owned small Tribal ambulatory health care facilities located apart from a hospital.

Green Infrastructure: $5 million

The Indian Health Service will use these funds to incorporate green infrastructure and the most current energy efficiency codes and standards available in its planning, design, and operations of buildings to the maximum extent practicable. This approach will reduce costs, minimize environmental impacts, and use renewable energy.

Mid-Sized Ambulatory Demonstration Projects: $10 million

This new effort would fund 2 small to medium ambulatory health care facilities projects, ranging from $4 million to $5 million in cost. Each project would follow the IHS Area's Master Plan and fit within the framework of the IHS Area Health Services Delivery Plan. These facilities would support a broader array of in-house services that a smaller clinic could not support. Each project would include a staffing package based on the identified in-house services to be requested as future staffing of new facilities funding.

- Many American Indian and Alaska Natives are unable to access high quality health care services in their communities due to lack of health care facilities infrastructure. While IHS has a number of facilities programs at its disposal, each has its own limitations, which means that ambulatory facilities that are larger than what can be supported by the Small Ambulatory Program ($2 million per facility) but smaller than the Joint Venture Program, fall through the cracks. Further, the IHS' current programs provide funding for small facilities with no staffing funding, and staffing for tribally constructed programs under the Joint Venture Program, which have the capital for major construction projects.

- This program would provide the initial funding to construct a facility of this size, and provide recurring staffing funding to ensure that the facility can provide the health care services envisioned in its design.

- Each project in this program has the potential to provide basic health care needs to 3,000 to 5,000 AI/AN individuals.

- By increasing the capacity of health care facilities to serve AI/AN communities, it increases 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.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/- FY 2022 Target
36 Health Care Facility Construction: Number of health care facilities construction projects completed. (Outcome)	FY 2021: 0 projects Target: 0 projects (Target Met)	1 project	1 Project	Maintain
HCFC-E Energy consumption in Leadership in Energy and Environmental Design (LEED) certified IHS health care facilities compared to the industry energy consumption standard for comparable facilities. (Outcome)	FY 2021: 0 projects Target: 0 projects (Target Met)	1 project	1 Project	Maintain

Projects expected to be completed in FY 2022 are River People Health Center (PIMC NE) and Dilkon Health Center. Completions in FY 2023 Rapid City Health Center.

GRANT AWARDS – Program has no grant awards.

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$263,982	$283,124	$371,326	+$88,202
FTE*	1,044	1,066	1,092	+26

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

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

SUMMARY OF PROGRAMS

Facilities and Environmental Health Support Account (FEHS) programs provide and support an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs directly and indirectly support all of the IHS facilities performance measures and improved access to quality health services. The programs and staff at the IHS Headquarters, Area Office, and Service Unit levels work collaboratively with Tribes and other agencies to promote and provide access to improvements in public health through surveillance, education, intervention activities, construction of sanitation facilities and health care facilities. These activities are aligned in sub-activities: Facilities Support, Environmental Health Support, and Office of Environmental Health and Engineering Support. In addition to personnel salary and benefits costs, funding under this activity is used for utilities, certain non-medical supplies and personal property, and biomedical equipment repair.

The IHS may use a limited amount of these FEHS funds for centrally charged assessments that benefit the staff and activities funded through the Indian Health Facilities appropriations. To date, the majority of IHS's assessments have been paid through the Indian Health Services appropriation; however, the amount of assessment costs have exceeded the amount of funds available within Services. In order to continue the emphasis on direct patient care, these FEHS funds that provide other types of administrative support for the Facilities appropriation may share in appropriate assessment charges proportionate to the underlying activities. For example, a centrally managed assessment for payroll services that is charged by the number of employees may be proportionately paid under both the Services and Facilities appropriations according to the number of staff supported by each appropriation.

FACILITIES SUPPORT

PROGRAM DESCRIPTION

Facilities Support Account (FS) provides funding for Area and Service Unit staff for facilities-related management activities, operation and maintenance of real property and building systems, medical equipment technical support, and planning and construction management support for new and replacement health facilities projects. The sub-activity directly supports the IHS Strategic Plan FY 2019-2023 priorities: (1) People - Recruit, develop, and retain a dedicated, competent, caring workforce collaborating to achieve the IHS mission; (2) Partnerships- Build, strengthen, and sustain collaborative relationships that advance the IHS mission; (3) Quality- Excellence in everything we do to assure a high-performing Indian health system; and (4) Resources- Secure and effectively manage the assets needed to promote the IHS mission.

Facilities operations, maintenance, repair, and improvements address deficiencies/BEMAR and medical equipment, which are complex and involve many variables such as accreditation standards, healthcare patient satisfaction, changing healthcare delivery standards, building codes, old building equipment/system, and medical devices/equipment plus telemedicine used by healthcare professionals.

The IHS owns approximately 10,850,000 square feet of facilities (totaling 2,147 buildings) and 1,760 acres of federal and trust land. The nature of space varies from sophisticated medical centers to residential units and utility plants. Facilities range in age from less than one year to more than 169 years, with an average age greater than 40 years. A professional and fully-functional workforce is essential to ensure effective and efficient operations. An estimated 600 Federal positions (fulltime equivalents) are funded under this sub-activity. Typical staff functions funded may include:

- Facilities engineers and maintenance staff responsible for ensuring that building systems are operated properly, facilities and grounds are maintained adequately, utilities are managed appropriately, environmental compliance requirements are met, and buildings are safe;
- Specialized clinical engineers and technicians who maintain and service medical equipment;
- Realty staff that manages the real property requirements and quarters; and
- Facilities planning, project management, and construction-monitoring that assist in the planning and construction of projects.

In addition, FS provides partial funding for related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities-related personal property, and biomedical equipment repair and maintenance. Accomplishments include supporting health delivery through the attainment of accreditation and the maintenance of the environment of care of buildings, utility systems, life safety systems, and medical equipment.

Adequate facilities/maintenance staffing both at the Area Offices and service units are paramount to maintain accreditation, for the continuity of health services, and ensuring that major building systems function correctly. Workload for the facilities and biomedical staff has continued to increase to meet the Agency’s emphasis on accreditation standards and supporting program enhancements/expansion, which is predominately funded with collections.

In consultation with Tribes and the Federal healthcare sites, IHS is coordinating with and allocating funding to the IHS Area Offices to complete BEMAR projects to make renovations and

improvements necessary to support health care delivery in the health care facilities and to modernize the health care facilities and staff quarters to expand access to quality health care services including modern medical equipment.

PROGRAM ACCOMPLISHMENTS

Maintaining effective and efficient healthcare buildings and equipment improve the ease and access to care, facilitate successful behavioral health services, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment to deliver services. This is all integral to quality health care for AI/ANs.

The Facilities Support Account and associated staffing level directly supports to the medical equipment, maintenance and repair of, and adjustments/modifications to IHS and Tribal healthcare sites to prevent, prepare for, and respond to coronavirus/COVID-19 medical services.

In FY 2021, total utility costs were $15.6 million and total utility costs per Gross Square Feet (GSF) were $2.97/GSF. In FY 2023, the total utility cost is expected to be $17.0 million reflecting a 9.0 percent annual increase. The cost per GSF is expected to rise to approximately $3.23/GSF. IHS makes conscious efforts to help stem the growth in utility costs to ensure appropriations are sufficient to fund these needs. For example, IHS constructs new space that is at least 30 percent more energy efficient than building code requires and expects LEED Silver certification at those facilities. Additionally, IHS seeks opportunities to fund renewable energy systems at IHS and tribally owned installations. For example, a current project is installing additional solar panels at the Fort Yuma Health Care Center in Yuma, Arizona, which has the potential to make the site net zero electricity.

ENVIRONMENTAL HEALTH SUPPORT

PROGRAM DESCRIPTION

The Environmental Health Support Account (EHSA) provides funding for IHS Area, District, and Service Unit management activities and environmental health staff which include engineers, environmental health officers, engineering aides, injury prevention specialists, and institutional environmental health officers. More than 70 percent of these IHS and Tribal staff live and work in Tribal communities; another 20 percent provide regional services to Tribes or IHS facilities; and less than 10 percent of our staff are administrative managers. AI/ANs face hazards in their environments that affect their health status, including communities in remote and isolated locations, severe climatic conditions, limited availability of safe housing, lack of safe water supply, and lack of public health and safety legislation (e.g., lack of local solid waste ordinances, vehicle safety laws, or food safety laws). In accordance with congressional direction, these funds are distributed to the Areas based upon the workload and need associated with the two programs noted below.

- Sanitation Facilities Construction Program (SFC) – This program is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated for SFC to provide safe water supply and waste disposal facilities for AI/AN people and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have been reduced. Research supported by the Centers for Disease Control and Prevention states populations in regions with a lower proportion of homes with water service, reflect significantly higher

hospitalization rates for pneumonia, influenza, and respiratory syncytial virus.[1] Researchers associate the increasing illnesses with the restricted access to clean water for hand washing and hygiene. The absence of clean water to sanitation facilities for tribal households exacerbate concern for the Indian Health Service Clinical Health Care program; further decreasing the quality of life for AI/ANs. Efforts by other public health specialists such as nutritionists and public health nurses are much more effective when safe water and adequate wastewater disposal systems are available in the home. In addition, the availability of such facilities is of fundamental importance to social and economic development, which leads to an improved quality of life and an improved sense of well-being.

The SFC Program works collaboratively with tribes to assure all AI/AN homes and communities are provided with safe and adequate water supply and waste disposal systems as soon as possible *(IHS Strategic Plan FY 2019 – 2023, Objective 1.2: Build, strengthen, and sustain collaborative relationships).* Under this program in FY 2020, staff managed and/or provided professional engineering services for 545 new sanitation projects with a total cost of over $302 million, including IHS funds and contributions from Tribes and other agencies. The program manages annual project funding that includes contributions from Tribes, states, and other federal agencies. The SFC Program is the environmental engineering component of the IHS health delivery system. Services funded include management of staff, pre-planning, consultation with Tribes, coordination with other federal, state and local governmental entities, identifying supplemental funding outside of IHS, developing local policies and guidelines with Tribal consultation, developing agreements with Tribes and others for each project, providing professional engineering design and/or construction services for water supply and waste disposal facilities, assuring environmental and historical preservation procedures are followed, and assisting Tribes where the Tribes provide construction management.

Consistent with the 1994 Congressional set aside for "…tribal training on the operation and maintenance of sanitation facilities," $1 million of these support funds are used for technical assistance, training, and guidance to Indian families and communities regarding the operation and maintenance of water supply and sewage disposal facilities.

In accordance with the Indian Health Care Improvement Act, the staff annually updates its inventory of sanitation facilities deficiencies for existing Indian occupied homes.[2] This is accomplished through extensive consultation with Tribes. The SFC staff also develops and updates an inventory of all open dump sites on Indian lands as required under the Indian Lands Open Dump Cleanup Act.[3] Both of these inventories are widely used by other governmental agencies in their evaluation and funding of sanitation facilities construction projects.

The IIJA appropriates $700 million in each year from FY 2022 – FY 2026, for a total of $3.5 billion for the IHS Sanitation Facilities Construction (SFC) program. These resources are available until expended, for the provision of domestic and community sanitation facilities for Indians, as authorized. Funding from the IIJA appropriation will be used to fund sanitation facilities construction projects listed in the IHS

[1] Thomas W. Hennessy, Troy Ritter, Robert C. Holman, Dana L. Bruden, Krista L. Yorita, Lisa Bulkow, James E. Cheek, Rosalyn J. Singleton, and Jeff Smith. The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives. American Journal of Public Health: November 2008, Vol. 98, No. 11, pp. 2072-2078.
[2] Title III, Section 302(g) 1 and 2 of P.L. 94-437.
[3] P.L. 103-399.

Sanitation Deficiency System.

Environmental Health Services (EHS) – National priority areas include: food safety, children's environments, healthy homes, vector-borne and communicable disease, and safe drinking water. The EHS Program identifies environmental hazards and risk factors in Tribal communities and proposes control measures to prevent adverse health effects. The EHS Program monitors and investigates disease and injury. The program provides inspections to identify environmental hazards in homes, healthcare facilities, food service establishments, Head Start centers, and many other types of Tribal establishments. In addition, EHS provides training, technical assistance, and cooperative agreements to enhance the capacity of Tribal communities to address environmental health issues.

EHS provides access to public health services to AI/ANs. Examples include: referrals for home investigations to reduce environmental triggers for asthma patients; home investigations to reduce exposure to lead-based paint or other lead hazards (including drinking water sources) for patients with elevated blood-lead levels; animal bite investigations in Tribal communities and potential patient exposure to rabies virus; home investigations to address fall risk for elderly and other patients at risk for falls; and referrals for investigation of communicable disease outbreaks from patient exposures to contaminated food or water.

The IHS Injury Prevention Program (IPP) leads IHS efforts to address injury disparities between AI/AN communities and U.S. all races. AI/AN experience injury mortality rates that are 2.5 to 8.7 times higher than the U. S. all races rates[4]. The IPP works with AI/AN, other agencies, and IHS programs to prevent unintentional injuries (e.g., motor vehicle-related, falls, burns, drowning, poisoning) and intentional injuries (e.g., suicide and violence-related) through technical assistance, training, and the Tribal Injury Prevention Cooperative Agreement Program (TIPCAP). Technical assistance is provided in the areas of data collection for project evaluation, building partnerships, implementing evidence-based strategies or innovative interventions, and developing tribal injury prevention programs.

The IHS Institutional Environmental Health (IEH) Program identifies hazards and risk factors in the built environment and proposes control measures to prevent adverse health effects to patients, staff, and visitors in health care and other community facilities. The IEH program supports development and management of safe, functional health care facilities which contributes to the quality of care and workforce retention. The IEH program collaborates with entities such as the National Institutes of Health, Administration for Children and Families, and Uniformed Services University to improve IEH practices in IHS facilities and in our tribal communities.

PROGRAM ACCOMPLISHMENTS

Environmental Health Services (EHS) staff have been involved with all aspects and at all levels of the National COVID-19 Pandemic response. The Division of Environmental Health Services has collaborated with Federal partners such as, National Indian Gaming Commission, Centers for Disease Control and Prevention, Department of the Interior, and the Bureau of Indian Education by serving as Subject Matter Experts for policy and guidance on the reopening of Tribal gaming facilities and tribal schools nationally. EHS staff remain focused on the community-based environmental health services by assisting tribal operations and businesses plan and prepare to reopen during COVID-19. EHS staff throughout the Indian Health Service are serving in critical leadership positions of the COVID-19 response. For example, many Environmental Health staff

[4] Trends in Indian Health 2017 Edition, IHS, Division of Program Statistics

serve as Incident Commanders, Safety Officers, IHS Area Emergency Management Points-of-Contact, Logistics Chief, and Liaisons to state and local emergency management entities.

EHS staff accomplishments reduce the need for direct healthcare services when environmentally related diseases and injuries are prevented. For example, the IHS Injury Prevention Program has been instrumental in reducing the injury mortality rate of AI/ANs by implementing a public health approach based upon effective strategies and initiatives to reduce the devastating burden of injuries. Preventing severe, debilitating injuries reduces the cost and need for healthcare service; however, the challenge remains that unintentional injuries are still the leading cause of death for AI/ANs ages 1-44.[5]

From 1997-2021 the TIPCAP funded 106 fulltime tribal injury prevention positions and provided over $34 million in funding. Through these efforts the IHS IPP has contributed to the 58 percent decrease in injury mortality rates since 1973 and continues to invest in preventing injuries, instead of treating the impacts of injury and violence through our health care delivery system. In FY 2021, the TIPCAP 2021-2025 five year funding cycle began in which 27 tribes or tribal programs from eleven IHS Areas we awarded a cumulative total of $2.4M per year. This new cycle of funding addresses motor vehicle related injuries, falls, and other emerging issues based on tribal needs. These could include, poisoning/opioids, suicide, traumatic brain injury, or drowning. *Strategic Goal 3: Strengthen the Economic and Social Well-Being of Americans Across the Lifespan. Strategic Objective 3.2: Safeguard the public against preventable injuries and violence or their results*.

The IEH Program provides extensive technical assistance and training to safety and facility management staff as well as the many inter-related medical program and leadership staff. These efforts have led to a reduction in the IHS total occupational injury & illness case rate which has decreased from 4.35 injuries/100 employees in 2004 to 1.43 injuries & illness/100 employees in 2021.

The IEH program supports healthcare management by providing local accreditation support including mock environment of care surveys in which regulatory requirements and conditions for general safety, environmental infection control, fire safety, and chemical safety are assessed and recommendations for corrective action are provided. The IEH Program works to foster multi-disciplinary engagement amongst all levels of the organization to improve transparency and efficiency.

Staff engage Tribal, county, and state public health and public safety officials in Tribal communities. For example, staff engage local Bureau of Indian Affairs law enforcement or Tribal police to enhance motor vehicle related injury prevention efforts through child safety seat interventions and enhanced police enforcement activities such as seat belt usage or driving under the influence checkpoints. Staff work extensively with Tribal, county, and state health departments on a variety of public health issues including response to foodborne (i.e., salmonellosis), vector borne (i.e., bubonic plague, Rocky Mountain spotted fever, hantavirus), and waterborne (i.e. legionellosis) disease outbreaks. Other examples of collaboration include surveillance activities related to emerging diseases and public health emergency preparedness. *Strategic Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play. Strategic Objective 2.2: Prevent, treat, and control communicable diseases and chronic conditions* and *Strategic Objective 2.4: Prepare for and respond to public health emergencies*.

[5] Indian Health Focus: Injuries, 2017 Edition

FUNDING HISTORY

Fiscal Year	Amount
2019	$252,060,000
2020	$261,983,000
2021 Final	$263,982,000
2022 Enacted	$283,124,000
2023 President's Budget	$371,326,000

BUDGET REQUEST

The FY 2023 budget submission for Facilities and Environmental Health Support of $371 million is $88 million above the FY 2022 Enacted level.

FY 2022 Base Funding of $283 million – Supports Facilities and Environmental Health Support for existing IHS and Tribal facilities.

FY 2023 Funding Increase of +$88 million includes:

- Current Services of +$13 million, including:
    - Pay Costs: +$7 million – to fund pay increases for Federal and Tribal employees.
    - Inflation +$1 million to fund inflationary costs of providing health care services.
    - Population Growth +$5 million – to address the impact of the additional services need arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.

Staffing for New Facilities: +$8 million to fund staffing and operating costs for new and replacement projects. These funds will support staffing and operating costs for new and replacement projects listed below. Funding for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address health care needs. The following tables display this request:

Staffing and Operating Costs for New/Replacement Facility	Amount	FTE/Pos
Naytahwaush Health Center (JV), Naytahwaush, MN	$1,041	3
NEACC (Salt River) Health Center, Scottsdale, AZ	$1,271	4
Ysleta Del Sur Health Center (JV), El Paso, TX	$413	1
Alternative Rural Health Center, Dilkon, AZ	$1,598	7
Elbowoods Memorial Health Center (JV), New Town, ND	$502	2
Rapid City Indian Health Service Hospital, Rapid City, SD	$3,589	15
Grand Total:	**$8,414**	**32**

These funds support a variety of critical facilities support and environmental health activities. A description of these activities along with program accomplishments is included below.

Infrastructure Investment and Jobs Act (IIJA) SFC Implementation: +$49 million to support the implementation of the $3.5 million provided by the IIJA for SFC. This funding will support additional salary, expenses, and administrative costs beyond the 3 percent allowed in the IIJA. These funds would also be available to Tribal Health Programs, unlike the 3 percent administrative set-aside in the IIJA. This additional funding is necessary to maintain existing

project completion deadlines and will support IHS and Tribes in successfully implementing IIJA resources. Specific activities supported will include:

- Hiring additional engineering staff to manage project workload and fill current vacancies;
- Hiring additional Contracting Specialists and Contracting Officer Representatives to support expanded contracting activities;
- Hiring additional HR specialists to recruit and retain the staff necessary to complete these projects; and
- Purchasing additional hardware and software licenses to support the additional project load.

Public Health Engineers Pipeline: +$18 million to bolster recruitment and retention efforts for public health engineers.

- Facility and Environmental Health Support funding supports 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. Facilities and Environmental health support funding and staff at the IHS Headquarters, Area Office, and Service Unit levels work collaboratively with Tribes and other agencies to promote and provide access to improvements in public health through surveillance, education, intervention activities, construction of sanitation facilities and health care facilities.

- The IHS owns over 10.2 million square feet of facilities across 2,119 buildings and 1,758 acres of federal and trust land. The nature of this space varies from sophisticated medical centers to residential units and utility plants. Facilities range in age from less than one year to more than 167 years, with an average age greater than 39 years. A professional and fully-functional workforce is essential to ensure effective and efficient operations.

- This proposal is intended to increase the number of qualified engineer applicants within the Sanitation Facilities Construction Program. The proposal will support training of engineers over a 3 year period to earn a Master of Science (MS) Degree in Civil or Environmental Engineering with a focus on developing technical and practical skills in planning, designing, constructing, and assessing the impact of sanitation facilities supporting Native American and Alaska Native homes and communities. The substantial SFC funding provided in the Infrastructure Investment and Jobs Act underscore the necessity of ensuring IHS has sufficient public health engineering staff to successfully carry out the sanitation facilities construction projects.

    - The program will be carried out by colleges and/or universities in collaboration with the IHS DSFC.

    - Funds provided by the IHS will be used to support tuition, books, fees, and stipends for living expenses for a period of up to 3 years (2 year Master program + 1 year field program) for each student. The fellowship recipients must agree to actively seek employment with the IHS DSFC Program at the end of their second year and complete a total of 3 years of service, similar to the IHS Scholarship Program.

- The IHS would award cooperative agreements to up to 4 recipient colleges and/or universities to fund 5 cohorts of students. Each cohort contains 5 students, totaling 100 students trained over the program's duration.

    - Eligible colleges and universities include those with ABET accredited programs in Civil and Environmental Engineering that have ongoing and longstanding relationships with American Indian and Alaska Natives as demonstrated by the university or college having:
        - A Chapter of Native American Science and Engineering Society (AISES) a national nonprofit organization focused on substantially increasing the representation of Indigenous peoples of North America in science, technology, engineering, and math (STEM) studies and careers.
        - A Chapter of the Society for Advancement of Chicanos/Hispanics and Native Americans in Science dedicated to fostering the success of Chicanos/Hispanics and Native Americans, from college students to professionals, in attaining advanced degrees, careers, and positions of leadership in STEM
        - Programs that support the leadership and training of American Indian and Alaska Natives in public health science and engineering.
        - Existing scholarship and fellowship programs that support American Indian and Alaska Natives in science, technology, engineering, and math (STEM).

    - If actions are not taken to target recruitment efforts to increase the number of engineer staff within the IHS DSFC Program the program will not be able to deliver the services required under the Indian Health Care Improvement Act (IHCIA). The federal workforce employed by the SFC program is aging, and the program is at risk of not maintaining an adequate staffing level to support program delivery into the future.

    - In 2018, it was estimated that 50% of the US Public Health Service Commissioned Corps (CC) Engineer Officers or an estimated 92 engineers employed by the IHS would be eligible for retirement in 3 years. Also, in 2018, over 60% of the IHS CC Engineer Officers held a senior level rank of O-5 or O-6.

    - Additionally, the number of student interns hired through the Commissioned Corp Student Training and Extern Training Program (COSTEP), historically the primary DSFC Program recruitment method, has steadily decreased over the past 10 years. These trends point to a need for a focused effort to strengthen the engineering staff pipeline within the DSFC.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2022 Target	FY 2023 Target	FY 2023 Target +/-FY 2022 Target
EHS-5 Number of persons who received injury prevention training (Output)	FY 2021: 473 trained Target: 473 trained (Baseline)	473 trained	473 trained	Maintain
EHS-6 Percent of food establishments with Certified Food Protection Manager (CFPM) (Output)	FY 2021: 87.5%Target: 87.5% (Baseline)	87.5%	87.5%	Maintain

Performance Discussion

In FY 2021, a new performance cycle was established with two new measures. The EHS-5 measure is the number of persons who received injury prevention training. The EHS-6 measure is the percent of food establishments with a Certified Food Protection Manager (CFPM).

Injury Intervention: In FY 2021, data from the Web-based Environmental Health Reporting System (WebEHRS) was used to determine 473 people were trained in injury prevention. This measure focusses on the importance of injury prevention training in building the capacity of staff and tribes to prevent injuries and deaths due to injuries in tribal communities. It raises awareness and empowers individuals and communities. Training is also one of the components of 3Es (Education, Environmental modifications and Enforcement) that are essential in a comprehensive approach to reduce health impacts from injuries. *Strategic Goal 3: Strengthen the Economic and Social Well-Being of Americans Across the Lifespan. Strategic Objective 3.2: Safeguard the public against preventable injuries and violence or their results*.

Environmental Surveillance: In FY 2021 WebEHRS data was used to determine 87.5% of food establishments had a CFPM present at time of inspection. Food service establishments includes restaurants and kitchens within other establishments. It is based on a Centers for Disease Control and Prevention Environmental Health Specialist-Network study that determined the presence of a CFPM reduces the risk of foodborne illness outbreaks for an establishment and was a distinguishing factor between restaurants/food services that experienced a foodborne illness outbreak and those that had not. The measure aligns with the DEHS Operational Model and Ten Essential Environmental Health Services and the data can be collected in WebEHRS. *DHHS Strategic Goal 2*: *Safeguard and Improve National and Global Health Conditions and* ***Outcomes*** *Strategic Objective 2.2*: *Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines*

GRANT AWARDS

In FY 2021, the TIPCAP 2021-2025 five year funding cycle began in which 27 tribes or tribal programs from eleven IHS Areas we awarded a cumulative total of $2.4M per year. This new cycle of funding addresses motor vehicle related injuries, falls, and other emerging issues based on tribal needs. These could include, poisoning/opioids, suicide, traumatic brain injury, or drowning. *Strategic Goal 3: Strengthen the Economic and Social Well-Being of Americans Across the Lifespan. Strategic Objective 3.2: Safeguard the public against preventable injuries and violence or their results*.

OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT
PROGRAM DESCRIPTION

The IHS Office of Environmental Health and Engineering Support activity (OEHE) provides funds for executive management activities, personnel, contracts, contractors, and operating costs for the OEHE Headquarters. Personnel have management responsibility for IHS facilities and environmental health programs, provide direct technical services and support to Area personnel, perform management functions and have responsibility for all construction contracting in excess of $150,000.

Management activities include:

- national policy development and implementation
- budget formulation, project review and approval
- congressional report preparation
- quality assurance (e.g., internal control reviews, Federal Managers Financial Integrity Act activities and other oversight)
- technical assistance (e.g., consultation and training)
- construction contracting
- long range planning
- meetings (with HHS, Tribes, and other federal agencies)
- recruitment and retention efforts.

Typical direct support functions are:

- Project officers and contracting officer representatives for health care facilities construction projects: reviewing and/or writing technical justification documents, participating in design reviews and site surveys, conducting onsite inspections, and monitoring project funding status.
- Staff support real property asset management requirements. These actions are to ensure management accountability and the efficient and economic use of federal real property.
- Staff serving as contracting officer representatives and project officers in support of data systems, cooperative agreements, inter-agency agreements, and community-based projects.

In accordance with appropriation committee direction, OEHE staff develop, maintain, and utilize data systems to distribute Facilities Appropriation resources to Area offices for facilities and environmental health activities and construction administration and management, based upon workload and need. Also, technical guidance, information, and training are provided throughout the IHS system in support of the Facilities Appropriation.

PROGRAM ACCOMPLISHMENTS

The following are activities which focus on the IHS mission and priorities:

- review and approval of Program Justification Documents (PJDs) and Program Of Requirements (PORs)
- announcement and review of Joint Venture and Small Ambulatory projects
- awarding and monitoring contracts for all aspects of the Facilities Appropriation, including all types of construction contracts and 638 construction project agreements.
- OEHE coordinating construction, environmental health, and real property activities through the 12 Area Offices to ensure program consistency, to ensure the most effective use of resources across IHS, and to support field programs through budget preparation and required reporting, thus ensuring the most effective, accountable use of resources to improve access to quality healthcare services.

OEHE strengthens the overall management of IHS by reviewing and approving the planning documents for health care facilities construction projects called PJDs and PORs. OEHE also reviews joint venture and small ambulatory projects which address assessing health care and improving health care delivery. These programs include behavioral health services. These programs include behavioral health services. The OEHE facilities programs integrate strategic planning, performance, and program integrity into the office's daily business practices. One example is the Sanitation Facilities Construction Strategic planning efforts and identification of needs (Strategy 1, "*Improve the transparency and quality of data collected regarding health care service and program outcomes*" from IHS Strategic Plan FY 2019-2023, Objective 2.1: *Create quality improvement capability at all levels of the organization*). Implementation of this plan has improved project management, reduced project durations and transformed the data system used by IHS and federal partners to manage sanitation programs in Indian country. Another example is the Environmental Health program strategic visioning and the Ten Essential Environmental Health Services as a framework. Implementation of these initiatives is ongoing.

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

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$29,087	$30,464	$102,017	+$71,553
FTE*	--	--	--	--

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

Authorizing Legislation .....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2023 Authorization.....Permanent

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

PROGRAM DESCRIPTION

Equipment funds are used for maintenance, upgrades, replacement, and the purchase of new medical equipment systems at Indian Health Service (IHS) and Tribal healthcare facilities. It directly supports the Agency's priorities of Partnerships and Quality.

Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment/systems to assure the best possible health diagnosis. The IHS and Tribal health programs manage approximately 90,000 devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $700 million. With today's medical devices/systems having an average life expectancy of approximately six to eight years and rapid technological advancements, medical equipment replacement is a continual process making it necessary to replace worn out equipment or provide equipment with newer technology to enhance the speed and accuracy of diagnosis and treatment. To replace the equipment at the end of its six to eight-year life would require approximately $100 million per year.

Many of the IHS hospital administrators reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance with the Medicare Hospital Conditions of Participation. Further, the administrators reported that maintaining aging buildings and equipment is a major challenge. Over one third of all IHS hospitals' deficiencies have been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors.

Equipment Funds Allocation Method

In FY 2022, the IHS Equipment funds were allocated in four categories: Tribally-constructed health care facilities, TRANSAM program, Tribal emergency generator, and new and replacement equipment:

1. Tribally-Constructed Health Care Facilities - The IHS provides medical equipment funds to support the initial purchase of equipment for tribally-constructed health care facilities. FY 2022 funds support approximately $5 million for competitive awards to Tribes and Tribal organizations that construct new or expand health care facilities space using non-IHS funding sources. Tribes and Tribal organizations will use these funds to serve approximately 500,000 patients with newly purchased medical equipment.

2. TRANSAM Program - Equipment funds may be used to acquire new and like-new excess medical equipment from the Department of Defense (DoD) or other sources through the TRANSAM (i.e., Transfer of DoD Excess Medical and Other Supplies to Native Americans) Program and to procure ambulances for IHS and Tribal emergency medical services programs.[1] FY 2022 appropriations included $500,000 for the TRANSAM Program from the Equipment budget. Under the TRANSAM Program, excess equipment and supplies, at an annual estimated value of $5 million, are acquired for distribution to federal and Tribal sites.

3. Tribal Emergency Generator - The IHS provides medical equipment funds to support the purchase of emergency generators at Tribally-operated health care facilities. FY 2022 funds support approximately $2 million for Tribal Health Programs located in areas impacted by de-energization events. Funding is allocated to the Tribal Health Program using the IHS ISDEAA compact/contract.

4. New and Replacement Equipment - Approximately $23 million will be allocated to IHS and Tribal health care facilities to maintain existing and purchase new medical equipment, including the replacement of existing equipment used in diagnosing illnesses. The funding allocation is formula based.

FUNDING HISTORY

Fiscal Year	Amount
2019	$23,706,000
2020	$28,087,000
2021 Final	$29,087,000
2022 Enacted	$30,464,000
2023 President's Budget	$102,018,000

TRIBAL SHARES

Equipment funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities at a Federal or Tribe healthcare site.

[1] The IHS Facilities appropriation limits total expenditures up to $500,000 for equipment purchased through the TRANSAM Program.

BUDGET REQUEST

The FY 2023 budget submission for Equipment of $102 million is $72 million above the FY 2022 Enacted level.

FY 2022 Base Funding of $30 million – Supports Equipment for existing IHS and Tribal facilities.

FY 2023 Funding Increase of +$72 million includes

- Current Services of +$640,000, including:
    - Inflation +$134,000 to fund inflationary costs of providing health care services.
    - Population Growth +$506,000 to address the impact of the additional services need arising from the growing AI/AN population. The IHS projects a population growth rate of 1.8 percent in CY 2022 based on state births and deaths data.
- Equipment: +$71 million for maintenance and upgrades for existing medical equipment, and procurement of new medical equipment to replace units that are at the end of their useable lifecycle at IHS and Tribal healthcare facilities. Facility deficiencies/BEMAR and medical equipment are complex and involve many variables such as accreditation standards, healthcare patient satisfaction, changing healthcare delivery standards, building codes, old building equipment/system, and medical devices/equipment plus telemedicine used by healthcare professionals.
- Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment and systems to assure the best possible health diagnosis. IHS and Tribal health programs manage approximately 90,000 devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $700 million.
- Today's medical devices and systems have an average life expectancy of approximately six to eight years. The average six year life cycle combined with rapid technological advancements means that medical equipment replacement is a continuous process that requires the replacement of aging equipment, and equipment that does not meet newer technological standards, to enhance the speed and accuracy of diagnosis and treatment. To replace equipment at IHS and Tribal health facilities at the end of its six-year life would require approximately $100 million per year, growing at an approximate 2 percent inflation rate per year. The FY 2023 funding request would be a substantial investment toward addressing critical equipment needs.
- Along with aging buildings, aging equipment presents challenges for maintaining accreditation, providing high quality care and ensuring patient safety. It also affects the recruitment and retention of high quality health care professionals. Having access to modern equipment and the ability to maintain skills and training on particular devices or equipment are important factors in our providers' decisions about working for IHS.

The total $102 million funding request for FY 2023 would support:

- Approximately $94.5 million for new and routine replacement medical equipment to over 1,500 federally and tribally-operated healthcare facilities;

- $5 million for new medical equipment in tribally-constructed health care facilities;

- $2 million for emergency generators at Tribal Health Programs located in areas impacted by de-energization events; and

- $500,000 for the TRANSAM program.

OUTPUTS / OUTCOMES

This program measures outcomes through its inventory of medical equipment. Maintaining and fielding modern medical equipment improve the ease and access to care, enhance the diagnostic capabilities leading to better health outcomes, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment with which to deliver services.

IHS targets Equipment funding and supplements these funds with collections where available, toward equipment purchases to reduce the backlog of over-age equipment and field new, state-of-the-art equipment and systems. A few examples of these purchases include: digital x-ray systems (dental, 3D panoramic x-ray, full radiology rooms, 3D mammography, computed tomography), optometry equipment (visual field analyzers, simultaneous fundus and optical coherence tomography), lab analyzers for in-house testing, sterilization equipment, specialized microscopes, patient lifting equipment, picture archiving & communications systems (PACS), central patient monitoring systems, and ultrasound systems. This equipment will improve diagnostic capabilities, provide faster analysis, and facilitate provision of services to American Indian and Alaska Native communities.

GRANT AWARDS – This program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2023 Performance Budget Submission to Congress

TABLE OF CONTENTS

Contract Support Costs

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Contract Support Costs: 75-0344-0-1-551

CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
PL	$916,000	$880,000	$1,142,000	+$262,000
FTE*	--	--	--	--

Authorizing Legislation ..... 25 U.S.C. §§ 450 et seq., Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended

FY 2023 Authorization.....Permanent

Allocation Method ..... P.L. 93-638 Self-Determination Contracts and Compacts

PROGRAM DESCRIPTION

The Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, provides Tribes or Tribal Organizations (T/TO) the authority to contract with the Department of Health and Human Services, through the Indian Health Service (IHS), to operate Federal programs serving eligible persons and to receive not less than the amount of funding that the Secretary would have otherwise provided for the direct operation of the program for the period covered by the contract (otherwise known as the "Secretarial amount"). The 1988 amendments to the Act authorized Contract Support Costs (CSC) be paid in addition to the Secretarial amount. Strategic Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.5: Bolster the health workforce to ensure delivery of quality services and care

CSC are defined as necessary and reasonable costs for activities that T/TO must carry out to ensure compliance with the contract and prudent management but that the Secretary either did not normally carry out in his or her direct operation of the program or provided from resources other than those transferred under contract. The IHS CSC policy was established in 1992 and most recently revised on August 6, 2019, which updates from the October 2016 policy revisions,[1] an update to reflect necessary changes. These changes include the method by which Congress has funded CSC, and moves from limited to uncapped awards, and the provision of CSC to an indefinite appropriation. Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability, Objective 5.1: Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices and Objective 5.2: Sustain strong financial stewardship of HHS resources to foster prudent use of

[1] *Indian Health Manual*, Part 6 – Services to Tribal Governments and Organizations, Chapter 3 – Contract Support Costs, *available at* http://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p6c3.

resources, accountability, and public trust.

CSC is administered for IHS by the Office of Direct Services and Contracting Tribes (ODSCT), an office with responsibility for three primary functions that directly impact the relationship with each Indian T/TO. The ODSCT serves as the primary conduit between the IHS and the Direct Service Tribes, management of P.L. 93-638 Title I, ISDEAA contracts, and CSC in support of both Title I contracts and Title V compacts.

PROGRAM ACCOMPLISHMENTS

- Following is a summary CSC funds for FY 2016 – FY 2021, as of August 13, 2021:

	FY 2016	FY 2017	FY 2018	FY 2019
Appropriations*	$686,859,423	$714,642,272	$762,642,272	$822,227,000
Paid to Tribes	($678,005,883)	($724,655,471)	($770,248,205)	($800,214,560)
Balance*	$8,853,540	($10,023,199)	($7,605,933)	$22,012,440

	FY 2020	FY 2021
Appropriations*	$855,000,000	$916,000,000
Paid to Tribes	($921,940,635)	($1,180,212,845)
Balance*	$66,940,635	($264,212,845)

* Funds remain in process for payment to tribes and/or pending final reconciliation with tribes to determine the final amounts.

- IHS developed a SharePoint to track CSC requirements for COVID-19 funds. Separate data set are maintained for the period of funds availability for each Supplemental Appropriation. *IHS SP Goal 5, Objective 5.1 and 5.2.*

- IHS Headquarters reconciles CSC fund requests on a quarterly basis and allocates funds to each Area office to pay tribes. *IHS SP Goal 1, Objective 1.5, Goal 5, Objective 5.1 and 5.2.*

- IHS uses the CSC automated data system to track and monitor all CSC activity. The CSC data set is used to track all CSC funds, including any new and expanded assumption, renegotiation of CSC amounts, and distribution and payment of funds. IHS also uses the system to project CSC need based on the most current data. *IHS SP , Goal 5, Objective 5.1 and 5.2.*

- IHS continues to use the internal electronic database to monitor each Title I and V ISDEAA negotiation, including CSC negotiations. The database monitors each phase of a negotiation to ensure that IHS uses a consistent agency business approach, meet statutory deadlines, and accurately calculate required funding amounts. In addition, the database tracks new and expanded assumptions and is used to determine the status of funds, workload, planning of resources, and subsequent years' funding needs. *IHS SP , Goal 5, Objective 5.1 and 5.2.*

- IHS continues to make progress in resolving Contract Disputes Act claims from T/TO for additional CSC funding for prior years. As of August 17, 2020, the IHS has extended settlement offers on 1,567 of the 1,624 claims, with settlement payments of approximately $880 million that has been tentative or confirmed for payment from the Judgment Fund. *IHS SP , Goal 5, Objective 5.1 and 5.2.*

FUNDING HISTORY

Fiscal Year	Amount
2019	$822,227,000
2020	$820,000,000
2021 Final	$916,000,000
2022 Enacted	$880,000,000
2023 President's Budget	$1,142,000,000

BUDGET REQUEST

The FY 2023 budget submission for Contract Support Costs of $1.1 billion is $262 million above the FY 2022 Enacted level. The budget request includes a mandatory indefinite appropriation for Contract Support Costs.

Contract Support Costs General Increases: +$262 million for activities that T/TO must carry out to ensure compliance with the contract and prudent management, but that the Secretary either did not normally carry out in his or her direct operation of the program or provided from resources other than those transferred under contract

The overall funding level varies with need that is adjusted to meet the actual need for each fiscal year, which means that the appropriated amount will continue to fluctuate until the CSC need is fully reconciled for each year. The requested funding level reflects IHS's best current estimate of the need.

AREA ALLOCATION

CONTRACT SUPPORT COSTS

(dollars in thousands)

DISCRETIONARY	FY 2021 Final			FY 2022 Estimated			FY 2023 Estimated			FY '21 +/- FY '20
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$271,766	$271,766	$0	$261,085	$261,085	$0	$338,817	$338,817	$77,732
Albuquerque	0	22,663	22,663	0	21,772	21,772	0	28,255	28,255	$6,482
Bemidji	0	48,513	48,513	0	46,607	46,607	0	60,483	60,483	$13,876
Billings	0	17,031	17,031	0	16,361	16,361	0	21,233	21,233	$4,871
California	0	76,284	76,284	0	73,286	73,286	0	95,105	95,105	$21,819
Great Plains	0	8,713	8,713	0	8,370	8,370	0	10,862	10,862	$2,492
Nashville	0	39,488	39,488	0	37,936	37,936	0	49,230	49,230	$11,295
Navajo	0	72,319	72,319	0	69,477	69,477	0	90,162	90,162	$20,685
Oklahoma	0	138,373	138,373	0	132,935	132,935	0	172,513	172,513	$39,578
Phoenix	0	50,230	50,230	0	48,256	48,256	0	62,623	62,623	$14,367
Portland	0	70,174	70,174	0	67,416	67,416	0	87,488	87,488	$20,072
Tucson	0	29,089	29,089	0	27,945	27,945	0	36,266	36,266	$8,320
Headquarters	0	71,358	71,358	0	68,554	68,554	0	88,964	88,964	$20,410
Total, CSC	**$0**	**$916,000**	**$916,000**	**$0**	**$880,000**	**$880,000**	**$0**	**$1,142,000**	**$1,142,000**	**$262,000**

Note: FY 2022 and FY 2023 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2023 Performance Budget Submission to Congress

TABLE OF CONTENTS

ISDEAA 105*(l)* Leases

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Section 105(*l*) Leases: 75-0200-1-551

ISDEAA SECTION 105(*l*) LEASES

(Dollars in Thousands)

	FY 2021	FY 2022	FY 2023	
	Final	Enacted	President's Budget	FY 2023 +/- FY 2022
Program Level	$101,000	$150,000	$150,000	--
FTE*	--	--	--	--

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.

Authorizing Legislation ..... 25 U.S.C. § 5324(*l*)
Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended

FY 2023 Authorization.....Permanent

Allocation Method .....P.L. 93-638 Self-Determination Contract and Compacts, Lease Cost Agreements

PROGRAM DESCRIPTION

The Indian Self-Determination and Education Assistance Act (ISDEAA), at 25 U.S.C. § 5324(*l*), also referred to as Section 105(*l*), requires the Indian Health Service (IHS) to enter a "lease" upon the request of a Tribe or Tribal Organization furnishing a tribally owned or leased facility used in support of its tribally operated ISDEAA contract or compact. IHS does not directly use or occupy the tribal facility under the lease. Through regulations contained in 25 C.F.R. Part 900, Subpart H, IHS identified elements of compensation included in a Section 105(*l*) lease.

A 2016 Federal Court's decision (Maniilaq Association v. Burwell) prohibits IHS from capping funding under Section 105(*l*) at the level that IHS would have otherwise spent to operate a facility if it were to carrying out the Federal health programs. There is no statutory or regulatory limitation on when proposals may be submitted to the IHS, so IHS is unable to reliably predict or project annual costs. Lease costs have grown exponentially, since the Maniilaq decision, and quadrupled between FY 2018 and FY 2019. Because IHS has not had sufficient dedicated funding for leases, IHS has been forced to reprogram funds twice in FY 2019 totaling $62 million and once in FY 2018 totaling $25 million. A funding increase in FY 2020 temporarily reduced the likelihood of reprogramming. , This changed in FY 2021 where Congress added appropriation language essentially authorizing full funding to cover all FY 2021 105(l) lease costs. This language continued in FY 2022 and is expected to continue going forward.

The prevalence of Section 105(*l*) leases in FY 2017 was largely confined to the Alaska Area. However, by FY 2020, leases have proliferated throughout the IHS system and proposals have been received in all 12 IHS Areas.

This new, separate funding source supports IHS Strategic Plan goals and objectives for increasing access to care by establishing a dedicated funding source for these required costs and preventing the redirection of other IHS funds intended for health care services (*Goal 1, Access, Objective 1.3, Increase access to quality health care services*).

PROGRAM ACCOMPLISHMENTS

IHS has received 422 proposals in FY 2022 to date, with a current total of $176.8 million. This amount is likely to increase before the end of the fiscal year. At this funding level, costs are 29 times higher than in FY 2017.

Based on the exponential growth of Section 105(*l*) leases from 37 proposals totaling $6 million in FY 2017, to 76 proposals totaling $21 million in FY 2018, to 189 proposals totaling $85 million in FY 2019, and 296 proposals totaling $123 million in FY 2020, costs for future years are expected to continue growing as more Tribes and Tribal Organizations submit additional proposals.

In FY 2021, the IHS received an indefinite discretionary appropriation for section 105(*l*) leases, scored at $101 million. Funding for Village Built Clinics (VBCs) remains in the Hospitals and Health Clinics funding line. Unlike in prior years when section 105(*l*) lease costs were paid from the IHS lump sum appropriation for the Indian Health Services account, the IHS will not have to reallocate funding from other budget lines to address unanticipated lease proposals.

The IHS conducted Tribal Consultation and Urban Confer in FY 2018 and again in FY 2019 on short-term and long-term options for meeting requirements of the ISDEAA related to Section 105(*l*). Tribal and Urban Indian Organization feedback strongly recommended seeking additional resources, such as through a separate indefinite appropriation, and remained critical of any redirection of existing funding, which diminishes the Indian health system's ability to provide direct health care services. At the recommendation of Tribes and Tribal Organizations, the IHS established a technical subgroup to help collect and analyze information necessary for developing cost projections. The subgroup includes representatives from the IHS Tribal Self-Governance Advisory Committee, the IHS Direct Services Tribes Advisory Committee, the IHS Facilities Appropriation Advisory Board, the IHS National Tribal Budget Formulation Workgroup (NTBFW), and subject matter experts from the IHS. This subgroup operates under the auspices of the NTBFW and their on-going work is included in the IHS's annual Tribal Consultation and Urban Confer on the budget.

In accordance with Congress's direction in the FY 2021 annual appropriation, the IHS partnered with the Department of Interior on an initial consultation regarding the development of a section 105(*l*) policy on August 27, 2021. The IHS and DOI continue to work together to review comments from that consultation to identify topics for additional consultation, and areas for collaboration.

FUNDING HISTORY

Fiscal Year	Amount
2019	$0
2020	$0
2021 Final	$101,000,000
2022 Enacted	$150,000,000
2023 President's Budget	$150,000,000

BUDGET REQUEST

The FY 2023 budget submission for ISDEAA Section 105(*l*) leases of $150 million is the same as the FY 2022 Enacted level. The budget request includes a mandatory indefinite appropriation for ISDEAA Section 105*(l)* leases.

The overall funding level varies with need that is adjusted to meet the actual need for each fiscal year, which means that the appropriated amount will continue to fluctuate until the leases need is fully reconciled for each year. The requested funding level reflects IHS's best current estimate of the need.

OUTPUTS / OUTCOMES -- There are no outputs/outcomes for this funding at this time.

GRANTS AWARDS -- The program does not award grants.

AREA ALLOCATION – Funds are allocated to Areas as ISDEAA Section 105(*l*) lease proposals are received and executed each fiscal year.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2023 Performance Budget Submission to Congress

TABLE OF CONTENTS

Drug Budget

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Drug Control Budget
FY 2023

Budget Authority (in Millions)	FY 2021 Enacted	FY 2022 Enacted	FY 2023 President's Budget
Function			
Prevention	34.217	34.632	41.961
Treatment	100.961	103.473	135.516
Total Drug Resources by Function	$135.178	$138.105	$177.477
Drug Resources by Decision Unit			
Alcohol and Substance Abuse[1]	131.556	134.483	173.855
Urban Indian Health Program	3.622	3.622	3.622
Total Drug Resources by Decision Unit	$135.178	$138.105	$177.477
Drug Resources Personnel Summary			
Total FTEs (direct only)	171	171	171
Drug Resources as a Percent of Budget			
Agency Budget	$ 6,236.279	$ 6,777.986	$ 9,268.023
Drug Resources Percentage	2.17%	2.04%	1.91%

[1] Adult Treatment funds are excluded from the ONDCP Drug Control Budget and Moyer Anti-Drug Abuse methodologies because this program reflects the original authorized program for IHS with the sole focus of alcoholism treatment services for adults. This determination was made in consultation with ONDCP when the drug control budget was initially developed in the early - 1990s.

MISSION

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing Federal health services to American Indian and Alaska

Native (AI/AN) people. IHS supports substance abuse treatment and prevention services as part of this mission.

METHODOLOGY

The IHS includes the appropriation for Alcohol and Substance Abuse (excluding the amount designated as Adult Alcohol Treatment) and the portion of Urban Indian Health funds that partially come from the National Institute on Alcohol Abuse and Alcoholism programs transferred to the IHS under the Urban Indian Health budget.

BUDGET SUMMARY

In FY 2023, IHS requests $344.7 million which is an increase of $86.3 million over the FY 2022 Enacted level for its drug control activities.

Alcohol and Substance Abuse
FY 2023 Request: $344.7 million

In FY 2023, the IHS budget request for its drug control activities supports the Office of National Drug Control and Policy (ONDCP) funding priorities as well as the ONDCP *Strategy*. The *Strategy* emphasizes the partnership between Federal agencies and their state, local, tribal, and international counterparts and reduce drug-induced mortality. IHS is also working with Federal partners to implement ONDCP's efforts to address the current opioid crisis and reduce the number of American's dying from dangerous drugs.

The Administration's ONDCP *Strategy* guides and expands Federal government efforts to: 1) expand access to evidence-based treatment; 2) advancing racial equity issues in our approach to drug policy; 3) enhancing evidence-based harm reduction efforts; 4) supporting evidence-based prevention efforts to reduce youth substance use; 5) reducing the supply of illicit substances; 6) advancing recovery-ready workplaces and expanding the addiction workforce; and, 7) expanding access to recovery support services. The *Strategy* offers a valuable opportunity for IHS to advance its mission by strengthening existing programs to control and reduce substance use and eliminate its deleterious effects on the health and safety of AI/AN patients and communities.

The IHS Alcohol and Substance Abuse program serves AI/ANs impacted by substance use disorders through IHS, Tribal, and Urban Indian operated treatment and prevention programs and Youth Regional Treatment Centers (YRTCs).

The IHS established a multi-disciplinary workgroup to form the IHS National Committee on Heroin, Opioids, and Pain Efforts (HOPE). The HOPE Committee is comprised of a multidisciplinary membership to include clinical representation from family medicine, pharmacy, behavioral health, nursing, pediatrics, physical therapy, epidemiology, and injury prevention. The HOPE Committee work plan supports the HHS 5-Point Strategy to Combat the Opioid Crisis with a specific focus on: 1) better pain management; 2) improving access to culturally relevant prevention, treatment, and recovery support services; 3) increasing availability and distribution of opioid overdose reversing drugs; and, 4) improved public health data reporting and surveillance.

In addition to direct services, the IHS Alcohol and Substance Abuse grant and federal award program supports the IHS Strategic Plan *Goal 2, Objective 2.2 to provide care to better meet the health care needs of AI/AN communities and Goal 1 to ensure comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people.*

Particularly, in the prevention, treatment, and recovery of alcohol and substance use disorders (SUD).

The IHS Division of Behavioral Health administers community-based grants that promote the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to substance misuse from a community-driven context. In particular, the IHS Opioid Grant Program and the Substance Abuse and Suicide Prevention program will support the IHS Strategic Plan *Goal 1, Objective 1.2 to build, strengthen, and sustain collaborative relationships and Objective 1.3 to increase access to quality health care services*.

Expanding Access to Evidence-Based Treatment:

Increasing Access to MAT Services: In June 2019, IHS released the Special General Memorandum *Assuring Access to MAT* that requires federal IHS facilities create an action plan to identify or create local medication assisted treatment resources and coordinate patient access to these services when indicated.[1] Key components of these approaches include enhanced screening and early identification of Opioid Use Disorders; improved care coordination and patient referral for treatment; and workforce development strategies to increase education and resources surrounding using medications in the support of recovery. In addition, the IHS created workforce development strategies that include SUD training for healthcare workers and technical assistance materials to support sites with creating integrated SUD approaches to care.

The IHS does face challenges in providing MAT in certain sectors within Indian Country. The rural and frontier nature of where AI/ANs live creates barriers to accessing health facilities. This is especially evident in Alaska where patients often only have access to a community health aide serving within a village-based clinic, hours away by plane and from a larger health center. Additionally, IHS has felt the impact of a declining supply of specific health professionals who could support the IHS workforce and address behavioral health needs. The IHS recognizes that telemedicine is one tool for increasing access to specialized medical services, such as MAT. The IHS has published a policy in the Indian Health Manual (Chapter 38) entitled *Internet Eligible Controlled Substance Prescriber Designation* to assure access to MAT using telemedicine models for remotely located Tribal members.[2] In December 2019, the IHS processed the first tribal clinician application to receive this designation.

IHS Opioid Grant Program: In FY 2021, IHS awarded a total of $16 Million in grants to combat the opioid crisis. IHS awarded thirty-five grants under the Community Opioid Intervention Pilot Project (COIPP) for AI/ANs targeted at opioid specific activities. These grants support the development of innovative, locally-designed, culturally-appropriate prevention, treatment, recovery, and aftercare services for opioid use disorders. The projects will focus on increasing public awareness and education about the impact of OUD on individuals, families and communities; and create comprehensive support teams to strengthen and empower families addressing the opioid crisis. Finally, all projects will prioritize efforts to reduce unmet needs and opioid overdose deaths through increased access to MAT. The IHS COIPP is a three-year program and part of the Department of Health and Human Services' five-point strategy to fight the opioid overdose epidemic in America.

[1] https://www.ihs.gov/ihm/sgm/2019/assuring-access-to-medication-assisted-treatment-for-opioid-use-disorder/

[2] https://www.ihs.gov/ihm/pc/part-3/chapter-38-internet-eligible-controlled-substance-provider-designation/

IHS Substance Abuse and Suicide Prevention (SASP): The SASP is a nationally-coordinated grant program (formerly referred to as the Methamphetamine and Suicide Prevention Initiative (MSPI)) which focuses on substance abuse and suicide prevention providing intervention resources targeted to Tribes, Tribal programs, and Urban Indian communities with the greatest need for these programs. Due to the COVID-19 pandemic, the majority of the 174 SASP projects reduced and/or ceased activities. Only a limited number of projects continued to operate and did so according to their local, state, and federal guidelines for COVID-19 by modifying in-person activities to virtual events. In June 2020, the IHS requested and received a 1-year extension for all SASP grants from the Department of Health and Human Services (DHHS) due to the impact of COVID-19. The new end date for all SASP grants was September 29, 2021.

The goals of the current SASP program are to:

1. Increase IHS, Tribal, and Urban (I/T/U) capacity to operate successful substance abuse prevention, treatment, and aftercare and/or suicide prevention, intervention, and postvention services through implementing community and organizational needs assessment and strategic plans;
2. Develop and foster data sharing systems among I/T/U behavioral health service providers to demonstrate efficacy and impact;
3. Identify and address suicide ideations, attempts, and contagions among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, intervention, and postvention strategies;
4. Identify and address substance use among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, treatment, and aftercare strategies;
5. Increase provider and community education on suicide and substance use by offering appropriate trainings; and
6. Promote positive AI/AN youth development and family engagement through the implementation of early intervention strategies to reduce risk factors for suicidal behavior and substance use.

SASP projects were awarded funding in at least one of four purpose areas and work to address the corresponding SASP goal listed above. SASP Purpose Areas are:

1. Community Needs Assessment and Strategic Planning;
2. Suicide Prevention, Intervention, and Postvention;
3. Substance Use Prevention, Treatment, and Aftercare; and
4. Generation Indigenous (Gen-I) Initiative Support.

All projects funded have a training objective to increase and expand the types of healthcare providers trained in SUD screening, assessment or treatment, including Brief Intervention and Motivational Interviewing. Projects also seek to hire additional behavioral health staff (i.e., licensed behavioral health providers and paraprofessionals, including but not limited to peer specialists, mental health technicians, and community health aides) specializing in child, adolescent, and family services. These new staff will be responsible for implementing project activities that address all of the required objectives listed. As with other IHS Behavioral Health Initiatives, these funded projects support ONDCP's efforts to *advance recovery-ready workplaces and expanding the addiction workforce.*

Successful outcomes during the fourth year of the program include expanded behavioral health services offered through school settings and home visiting with a total of 1,475 patients receiving care. Over 270 providers were trained in behavioral health integration with 163 of those

providers located within a primary care setting. Project accomplishments include 67,168 individuals screen for suicide ideation, 54 percent of the SASP program suicide prevention projects implemented an enhanced process for suicide screening, and over 11,003 community members have been trained in suicide and/or substance use prevention. Fifty-three percent of projects hosted a successful prevention education community event. Twenty-nine percent reported implementation and documentation of a system change. In addition, among projects supported, a total of 76,054 individuals received cultural services, a high percentage of projects have continued to offer integrated traditional healing into care, extended service hours, provision of follow-up care, new counseling and case management services. In summary, the SASP program continues to support tribes, tribal organizations, urban Indian organizations (UIOs), and federal facilities offering care.

Preventing Alcohol-Related Deaths (PARD): In the 2017 Senate Appropriations Committee Report 114-281, the Committee directed IHS to "allocate $2,000,000 of the increase provided for the alcohol and substance abuse program to fund essential detoxification and related services." Specifically, in the report the number of alcohol related deaths in the community of Gallup, New Mexico was addressed with the report stating, "these deaths underscore the urgent need for substance abuse treatment, residential services and detoxification services" in this community. In response, the IHS used the increased appropriated funds to address the urgent need in the city of Gallup, New Mexico. In addition to Gallup, New Mexico, IHS was aware of the urgent need for alcohol detoxification services in the Great Plains Area after the removal of liquor licenses and alcohol sales in White Clay, Nebraska, leading to the potential for increased mortality if services were unavailable for alcohol detoxification. As a result, funds were also made available to address this urgent need. The funds provided to Gallup, New Mexico and the Great Plains Area (specifically the Oglala Sioux Tribe) to address the need for social detoxification services were made available in FY 2017 through a competitive cooperative agreement. The funding announcement was released in FY 2017 and two projects were selected and funded. The project period is for five years and will run from September 15, 2017, to September 14, 2022. With the additional funding, the Gallup NM site reported detoxification services to 9,482 unique individuals with over 75 percent of those clients including males. In addition to services offered for monitoring, supervising and managing detoxification, this site has increased coordination and transportation with the Emergency Department; and established a contract with the Gallup Police Department to transport patients to the detoxification center. The Great Plains' site has used the funding to increase coordination with behavioral health programs, provide screenings and brief interventions to individuals incarcerated in jails, and serve as an immediate placement for individuals who are in need of treatment services following detoxification. In FY 2020, nearly 100 percent of individuals held in detoxification for more than two weeks were successfully admitted into a higher level of residential treatment care for their SUD.

During the COVID-19 pandemic, services were temporarily interrupted at the City of Gallup detoxification site, and the Great Plains Area PARD site. IHS continues to work with both sites to ensure each has adopted guidelines provided by the local and state health departments, and the CDC for continued operations for detoxification programs.

Supporting Evidence-Based Prevention Efforts to Reduce Youth Substance Use:

IHS SASP - Generation Indigenous (Gen-I): Of the 174 SASP projects funded, 19 projects specifically focus on substance use prevention, treatment, and aftercare, while 107 focus on substance use and suicide prevention among Native youth. IHS established the Universal Alcohol Screening (UAS) as a national measure to increase screening and improve detection and intervention strategies among patients' ages 9 through 75 years of age. In FY 2021, 31.1 percent

of eligible patients were screened for risky alcohol use, which is less than the IHS target of 39.0 percent.

Youth Regional Treatment Centers: The IHS YRTCs provide residential substance abuse and mental health treatment services to AI/AN youth. Congress established these YRTCs in each of the 12 IHS Areas, with two (northern and southern) specifically authorized for the California Area. The YRTC in Northern California is expected to be operational in early 2021. The 12 currently funded YRTCs provide quality holistic behavioral health care for AI/AN adolescents that integrate traditional healing, spiritual values, and cultural identification. In FY 2021, all federal YRTCs in operation 18 months or longer have achieved and maintained accreditation status. In response to the challenges YRTCs experienced to maintain facility operations, YRTCs partnered with the IHS, SAMHSA's Office of Tribal Affairs and Policy and the Addiction Technology Transfer Center (ATTC) Network Coordinating Office to identify and develop response and recovery resources specific to YRTCs continuity of care. The document "Guidance for Caring for Patients in Youth Regional Treatment Centers During the COVID-19 Pandemic" was developed to support the delivery of care among the YRTCs during this ever-evolving situation.[3]

YRTC Aftercare Pilot Project: Two YRTC facilities, Desert Sage and the Healing Lodge of the 7 Nations are in the last year of an IHS supported aftercare pilot project. YRTCs have an important role in maintaining the health of patients after discharge. This aftercare pilot emphasizes developing culture-based treatment that prevents alcohol and substance abuse relapse among youth discharged. While evaluations are in place, current data indicates that these programs have resulted in improved coordination around aftercare and case management, increased training of community supports for the adolescents, improved identification of transitional living, increased awareness of the use of social media, and improved follow-up with data collection after discharge. This pilot program will continue to support the YRTC's ability to support the IHS Strategic Plan *Goal 1 to ensure comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people. The YRTC Aftercare Pilot Project supports the Strategy's efforts to expand access to recovery support.* Particularly, in the recovery from alcohol and substance use disorders.

The DOI through the Bureau of Indian Affairs (BIA) and the Bureau of Indian Education (BIE), and the IHS have a Memorandum of Agreement (MOA) on Indian Alcohol and Substance Abuse Prevention, which was amended in 2011 as a result of the permanent reauthorization of the Indian Health Care Improvement Act. Through this MOA, BIA, BIE, and IHS coordinate and implement plans in cooperation with Tribes to assist Tribal governments in their efforts to address behavioral health issues. The MOA includes coordination of data collection, resources, and programs of IHS, BIA, and BIE.

The Tribal Law and Order Act (TLOA) requires interagency coordination and collaboration among HHS (IHS and SAMHSA), DOI (BIA/BIE), DOJ (Office of Justice Programs/Office of Tribal Justice), and the Office of the Attorney General. The coordination of Federal efforts and resources will assist in determining both the scope of alcohol and substance abuse problems as well as effective prevention and treatment programs. The MOA required by Section 241 of the TLOA was signed on July 29, 2011, by the Secretaries of the Departments of Health and Human Services, the Interior and the Attorney General to: (1) determine the scope of the alcohol and substance abuse problems faced by Tribes; (2) identify and delineate the resources each entity can

[3] https://attcnetwork.org/sites/default/files/2020-08/YRTC_Document_08_05_20.pdf

bring to bear on the problem; (3) set standards for applying those resources to the problems; and (4) coordinate existing agency programs.

Enhancing Evidence-Based Harm Reduction Efforts:

The IHS has expanded access to harm reduction interventions that include increased access to the opioid overdose reversal medication, naloxone. Since 2015, the IHS has maintained an ongoing collaboration with the Bureau of Indian Affairs (BIA) to train and provide naloxone to BIA Law Enforcement Officers (LEO) for responding to opioid overdoses. These initial efforts have evolved into a robust harm reduction strategy that includes a combination of policy and workforce development efforts. In March 2018, the IHS implemented a policy in the Indian Health Manual (Chapter 35) entitled *Prescribing and Dispensing of Naloxone to First Responders* to require IHS federal pharmacies to provide naloxone to Tribal law enforcement agencies and other trained first responders. A revision to Chapter 35 was released in 2020 to further expand first responder definitions to community members and to reduce administrative reporting requirements related to requests for resupply. The IHS has also created a naloxone toolkit for tribal communities that includes a culturally responsive training video and a digital story from two LEOs involved in a naloxone 'save'. This toolkit also contains a train the trainer curriculum and standardized forms to support first responder initiatives. The IHS has also created sample protocols and pharmacist collaborative practice agreements to expand access to co-prescribed naloxone for patients on long-term opioid therapy or at increased risk for opioid overdose. In November 2019, the IHS developed and released a health education video that shared best and promising practices surrounding naloxone distribution and the way IHS and the Red Lake Nation are responding to the opioid crisis. A companion video was released in August 2020 that shares basic information related to opioids, naloxone, treatment and prevention.

The IHS has further adapted the toolkit and strategy to equip community first responders and paraprofessionals with training on opioid overdose response and naloxone. These expanded collaborations with local law enforcement and community first responders resulted in an initial pilot community-health naloxone train-the-trainer program to include naloxone distribution.

In August 2019, ninety-six community-health workers completed training as naloxone trainers for their tribal communities in one week.

In FY 2018, buprenorphine and suboxone were added to the IHS Core Formulary. Buprenorphine and suboxone are common medications used to treat opioid use disorder. With these added to the Core Formulary, all IHS facilities with pharmacies have these medications readily available for their patients. Data related to buprenorphine and suboxone will be captured in reporting tools that will support regional-level efforts to better monitor MAT and SUD treatment across IHS.

The strategic goal is to support Tribal programs and UIOs in their continued substance abuse prevention, treatment, and infrastructure development. These efforts represent an innovative partnership with IHS to deliver services developed by the communities themselves, with a national support network for ongoing program development and evaluation.

Substance use disorders continue to rank high on the concern list of Tribal partners. IHS believes that a shift in emphasis to earlier intervention is required to be successful in reducing the consequences of substance use disorders. IHS proposes focusing on early intervention with adolescents and young adults and preventing further progression by recognizing and responding to the source of the abuse.

IHS continues to support the integration of substance use disorder treatment into primary care and emergency services through its activities to implement the *Strategy*. Integrating treatment services into outpatient primary care offers opportunities for healthcare providers to identify patients with substance use disorders, provide them with medical advice, help them understand the health risks and consequences, and refer patients with more severe substance use-related problems to treatment.[4] One integration activity is Screening, Brief Intervention, and Referral to Treatment (SBIRT), which is an early intervention and treatment service for people with substance use disorders and those at risk of developing these disorders.

IHS has increased efforts to implement the SBIRT across IHS facilities as an evidence-based practice to identify patients with alcohol related problems. The SBIRT is a Government Performance and Results Act (GPRA) measure that IHS reports annually. In FY 2021, the SBIRT was administered at 14.3 percent for AI/AN ages 9-75, exceeding the target of 15.8 percent screened. IHS promotes the use of this clinical process by training providers in clinical and community settings. IHS currently offers 10 SBIRT on-demand trainings. SBIRT is intended to meet the public health goal of reducing the harms and societal costs associated with risky use by reducing diseases, accidents, and injuries. As an additional resource, IHS developed an Alcohol and Substance Abuse Program webpage: https://www.ihs.gov/asap/providers/sbirt/.

The IHS requires all prescribers to conduct a full patient medical history and physical examination including review of the patient's current psychosocial status, any history of mental health or substance abuse concerns, and assessment for relevant signs of misuse or abuse of substances. Examination is done at the time of consideration of use of chronic opioid therapy and periodically during active pain management treatment. Patient screening surveys and urine drug tests are helpful in determining the risk of opioid misuse and guiding the frequency of ongoing monitoring. Screening surveys are incorporated into the triage/nurse screening process prior to seeing the clinician. IHS developed a Pain Management website: https://www.ihs.gov/painmanagement/substancescreening/.

Patients treated for SUD often present with a need to address co-occurring mental disorders. In FY 2017, the IHS Division of Behavioral Health awarded 12 new grantees through the Behavioral Health Integration Initiative (BH2I), a nationally-coordinated grant program that provides funding to Tribes, Tribal organizations, UIOs and federal facilities to plan, develop, implement and evaluate behavioral health integration with primary care. A primary goal of the BH2I is to formalize integration across the system, develop care teams, strengthen infrastructure, and enhance clinical processes including increased depression screenings in primary care clinics. Additionally, IHS contracted with a technical assistance (TA) provider to guide this pilot project through the implementation of their integrated care efforts with expertise from psychiatrists, primary care physicians, and social workers. Thus far, BH2I projects have reported successes such as new behavioral health integration policies and procedures including same day access to behavioral health providers within primary care and emergency room settings. Sites have also reported increased screening rates for depression, anxiety, trauma and early childhood development disabilities and reduction in wait times to see a mental health counselor and psychiatrist. In response to the COVID-19 pandemic, these efforts were extended into FY 2021, providing additional time in the project period to complete proposed activities with a focus on meeting the needs of the community and developing sustainability plans.

[4] ONDCP. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.

In FY 2022, IHS will award approximately 15 new BH2I grantees on a five-year funding cycle. Additionally, IHS will contract with a technical assistance provider to assist grantees with the implementation of integrated care efforts.

While screenings remain critical to ensure that appropriate health services are available to AI/AN population, IHS acknowledges the importance of understanding a patient's life experiences in order to deliver effective care and improving treatment adherence. In FY 2020, IHS released a trauma informed care policy to provide guidance to Indian Health Service facilities to improve patient engagement and improve health outcomes as well as supporting provider and staff wellness. IHS continues to implement the principles of trauma informed care to ensure its system understands the prevalence and role of trauma in patient care. In FY 2021, IHS released 13 Trauma Informed Care on-demand trainings which included 211 attendees. These efforts ensure comprehensive, culturally appropriate services are provided and support the *Strategy's* priority to *advance racial equity issues in our approach to drug policy.*

In FY 2022, IHS will support the new trauma informed care policy by developing on-demand online training for clinical and non-clinical staff. This training will provide guidance to IHS facilities in delivering trauma-informed care services along with promoting self-care to prevent secondary traumatic stress, which can lead to compassion fatigue and burnout.

Reducing the Supply of Illicit Substance:

Increase Mandatory Prescriber Education and Continuing Training on Best Practices and Current Clinical Guidelines: The IHS implemented the "Chronic Non-Cancer Pain Management Policy" to promote appropriate pain management as a primary prevention tool. In February 2018, IHS released a revised policy to include clinical practice guidelines contained in the 2016 *CDC Guideline for Prescribing Opioids for Chronic Pain*. This revised policy adopts CDC guidance and specifically requires IHS sites to establish and implement local chronic non-cancer pain protocols and procedures; requires prescribers to complete training on appropriate and effective use of controlled substance medications; and establishes the requirement to initiate opioid treatment as a shared decision between the prescriber and the patient to respect and support the patient's right to optimal pain assessment and management.

Substance Use Disorder and Chronic Pain Case Consultation Services: To provide ongoing clinical support for providers, IHS, in partnership with the University of New Mexico Pain Center, provided a Substance Use Disorder and Chronic Pain ECHO. ECHO is a case-based learning model in which consultation is offered through virtual clinics to healthcare providers by an expert team to share knowledge and elevate the level of specialty care available to patients. In FY 2021, a total of 20 ECHO sessions were offered with over 748 attendees.

In May 2019, the IHS released its "*Recommendations for Management of Acute Dental Pain*" for prescribing opioids for acute pain secondary to common general dentistry conditions and procedures. These guideline limit opioid prescribing for patients who cannot safely use alternative pain medication. The guidelines also include a decision tree for pre- and post-operative pain management, as well as recommended dosage limits for analgesics based on the degree of anticipated operative pain. The IHS collaborated to create content for a five-part CEU webinar series to influence dental prescribing practices and enhance screening for substance use disorders in general dentistry.

The IHS has also implemented IHM Chapter 32 "State Prescription Drug Monitoring Programs" that establishes policy requirement for Federal facilities to participate with state-based

Prescription Drug Monitoring Programs (PDMP). Controlled substance prescribers working in IHS federal-government-operated facilities must query state PDMP databases prior to prescribing opioids for pain treatment longer than seven days and periodically throughout chronic pain treatment. In FY 2019, IHS developed and released software programming to automate controlled substance dispensing reports to state-based PDMPs to near real-time reporting to improve the fidelity of IHS dispensing data in state PDMP databases. The IHS has been in preliminary planning and design discussions to evaluate feasibility of PDMP interoperability and integration into the IHS Electronic Health Record. These efforts support the IHS Strategic Plan *Goal 3, Objective 3.3 Modernize information technology and information systems to support data driven decisions.*

In March 2019, the IHS released the *Recommendations to the Indian Health Service on American Indian/Alaska Native Pregnant Women and Women of Childbearing Age with Opioid Use Disorder* developed in collaboration with the American College of Obstetricians and Gynecologists' (ACOG) Committee on American Indian and Alaska Native Women's Health.[5] This resource will help providers improve maternal participation in early prenatal care, improve screening for substance use disorder, and increase access to MAT for pregnant women and women of child-bearing age. The goal of these clinical recommendations is to foster relationships and improve awareness surrounding trauma-informed approaches to maternal opioid use that may lead to recovery, hope, and healing. Additionally, the IHS and the American Academy of Pediatrics Committee on Native American Child Health (CONACH) recently released the *Recommendations to the Indian Health Service on Neonatal Opioid Withdrawal Syndrome* that includes clinical recommendations on the prevention and management of neonatal opioid withdrawal syndrome.[6] These recommendations provide standards of care for screening, diagnosing, support, and treatment of pregnant mothers and infants affected by prenatal opioid exposure. In August 2019, the IHS developed and released two additional Clinical Reporting System measures to track implementation of the ACOG recommendations and substance use disorder screening in women of childbearing age.

Proper Pain Management and Opioid Stewardship Training: The IHS has created and released a comprehensive Opioid Stewardship workbook to assist sites with creating best practices surrounding safe opioid prescribing recommendations and increasing access to integrative pain treatments. The workbook emphasizes utilizing opioid surveillance strategies to evaluate population health outcomes, target opioid interventions, enhance clinical decision support, and create professional practice evaluation strategies. In August 2022, IHS completed data definitions to support creation of an opioid prescribing surveillance dashboard that will assist with the analysis of opioid-related data at the local and regional levels. The IHS opioid stewardship program evaluation considers metrics that evaluate trends in Morphine Milligram Equivalents versus a restricted focus on total opioid prescription fills, include analysis of risk reduction strategies with co-prescribed naloxone, and monitor patient conversion to chronic opioid therapy. These efforts support the IHS Strategic Plan *Goal 3, Objective 3.3 Modernize information technology and information systems to support data driven decisions.*

The IHS has also recently facilitated dedicated access to tele-consultation services for IHS clinicians to receive on-demand substance use expert recommendations and tailored clinical guidance for IHS healthcare providers of all experience levels. This service is also available to assist IHS health systems with creating clinic policies and procedures to support creation of integrated MAT services in IHS facilities.

[5] https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/acogguidelines2018.pdf

[6] https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/aapnowsrecommendationstoihs.pdf

In May 2016, the IHS implemented a policy on mandatory opioid training requiring all federally controlled substance prescribers to complete the "IHS Essential Training on Pain and Addiction" with required refresher training every 3 years. This training is now available on demand with continuing education credits. The IHS released its Refresher training course in January 2018, including four sessions of its mandatory five-hour training course for providers on proper opioid prescribing. In FY 2021, 276 new clinicians completed this course. The mandate also includes an additional refresher training after three years. In FY 2021, 327 participants completed the Essential Training on Pain and Addiction Refresher course. This course will be updated in FY 2021.

The IHS has also created a robust workforce development strategy to include didactic training. In September 2019, the IHS launched its Pain Management and Opioid Use Disorder Continuing Medical Education series. The IHS has hosted learning sessions in this series that include buprenorphine prescribing in pregnancy as well as a live instructor-led auricular acupuncture-training program, implementation of MAT programs, management of co-occurring disorders, and initiating Buprenorphine in the acute care setting. Future session include an intensive training program related to the management of substance use disorders for advanced practice pharmacists and additional content surrounding integrated MAT models.

In FY 2021, IHS provided three webinars that addressed pain management, opioids, and opioid misuse with a total of 179 attendees.

- Treatment of OUD in the ED, Should it be a Choice?
- Opioid Management in Primary Care: An Integrated Approach
- Novel Buprenorphine Induction Strategies

Enhanced communication during the opioid crisis response is vital to program development, policy implementation, and ongoing evaluation. The IHS created an Opioid Information Sheet that serves as a public-facing logic model to share opioid-related measure, agency goals, and available resources for both clinicians and tribal stakeholders. The IHS opioid strategy and a host of available resources is housed on two IHS webpages that support a unified user experience in addition to publication of a quarterly opioid newsletter.

The IHS collaborated in FY 2018 with the CDC to participate in the CDC Opioid Quality Improvement Collaborative to implement five opioid quality improvement measures at four IHS sites. Communication to employees and stakeholders involving best and promising practices and resources addressing pain management and addiction is achieved through our expanded internet presence. The IHS released a combined website for opioids in FY 2018 located at: www.ihs.gov/opioids.

In August 2020, the IHS released new clinical decision support tools for RPMS to assist providers in meeting documentation standards outlined in IHM, Part 3 – Chapter 30. The EHR reminders and dialogue note templates facilitate accurate and timely documentation to support patient care and the pain management policy. The tools also address OIG findings from a recent IHS prescribing review.

Increase Prescription Drug Monitoring Program (PDMP) Interoperability and Usage: The IHS is working to improve public health data surveillance and reporting and has developed a data reporting system that will provide prescribing and diagnosis data on national and regional levels. This will enable IHS to track emerging trends, evaluate changes in prescribing practices, monitor

overdose rates and emergency department utilization, and assess changes with access to MAT. The IHS will evaluate expanded partnerships and data-related resources with other Federal partners and Tribal Epidemiology Centers in FY 2019. These reporting and surveillance tools will strengthen IHS program management and operations by improving communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public Strategic Plan Goal 3, Objective 3.1 *Improve communication within the organization, Tribes, Urban Indian Organizations, and other stakeholders, and with the general public*.

The IHS National Combined Councils Meeting (NCC) is an agency wide meeting which provides opportunities for multidisciplinary collaboration focusing on the clinical and administrative needs of the agency. This meeting offers an opportunity to provide continuing education trainings for healthcare providers, and previous session topics typically include: 1) Addressing the Opioid Crisis in Indian Country, 2) Exploring Best Practices in Chronic Pain Management, and 3) Evaluating Options for Creating and Sustaining Integrated Primary Care MAT Models. IHS also provided a 4.25-hour training, titled "Prescriber Data Waiver Training." This training session assist participants with meeting the SAMHSA and DEA requirements to apply for a DATA waiver to prescribe buprenorphine in the treatment of opioid use disorder. Due to the COVID-19 pandemic, the 2021 NCC was held virtually with a limited agenda however IHS plans to resume NCC in-person meetings and trainings in FY 2022.

Reducing Availability of Illicit and Dangerous Drugs: The IHS supports the safe and effective disposal of unused pharmaceuticals at the enterprise level through the provision of reverse distributor services at Federal pharmacies for unopened expired controlled substances. The agency has participated in interagency efforts to support proper collection and disposal of pain medications.

I/T/U pharmacies have continued to enroll as DEA collectors and to participate in prescription drug disposal efforts. IHS collaborated with the State of North Dakota to achieve 100 percent of IHS sites in the state (both Federal and Tribal) to be registered as DEA collectors. In FY 2019, the IHS expanded patient level disposal through the addition of 29 Federal Pharmacy sites as registered DEA controlled substance collectors. This included funding for supplies and technical assistance with DEA requirements.

On the IHS pain management website, IHS provides resources for tribal and urban Indian communities on Take-Back Event, Permanent Collection Sites, Mail-Back Programs and Environmentally Safe Options from Home. The website also has two sessions focused on safe storage of medications and medication disposal for providers on proper opioid disposal. https://www.ihs.gov/painmanagement/disposal/patientdisposal/

Urban Indian Health Program – Alcohol and Substance Abuse Title V Grants
FY 2023 Request: $3.6 million

The 41 UIOs are an integral part of the Indian health care system and serve as resources to both tribal and urban communities. Urban Indians are often invisible in the urban setting and face unique challenges when accessing healthcare. A large proportion of Urban Indians live in or near poverty and face multiple barriers such as the lack of quality and culturally relevant health care services in cities. UIOs are an important support to Urban Indians seeking to maintain their tribal values and cultures and serve as a safety net for our urban patients. UIOs that offer inpatient and outpatient substance use disorder treatment have become reliable referral sites for Tribes and Urban Indians. In FY 2023, IHS is proposing $3.6 million for the urban ONDCP budget.

AI/AN people who live in urban centers present a unique morbidity and mortality profile. Urban AI/AN populations suffer disproportionately higher mortality from certain causes in sharp contrast to mainstream society. These unique challenges require a targeted response. Existing UIOs see their efforts in health education, health promotion, and disease prevention as essential to impacting the behavioral contributors to poor health[7]:

- Alcohol-induced death rates are 2.8 times greater for urban AI/AN people than urban all races.
- Chronic liver disease death rates are 2.1 times greater for urban AI/AN people than urban all races.
- Accidents and external causes of death rates are 1.4 times greater for urban AI/AN people than urban all races.

Alcohol and drug-related deaths continue to plague urban AI/AN people. Alcohol-induced mortality rates for urban AI/AN people are markedly higher than for urban all races. All regions, with the exception of eastern seaboard cities in the Nashville Area, show dramatically higher rates for urban AI/AN people than for urban all races who live in the same communities: the Billings Area is 4 times greater, the Phoenix Area is 6 times greater, the Tucson Area is 6.7 times greater, and the Great Plains Area has a 13.4 times greater alcohol-induced rate of mortality.[8]

Urban AI/AN populations are more likely to engage in health risk behaviors. Urban AI/AN people are more likely to report heavy or binge drinking than all-race populations and urban AI/AN people are 1.7 times more likely to smoke cigarettes. Urban AI/AN people more often view themselves in poor or only fair health status, with 22.6 percent reporting fair/poor health as compared to 14.7 percent of all races reporting as fair/poor.

Fetal alcohol spectrum disorders is a term used to describe a range of effects that can occur in someone whose mother consumed alcohol during pregnancy. Fetal alcohol spectrum disorders include disorders such as fetal alcohol syndrome, alcohol-related neuro developmental disorder, and alcohol-related birth defects. Interventions are needed in urban centers to address prevention efforts for urban AI/AN people with fetal alcohol spectrum disorders. The IHS policy requires the IHS to confer with UIOs “to develop and implement culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol spectrum disorders clinics for use in Indian communities and urban centers." Heavy drinking during pregnancy can cause significant birth defects, including fetal alcohol syndrome. Fetal alcohol syndrome is the leading and most preventable cause of intellectual disability. The rates of fetal alcohol syndrome are higher among AI/AN people 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 fetal alcohol syndrome.

The UIOs emphasize integrating behavioral health, health education, health promotion, and disease prevention into primary care offered within a culturally appropriate framework, which leads to positive outcomes for urban AI/AN people. Urban AI/AN people in need of substance use disorder treatment commonly exhibit co-occurring disorders. UIOs have recognized the need for more mental health and substance use disorder counselors to adequately address the needs presented by AI/AN people with co-occurring disorders. Stakeholders reported the need for more age and gender-appropriate resources for substance use disorder outpatient and residential

[7] Indian Health Service, Report to Congress: New Needs Assessment of the Urban Indian Health Program and the Communities it Services at 10 (Mar. 31, 2016) (hereinafter New Needs Assessment), available at https://www.ihs.gov/urban/includes/themes/newihstheme/display_objects/documents/ReportToCongressUrbanNeedsAssessment.pdf.
[8] Ibid.

treatment. While male AI/AN people can encounter wait times for treatment admission up to six months, treatment options for youth, women, and women with children can be greater than six months. Some of the most successful AI/AN treatment programs for youth, women, and women with children are administered by UIOs. Affecting lifestyle changes among urban AI/AN families requires a culturally sensitive approach. UIOs have operated culturally appropriate initiatives to reduce health risk factors. The continued efforts of UIOs to target behavioral or lifestyle changes offer the best hope for impacting the major health challenges of the urban AI/AN population.

The IHS has contracts and grants with 41 UIOs to provide health care and referral services for Urban Indians in 22 states. These IHS contracts and grants with UIOs address the *IHS Strategic Plan Goal 1 by ensuring that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people.* UIOs provide high quality, culturally relevant prevention, early intervention, outpatient and residential substance abuse treatment services, and recovery support to address the unmet needs of the Urban Indian communities they serve. Social determinants of health play a key role in health and wellness and UIOs are addressing a range of factors which contribute to improved health outcomes.

According to the most recent urban Indian data, 76,760 AI/AN patients access services through UIO programs. Also, UIOs performed 729,888 visits for AI/AN patients including medical, dental, behavioral health, other professional and enabling services directly or by paid referral. Data also indicates that members from 529 of the 574 (92 percent) federally recognized Tribes accessed services from at least one of the 41 UIOs.

In FY 2021, the IHS Office of Urban Indian Health Programs awarded 4-in-1 grants to 33 UIOs. The grantees are awarded for a three-year funding cycle from April 1, 2019 - March 31, 2022. These grants provide funding to UIOs to make health care services more accessible for AI/ANs residing in urban areas. Funding is used to support four health program areas: health promotion and disease prevention services; immunization services; alcohol and substance abuse related services; and mental health services. Grantees are required to participate in a national evaluation of the 4-in-1 grant program, which addresses *IHS Strategic Plan Goal 2 to promote excellence and quality through innovation of the Indian health system into an optimally performing organization*. The national evaluation includes reporting on the cultural interventions integrated into the 4-in-1 program activities, and practice based and evidence based approaches that are implemented or modified to meet the needs of the Urban Indian service population.

Many of the grantees reported interruptions/changes with their programs due to the COVID-19 pandemic:

- Many clinics run by UIOs had to temporarily close because they did not have the resources to provide a safe visit experience.
- Nearly all UIOs reported expanding telehealth services.
- There was an increase in demand for substance abuse and mental health treatment due to elevated levels of anxiety and stress.
- All non-essential in-person activities were halted.
- Many programs across various UIOs were switched to a virtual format. Some activities, such as a back-to-school health fair, were transitioned to be a drive-thru process.
- Despite the importance of many of these virtual services, many clients that UIOs serve lack internet capabilities, creating a significant barrier to accessing services.

- Elders expressed less desire in meeting virtually.

EQUITY

Alcohol and Substance Abuse

In FY 2023, the IHS budget request for its drug control activities supports the Office of National Drug Control and Policy (ONDCP) funding priorities as well as the ONDCP *Strategy*. The *Strategy* emphasizes the partnership between Federal agencies and their state, local, tribal, and international counterparts and reduce drug-induced mortality. IHS is also working to improve equity and reduce barriers to substance use disorder (SUD) treatment and services. In May of 2020, IHS released a trauma informed care policy to provide guidance to Indian Health Service facilities to improve patient engagement and improve health outcomes as well as supporting provider and staff wellness. In 2021, IHS established a multidisciplinary workgroup to create and sustain a culture of physical, psychological, and emotional safety for all individuals and staff that have experienced trauma. In additional, many of the IHS Division of Behavioral Health SUD programs and initiatives include objectives such as "Increasing Access to Care" and "Increasing Access to Medication-assisted Treatment." Understanding the urgent need to the prioritize specific populations such as children and youth, and their families as appropriate in SUD prevention, treatment and recovery efforts, IHS will require each of the Substance Abuse and Suicide Prevention (SASP) grantees to develop culturally-appropriate approaches to engage youth in prevention and treatment activities. IHS recognizes that telemedicine is one tool for increasing access to specialized medical services, such as telebehavioral health. To that end, IHS provided a 23 percent increase in telebehavorial health encounters nationally among AI/AN between FY 2020 and FY 2021. Finally, as resource to AI/AN healthcare providers, IHS hosted Clinician Extension for Community Healthcare Outcomes (ECHOs) sessions to provide, timely, up-to-date information related to emerging SUD treatment and services among rural and remote AI/AN communities.

Urban Indian Health Program

In FY 2021, the OUIHP leveraged the IHS Office of Public Health Support's Indefinite Delivery Indefinite Quantity (IDIQ) contract to develop a new 5-year IHS OUIHP strategic plan. On December 3, 2021, the IHS initiated urban confer to seek input and recommendations on the new strategic plan to improve access to high quality, culturally competent health services for Urban Indians, which addresses IHS Strategic Plan Goal 2 to promote excellence and quality through innovation of the Indian health system into an optimally performing organization. In FY 2022, the expectation is to evaluate the existing OUIHP strategic plan and establish a new strategic plan, including goals, strategies and performance measures based on recommendations from UIOs, partners, and external stakeholders.

On December 27, 2020, the Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260) (hereinafter "the Act") was signed into law. The Act provided the Indian Health Service (IHS) with a total FY 2021 appropriation of $6.4 billion. The Joint Explanatory Statement for Division G for the Act designated $1,000,000 to conduct an infrastructure study for facilities run by Urban Indian Organizations (UIOs). The infrastructure study provides the first step towards creating a comprehensive action plan to focus on improving equity and reduce barriers to programs and services, which addresses IHS Strategic Plan Goal 1 to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people. In FY 2021, the IHS initiated urban confer to seek input on developing

and implementing the infrastructure study from UIOs. In FY 2022, the IHS awarded a contract to The Innova Group to conduct the infrastructure study to identify future facility needs of UIOs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2023 Performance Budget Submission to Congress

TABLE OF CONTENTS

Supplemental Tables

INDIAN HEALTH SERVICE
Budget Authority by Object

	FY 21 Final	FY 22 Enacted	FY 23 Pres Bud	FY 2023 +/- FY 2022
[Object Class]				
Personnel compensation:				
Full-time permanent (11.1)	$419,146	$540,464	$619,367	$78,903
Other than full-time permanent (11.3)	$16,046	$21,401	$24,205	$2,805
Other personnel compensation (11.5)	$81,983	$101,453	$115,934	$14,481
Military personnel (11.7)	$78,701	$100,424	$117,638	$17,214
Special personnel services payments (11.8)	$347	$412	$412	$0
Subtotal personnel compensation	**$596,222**	**$764,154**	**$877,557**	**$113,403**
Civilian benefits (12.1)	$192,848	$246,755	$282,447	$35,692
Military benefits (12.2)	$11,855	$14,800	$18,285	$3,485
Benefits to former personnel (13.0)	$38	$41	$41	$0
Subtotal Pay Costs,	**$800,964**	**$1,025,751**	**$1,178,331**	**$152,580**
Travel and transportation of persons (21.0)	$21,983	$26,877	$33,338	$6,461
Transportation of things (22.0)	$6,445	$7,235	$10,931	$3,696
Rental payments to GSA (23.1)	$14,968	$17,274	$30,445	$13,171
Rental payments to others (23.2)	$9,746	$8,352	$8,602	$250
Communication, utilities, and misc. charges (23.3)	$20,163	$25,483	$37,291	$11,807
Printing and reproduction (24.0)	$53	$63	$85	$22
Other Contractual Services:				
Advisory and assistance services (25.1)	$7,355	$197,726	$308,233	$110,507
Other services (25.2)	$159,610	$213,528	$394,023	$180,495
Purchase of goods and services from government accounts (25.3)	$90,095	$127,956	$238,521	$110,564
Operation and maintenance of facilities (25.4)	$3,373	$17,989	$25,078	$7,089
Research and Development Contracts (25.5)	$0	$0	$0	$0
Medical care (25.6)	$194,649	$240,615	$322,559	$81,944
Operation and maintenance of equipment (25.7)	-$2,740	$82,382	$224,223	$141,841
Subsistence and support of persons (25.8)	$40,214	$46,647	$64,134	$17,487
AP Branch Services (25.9)	$107,945	$126,904	$132,611	$5,707
Subtotal Other Contractual Services	**$673,859**	**$1,139,033**	**$1,830,073**	**$691,041**
Supplies and materials (26.0)	$53,302	$62,443	$138,150	$75,707
Equipment (31.0)	$3,163	$16,304	$33,761	$17,456
Land and Structures (32.0)	$2,184	$3,400	$5,464	$2,063
Investments and Loans (33.0	$0	$0	$0	$0
Grants, subsidies, and contributions (41.0)	$4,026,435	$4,383,440	$6,081,611	$1,698,172
Insurance payments (42.0)	$173	$211	$223	$12
Interest and dividends (43.0)	$24	$28	$28	$0
Refunds (44.0)	-$1	-$1	-$1	$0
Unvouchered (91.0)	$344.04	$377	$382	$5
Subtotal Non-Pay Costs	**$4,759,484**	**$5,605,235**	**$8,089,692**	**$2,484,457**
Total Direct Obligations	**$5,560,448**	**$6,630,986**	**$9,268,023**	**$2,637,037**

Salary and Expenses INDIAN HEALTH SERVICE (Budget Authority in Thousands)			
Object Class	FY 2021 Final Level	FY 2022 Enacted Level	FY 2023 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$419,146	$540,464	$619,367
Other than full-time permanent (11.3)	$16,046	$21,401	$24,205
Other personnel compensation (11.5)	$81,983	$101,453	$115,934
Military personnel (11.7)	$78,701	$100,424	$117,638
Special personnel services payments (11.8)	$347	$412	$412
Subtotal personnel compensation	$596,222	$764,154	$877,557
Civilian benefits (12.1)	$192,848	$246,755	$282,447
Military benefits (12.2)	$11,855	$14,800	$18,285
Benefits to former personnel (13.0)	$38	$41	$41
Subtotal Pay Costs	$800,964	$1,025,751	$1,178,331
Travel (21.0)	$21,983	$26,877	$33,338
Transportation of things (22.0)	$6,445	$7,235	$10,931
Communication, utilities, and misc. charges (23.3)	$20,163	$25,483	$37,291
Printing and reproduction (24.0)	$53	$63	$85
Other Contractual Services:			
Advisory and assistance services (25.1)	$7,355	$197,726	$308,233
Other services (25.2)	$159,610	$213,528	$394,023
Purchase of goods and services from government accounts (25.3)	$90,095	$127,956	$238,521
Operation and maintenance of facilities (25.4)	$3,373	$17,989	$25,078
Research and Development Contracts (25.5)	$0	$0	$0
Medical care (25.6)	$194,649	$240,615	$322,559
Operation and maintenance of equipment (25.7)	-$2,740	$82,382	$224,223
Subsistence and support of persons (25.8)	$40,214	$46,647	$64,134
Subtotal Other Contractual Services	$492,556	$926,844	$1,576,771
Supplies and materials (26.0)	$53,302	$62,443	$138,150
Subtotal Non-Pay Costs	$594,502	$1,048,945	$1,796,565
Total Salary and Expenses			
Rental Payments to GSA(23.1)	$14,968	$17,274	$30,445
Rental Payments to Others(23.2)	$9,746	$8,352	$8,602
Grant Total, Salaries & Expenses and Rent	$1,420,180	$2,100,322	$3,013,943
Direct FTE 1/	8,692	9,350	10,149

1/ Reflects staff paid for only within Indian Health Services and Indian Health Facilities Accounts.

INDIAN HEALTH SERVICE
Detail of Full-Time Equivalents (FTE)

	FY 2021 Final	FY 2022 Estimate	FY 2023 Estimate
Headquarters			
Sub-Total, Headquarters	701	731	767
Area Offices			
Alaska Area Office	291	303	318
Albuquerque Area Office	1,053	1,098	1,152
Bemidji Area Office	568	592	621
Billings Area Office	1,009	1,052	1,104
California Area Office	155	162	170
Great Plains Area Office	2,158	2,249	2,360
Nashville Area Office	188	196	206
Navajo Area Office	4,210	4,388	4,605
Oklahoma City Area Office	1,788	1,864	1,956
Phoenix Area Office	2,654	2,766	2,903
Portland Area Office	519	541	568
Tucson Area Office	251	262	275
Sub-Total, Area Offices	14,844	15,472	16,235
TOTAL FTES[1]	15,545	16,203	17,002

[1] Total does not include Trust Funds FTEs (21)

INDIAN HEALTH SERVICE

DETAIL OF POSITIONS

(Dollars in Thousands)

	FY 2021 Final	FY 2022 Enacted	FY 2023 President's Budget
Total - ES	24	23	21
Total - ES Salaries	$4,453	$4,493	$4,534
GS/GM-15	492	512	538
GS/GM-14	440	459	481
GS/GM-13	610	636	668
GS-12	1,417	1,479	1,553
GS-11	1,498	1,561	1,639
GS-10	602	627	658
GS-9	1,135	1,184	1,242
GS-8	465	485	509
GS-7	1,358	1,416	1,485
GS-6	1,640	1,709	1,793
GS-5	1,951	2,033	2,133
GS-4	924	963	1,011
GS-3	137	142	149
GS-2	25	26	28
GS-1	0	0	0
Subtotal	12,694	13,233	13,889
Total - GS Salaries	$656,520	$842,572	$965,183
CO-08	3	3	3
CO-07	7	7	8
CO-06	276	288	302
CO-05	479	499	524
CO-04	525	547	574
CO-03	266	277	291
CO-02	8	8	9
CO-01	8	8	9
Subtotal	1,572	1,639	1,719
Total - CO Salaries	$90,556	$115,224	$135,923
Ungraded	1,255	1,308	1,373
Total - Ungraded Salaries	$49,417	$63,419	$72,648
Average ES level	ES	ES	ES
Average ES salary	$178	$184	$187
Average GS grade	8	9	9
Average GS salary	$66	$67	$68

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2023 Performance Budget Submission to Congress

TABLE OF CONTENTS

Significant Items in Committee Reports

Payment for Tribal Leases – The bill includes language establishing an indefinite appropriation for payment of Tribal leases under section 105(1) of the Indian Self-Determination and Education Assistance Act, which are estimated to be $101,000,000 in fiscal year 2021. The new account provides additional budget authority to fully fund such costs without the need for reprogramming, if actual costs exceed the current estimate. IHS is reminded of the directive to continue to seek a longer-term solution, as contained in the explanatory statement accompanying Public Law 116-94. Further direction is provided in the bill under Title IV of this division. (pg. 80)

Action taken or to be taken:
The FY 2023 President's Budget proposes to shift funding for Tribal Lease Payment and Contract Support Costs to an annual mandatory indefinite appropriation.

- Section 105(l) Lease Agreements. In March 2016, the Maniilaq Association v. Burwell decision established a new funding entitlement for Tribal contractors and compactors as authorized by section 105(l) of the ISDEAA. The court ruled that the Secretary must compensate reasonable costs to each Tribe or Tribal organization who enters into a section 105(l) lease agreement. The court also prohibits IHS from capping funding under section 105(l) at the level that IHS would have otherwise spent to operate a facility if it were carrying out the health programs.

    - In FY 2021, Congress enacted an indefinite discretionary appropriation to fully fund these costs. An indefinite discretionary appropriation allows IHS to fund section 105(l) lease agreements at the actual total funding need for the fiscal year, aligning the budget to the court decisions in Maniilaq Association v. Burwell. This funding mechanism avoids the need to redirect funding that IHS would otherwise use to provide direct services to Tribes.

    - These costs are more appropriately funded from mandatory appropriations, consistent with other indefinite authorities.

Current Services. - The Committee expects the Service to continue including current services estimates for Urban Indian health in annual budget requests. (p. 80)

Action taken or to be taken:
The FY 2023 Congressional funding request for Current Services is $207,070,000, which would fully fund pay cost, inflation, and population growth needs for IHS, Tribal, and urban Indian health programs in FY 2023. Please see the detailed Current Services request below:

Sub Activity	FY 2023 Current Services Estimate			
	Pay Total	**Inflation Total**	**Population Growth 1.8%**	**Current Services Total**
SERVICES				
Hospitals & Health Clinics	65,609	7,607	41,843	115,059
Electronic Health Record	0	0	0	0
Dental Services	6,659	626	3,791	11,076
Mental Health	2,631	349	1,961	4,941
Alcohol & Substance Abuse	4,075	790	4,421	9,286
Purchased/Referred Care	291	8,577	17,367	26,235
Indian Health Care Improvement Fund	913	312	1,301	2,526
Total, Clinical Services	80,178	18,261	70,684	169,123
Public Health Nursing	2,703	290	1,656	4,649
Health Education	589	63	370	1,022
Comm. Health Reps	1,281	252	1,132	2,665
Immunization AK	0	9	38	47
Total, Preventive Health	4,573	614	3,196	8,383
Urban Health	1,561	403	1,038	3,002
Indian Health Professions	6	523	0	529
Tribal Management	0	20	0	20
Direct Operations	2,603	156	0	2,759
Self-Governance	162	22	0	184
Total, Other Services	4,332	1,124	1,038	6,494
Total, Services	89,083	19,999	74,918	184,000
FACILITIES				
Maintenance & Improvement	0	931	3,041	3,972
Sanitation Facilities Constr.	2	1,382	3,484	4,868
Health Care Fac. Constr.	0	603	0	603
Facil. & Envir. Hlth Supp.	7,131	1,141	4,716	12,988
Equipment	0	134	506	640
Total, Facilities	7,133	4,191	11,747	23,071
TOTAL, IHS	**96,216**	**24,190**	**86,665**	**207,071**

Accreditation Emergencies – The Committee has heard complaints that not all funds appropriated for accreditation purposes are being distributed. Thus, the Committee continues to expect IHS to submit, within 90 days of enactment of this Act, a full accounting of the funds provided for accreditation emergencies in fiscal years 2018, 2019, 2020, and 2021, including the amount and purpose of funds allocated to each facility.

The Committee is concerned about financial losses from loss of CMS accreditation or of the requirement to divert patients at Service-operated facilities. The Committee considers the loss or imminent loss of accreditation to be an emergency. Funds allocated to a facility may be made available to Tribes newly assuming operation of such facilities pursuant to the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA) and shall be used by such Tribes to cover replacement of third-party revenues lost as a result of decertification, replacement of third-party carryover funds expended to respond to decertification, and reasonable costs of achieving recertification, including recruitment costs necessary to stabilize staffing.

Additionally, the Committee continues to urge IHS to develop new strategies to improve how IHS programs, including those operated by Tribes under ISDEAA, can be supported to avoid these challenges and to refocus on both the quality of health care delivery and the improvement in health outcomes for, and health status of, Indian health program beneficiaries. This requires full Tribal consultation and the participation of the Department of Health and Human Services, CMS, CMS Innovation, and State Medicaid and State Children's Health Insurance programs.

Action taken or to be taken:
Since our last response to this report language in the FY 2021 and FY 2022 Congressional Justifications, the IHS has taken a number of steps to develop and implement new strategies to avoid future accreditation challenges.

FY 2022 Activities to Date:

- **Strategic Plan Implementation**. The IHS Strategic Plan FY 2019-2023 provides the framework on how the IHS will achieve its mission (to raise the physical, mental, social, and spiritual health of AI/AN to the highest level) through three Goals, eight objectives, and 70 strategies. To monitor implementation of the framework, the Office of Quality (OQ) created a site that allows for IHS Area and Headquarter (HQ) Office reporting into a centralized location, the Strategic Plan Activity Repository (SPAR). Area and HQ offices select high bar activities to include in the SPAR. These activities are updated quarterly (or more frequently depending on office use of the SPAR) and tied to a strategy. The IHS Strategic Plan has focused IHS programs and activities on improving quality, safety, and sustained compliance across the IHS healthcare system. To date in FY22, 342 total activities from Areas and HQ offices are currently tied to the IHS Strategic Plan, all 12 Areas and 12 HQ offices have contributed activities and updates.
- **Current Accreditation Status**. The IHS has supported facilities in all 12 IHS Areas to achieve and maintain The Joint Commission (TJC) and Accreditation Association for Ambulatory Health Centers (AAAHC) accreditation standards and Centers for Medicare and Medicaid (CMS) regulations for IHS Hospitals, Health Centers, Behavioral Health facilities, and Critical Assess Hospitals (CAH).
    - In FY22, as of March 25, there have been 16 successful surveys by TJC (including TJC Lab surveys), AAAHC, and CMS completed at facilities.
    - The IHS has also directed that all ambulatory care facilities attain Patient Centered Medical Home (PCMH) designation by the end of calendar year 2022.
        - In FY22, eight facilities have attained PCMH designation.
- **Credentialing and Privileging**. The IHS monitors the credentialing and privileging system and continuously optimizes its functions.
    - To date in FY22, the IHS is 96% complete with an initial phase of standardization.
- **Safety Tracking & Response**. The IHS Safety Tracking & Response (I-STAR), a system for reporting adverse events, is fully implemented across the Agency. The IHS monitors the system and is continuously optimizing its functions. In FY22, as of December 2021 events were reported

in I-STAR from 135 facilities and 32 Tribal facilities. These sites entered 5,172 events with 1,746 medication good catch events entered. After an event is entered into I-STAR, relevant users are notified and events are investigated by the facility or Service Unit I-STAR investigator.

- **Infection Prevention and Control**. The IHS continues to provide infection prevention and control activities.
    - In FY22, the Infection Control and Prevention (ICP) program completed an Infection Control Assessment and Response (ICAR) at a Nashville Area YRTC as part of a project that provided (77 total) COVID-19 infection control assessments at IHS and Tribal facilities in partnership with the Centers for Disease Control and Prevention (CDC). Additional ICARs can be requested by IHS, tribal, and urban Indian organizations. The ICP coordinated with the Organization for Safety Asepsis and Prevention (OSAP) to secure tribal and Urban Indian Organization scholarships for the annual OSAP Dental Infection Control Bootcamp which was held in January 2022. In total, 14 tribal scholarships were awarded and participants will be able to describe disease transmission and principles of infection prevention and control in a variety of oral health care settings; identify relevant infection control laws, regulations, guidelines, standards, and best practices; and, utilize tools to assist with quality assurance measures.

FY 2021 Activities:

- **Accreditation Support**. In FY21, survey and PCMH designation outcomes include:
    - 100 percent of all IHS hospitals and CAHs have achieved and maintained CMS conditions of participation, 21 of 24 hospitals and CAHs have TJC accreditation.
    - 29 of 30 of IHS health centers are accredited by TJC or AAAHC. The one health center not accredited does not provide the services required to obtain accreditation.
    - 16 of 24 IHS Hospitals and Critical Access Hospitals have PCMH designation, of these facilities are awaiting TJC survey that is overdue due to the delay in survey activity due to the COVID-19 Public Health Emergency.
    - 28 of 30 established health centers have achieved PCMH designation. Two facilities are awaiting TJC accreditation survey that are overdue due to the delay in survey activity due to the COVID-19 Public Health Emergency.
- In August 2020, the Labor and Delivery Service at Phoenix Indian Medical Center (PIMC) was temporarily closed due to safety concerns arising from facility infrastructure, equipment, and challenges with staffing. PIMC contracted for an intensive Joint Commission Resources Review in September 2020 as well as an internal review by the IHS Chief Clinical Consultant for Obstetrics on September 17-18. Both reviews focused on facility deficiencies, equipment deficiencies, infection control, OB Triage, and interdisciplinary teamwork. To support addressing concerns identified in these reviews, IHS engaged a contractor to provide accreditation support and review care provided by the Obstetrics Department at PIMC. The contractor conducted a review of IHS operations at PIMC, provided a gap analysis, and then worked with IHS leadership and management to provide training and mentoring, providing training, sharing best practices and conducting a mock survey to test PIMC's readiness for an accreditation survey. In October 2021, TJC conducted an announced survey of PIMC, which resulted in reaccreditation. Without Accreditation Emergencies Funding, PIMC would have been forced to curtail some patient services to afford this level of support for their operations.
- **Credentialing and Privileging**. In FY21, the OQ continues to improve the IHS credentialing and privileging process through the implementation of Applied Statistics & Management, Inc. (ASM) Products credentialing and privileging software which is being used in 11/12 Areas to facilitate the hiring and ongoing monitoring of qualified

practitioners. The Alaska Area is pending implementation by tribal facilities, the Area does not have any direct service sites. The OQ provides technical assistance through training and support to Areas and facilities for ASM use and promotes the transition to 100 percent paperless. The OQ is also facilitating a quality improvement project for standardization. The system completes a monthly check on an average of 3,000 active medical staff provider credentials, flagging any negatively changed items and to date has processed nearly 2,459 initial appointment and reappointment applications. An initial phase of standardization is at 95 percent implementation across all IHS areas. In FY21, standardization increased from 54 percent to 95 percent (over 40 percent increase), there were 858 initial applications, 2,791 reappointment applications, 141,445 total verifications, and 21,785 MD-Staff reports generated. As of December 2021, the system continues to process user Logins, virtual Committee Reviews, MD-App Initial Applications, and MD-App - Reappointment Applications.

- **Safety Tracking & Response**. In FY21, events were reported in I-STAR from 172 facilities and 42 Tribal facilities. 20,668 events were entered with 7,637 medication good catch events entered. In FY 21, the OQ began holding regular office hours and provided 37 Q&A sessions; modified I-STAR to allow for enhanced reporting and collection of data for sexual assault and worker COVID-19 vaccine ADRs; developed back-up forms for user use during I-STAR downtimes; developed an IHS Medication Safety Dashboard that includes 13 standard reports commonly used for reporting medication errors to Area Governing Boards; added three new facilities as I-STAR users; developed a new I-STAR profile to help Tribal I-STAR users to review and close events; developed and disseminated five I-STAR Updates to provide an overview of use and education tips to help users; developed and posted 13 new job aides to assist users; added 33 new drugs to the I-STAR formulary; and, migrated non-patient safety data from WebCident to I-STAR.
- **Infection Prevention and Control.** The IPC program drafted the IHS Indian Health Manual Infection Control and Prevention (Chapter 33), the purpose of the chapter is to establish infection control and prevention program policies, procedures, and responsibilities required for ensuring a comprehensive ICP program exists in all IHS health care facilities and Service Units. An ICP program is required to meet and maintain readiness with applicable healthcare accreditation standards. The IHS manages the ICP listserv with 312 I/T/U users that regularly distributes infection prevention and control resources, updates and provides expert technical assistance across the health system. In FY21, the IHS conducted 43 ICAR assessments at IHS and Tribal facilities.

Electronic Health Record – The Committees recognize the need for a new electronic health record system to improve the overall interoperability, efficiency, and security of the Service's information technology system. The Committees also note that the Service has not completed directives on this topic included in previous fiscal years and solicited in hearings. The Committees direct the Service to report back within 120 days of enactment of this Act with a list of Tribes that currently maintain their own non-RPMS electronic health record systems along with cost estimates required for those Tribes to implement, maintain, and make any necessary upgrades to these systems. Further directions and limitations on expenditures are provided in the bill. The Committees understand that many Tribes recently upgraded their systems to be compatible with the new Veterans Affairs' system, and that these systems must be compatible with any new IHS system to the maximum extent practicable. It is the Committees' expectation that the Service will be able to use the compiled information gathered during this recent effort with Veterans Affairs to inform both the Service and the Committees on which Tribes use their own system and the estimated costs. (p. 78-79)

Action Taken or to be Taken:
On January 13, 2022 IHS submitted a report to the Committee, Tribal Health Programs Electronic Health Reports Systems, as requested in the Explanatory Statement which accompanied the Consolidated Appropriations Act, 2021.

Unfunded IHCIA Provisions. - It has been over nine years since the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), yet many of the provisions in the law remain unfunded. Tribes have specifically requested that priority areas for funding focus on diabetes treatment and prevention, behavioral health, and health professions. The Committee requests that the Service provide, no later than 90 days after enactment of this Act, a detailed plan with specific dollars identified to fully fund and implement the IHCIA. (pg. 132)

Action taken or to be taken:
The Indian Health Care Improvement Act (IHCIA) is the cornerstone legal authority for the provision of health care to American Indian and Alaska Natives. The authorization was made permanent as part of the Patient Protection and Affordable Care Act (P.L. 111-148) on March 23, 2010.

The IHCIA includes a number of authorizations, and a list of those sections is included in Appendix A. Estimating the cost of fully funding those provisions would be a significant endeavor, requiring significant tribal consultation and urban confer. It would also be a resource intensive process that would likely require additional appropriations to conduct appropriately.

However, the IHS has several existing methodologies of estimating funding need that can be used as a proxy to estimate the funding needed for the various authorized sections of the IHCIA. Those measures include:

- Indian Health Care Improvement Fund Workgroup Interim Report. The 2018 Indian Health Care Improvement Fund Formula identified a total funding need of over $11 billion for health care and related services to American Indians and Alaska Natives after taking into account the FY 2018 IHS appropriation. This estimate does not take into account facilities funding needs, or funding needs for major projects, like Electronic Health Record modernization. (Microsoft Word - IHCIF Interim Report_Final June 2018 (ihs.gov)
- Indian Health Service and Tribal Health Care Facilities' Needs Assessment. Every five years, the IHS transmits the *Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*. This report describes the comprehensive, national, ranked list of all health care facilities needs for the IHS, Indian tribes, and tribal organizations. The most recent version of this plan was completed in FY 2016 (https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf , and identifies a $14.5 billion funding need for health care facilities in Indian Country.
    - This estimate includes the $2.1 billion needed to complete the 1993 Health Care Facilities Construction Priority List.
    - It also includes the top 5 Tribally-prioritized facility types newly authorized in the IHCIA, listed below. These five facility types total $4.3 billion of the $14.5 billion total.
        - Inpatient mental health/behavioral health and alcohol substance abuse program facilities,
        - Long-term care facilities – Clinical,
        - Long-term care facilities – Non-clinical,
        - Specialty Medical Services facilities, and
        - Dialysis facilities.

- Annual Report on Sanitation Deficiency Levels for Indian Homes and Communities. Each year, the IHS transmits the *Annual Report on Sanitation Deficiency Levels for Indian Homes and Communities to Congress* (Annual Report To the Congress of the United States On Sanitation Deficiency Levels for Indian Homes and Communities Fiscal Year 2018 (ihs.gov). The information in this report to Congress is used by the Indian Health Service (IHS) to establish budgetary funding requests and to allocate funding resources received. Additionally, the United States (U.S.) Environmental Protection Agency (EPA), the U.S. Department of Agriculture Rural Development, and the U.S. Department of the Interior's Bureau of Reclamation utilize the information contained in this report to aid in the implementation of their programs that support tribal water, sewer, and solid waste infrastructure. At the end of year (EOY) 2021, the Feasible Project Cost Estimate from the IHS Sanitation Deficiency System (SDS) totals $1 billion, and the total cost of all projects in the SDS is over $3.3 billion. The EOY 2021 SDS project listing will be used to identify projects that will be funded with funding appropriated to the IHS through the Infrastructure, Investment and Jobs Act (IIJA). The IIJA appropriates $700 million in each year from FY 2022 – FY 2026, for a total of $3.5 billion for the IHS Sanitation Facilities Construction (SFC) program. These resources are available until expended, for the provision of domestic and community sanitation facilities for Indians, as authorized.
- Backlog of Essential Maintenance and Repair (BEMAR). The IHS maintains and regularly updates the BEMAR for IHS and Tribal health programs. The total BEMAR as of October 1, 2021 is $1,022 million.

Alzheimer's — The Committee expects IHS to work with the Health Resources and Services Administration in the development of any training curriculum. Finally, the Committee directs IHS to prepare and submit a report to the Committee describing the incident rates of Alzheimer's among AI/AN and access to services within IHS-funded programs.

In addition, the Committee is concerned that IHS-funded facilities are not adequately prepared for the expected increase in Native patients with Alzheimer's. Therefore, the Committee directs IHS, in consultation with Indian Tribes and Urban Indian Organizations (UIOs), to develop a plan to assist those with Alzheimer's, the additional services required, and the costs associated with increasing Alzheimer's patients and submit this information to Congress within 270 days of enactment of this Act.

Action taken or to be taken:

- The IHS hosted Tribal Consultation and Urban Confer with Tribes and Urban Indian Organizations on the approach to address the impact of Alzheimer's disease and related dementias and on the best use of this funding. That consultation began on March 31 and concluded on June 1, 2021. The IHS issued the joint Dear Tribal Leader and Dear Urban Indian Organization Leader Letter that formally closes out that process on March 24, 2022. We have incorporated the consultation received throughout the process in our program development which will be reflected in the 2021 funding appropriation plan for the Alzheimer's Grant Program. The IHS will use this data to inform the Report to Congress.
- The IHS is working with the CDC on an analysis of IHS data that indicates the impact and burden of Alzheimer's disease and related dementias among AI/AN and access to services within IHS-funded programs. The IHS is in the process of gathering data to quantify the impact of Alzheimer's on AI/AN people, additional services needed, and costs associated with care of IHS beneficiaries living with Alzheimer's disease and their caregivers.
- The IHS has engaged with HRSA to explore training curriculum. The HRSA Core Curriculum in Dementia provides a comprehensive set of on-line modules with training guides. https://bhw.hrsa.gov/alzheimers-dementia-training. The IHS has made this available to IHS, Tribal, and Urban Indian health providers through a link on our website and will continue to discuss with

HRSA opportunities for further curriculum development, including curriculum specific to IHS, Tribal, and Urban Indian Health. The IHS will also work with HRSA and the HRSA-funded Geriatric Workforce Enhancement Program (GWEP) awardees with a focus on outreach and engagement with IHS, Tribal, and Urban Indian Health programs to identify training opportunities for Indian Health.

- In addition, the IHS has engaged with the CDC-funded NYU BOLD Public Health Center for Excellence on Early Detection of Dementia to develop a strategy and resources to support improved detection of dementia leading to effective care.
- The IHS and Alzheimer's Association is in the final stages of establishing an MOU to identify areas of collaboration to address and improve the health and well-being of American Indians and Alaska Natives living with Alzheimer's disease and all other dementias and their caregivers.

Green Infrastructure. - The Committee directs IHS to submit a report to the Committee within 90 days of enactment of this Act explaining how it proposes to use the funds provided for green infrastructure and renewable energy.

Action taken or to be taken:
The IHS will support the following green infrastructure activities with the $5 million provided in the Consolidated Appropriations Act, 2021:

- **Funded with GI FY21**
    - Southcentral Foundation LED Conversion for Building 119,
    - Southcentral Foundation LED Conversation for Building 122,
    - Village Clinic Energy Retrofits,
    - Prairie Band Potawatomi Nation Solar and Water Project,
    - Pascua Yaqui Tribe Lighting, Solar Water Heater, and Solar Energy Project,
    - Parker Energy Renovation,
    - Pechanga Indian Health Clinic Solar Energy Project,
    - MCAT Health Board Carport Solar Energy Project,
    - Cass Lake Geothermal Energy Project, *(Partial Funded)*

Urban Indian Organization. - Similar to Indian country, the coronavirus pandemic is showcasing the need for infrastructure at UIO facilities. Within funds provided, the recommendation includes $1,000,000 for IHS to confer with UIOs, conduct a study on UIO infrastructure needs and to prepare a report on the study to Congress. The Committee directs IHS to complete urban confer with UIOs within 120 days of enactment of this Act. The study and report shall be completed within one year after completion of urban confer with UIOs. Within 30 days of completion of the study and report, the Committee expects IHS to submit the report to the Committee.

Action taken or to be taken:
Urban confer was held on July 22, 2021 and a contractor was chosen for the UIO Infrastructure Study. The Innova Group was contracted to conduct the UIO Infrastructure Study and preliminary activities began February 2022. Estimated completion date for the study is January 2023.

Indian Health Professions -Within amounts provided, the Committee expects IHS to continue the Quentin N. Burdick American Indians Into Nursing Program, the Indians into Medicine Program, and the American Indians Into Psychology Program at enacted levels. The Committee heard complaints about the numerous steps and delays in processing scholarship and loan repayment applications to the point that some medical professionals have turned down IHS positions to accept other positions. As a result, the

Committee directs IHS to review its processes and timeliness in reviewing and approving applications and submit a report within 180 days of enactment of this Act to the Committee on how IHS can streamline the application process and expedite its review processes. The Committee directs IHS to report to the Committee specifying the types of scholarship, loan repayment programs, and other incentives for which Commission Corps officers are eligible. IHS should highlight any incentive programs directed towards those officers who work in Indian Country. (Pg. 131)

Action taken or to be taken:
This request applies to multiple programs and services within the IHS. The IHS fully supports the continuing administration of the Quentin N. Burdick American Indians Into Nursing Program, the Indians into Medicine Program, and the American Indians Into Psychology Program. The IHS Scholarship and Loan Scholarship Program application processing timeline is separate from the hiring of medical personnel. The IHS continues to partner with the U.S. Public Health Service Commissioned Corps to commission and onboard new Commissioned Officers and optimize special pays through the Commissioned Corps for which an Officer may be eligible.

The reviewing and approving applications for the IHS Scholarship Program (SP) has no impact on the hiring process because the recipients are not medical professionals. The IHS SP funds health care professions students entering into their educational career. Students are awarded funding each semester of school by the Program. Scholarship recipients are unable to apply for positions because they are not licensed and trained healthcare professionals. Once they finish the program, and become licensed, they receive the highest priority in IHS to secure a position. In addition, IHS works closely with the Scholars prior to graduation to assist them in securing a position.

The hiring process of medical personnel is separate and not dependent on the IHS Loan Repayment Program (LRP) award process. IHS LRP applicants must be employed in an eligible Indian health program first, in order to be considered for an award. Medical personnel must submit employment verification from an eligible/approved facility when applying. The LRP application cycle is open year around. Awards are made with available funding from January –August each year.

The timeline to administer the program and fund recipients is based on a fully funded budget for the fiscal year. In recent years, partially approved budgets have delayed the program's ability to fund recipients in January. All recipients that applied and met the program requirements in FY 2021 were funded. If a health care professional was not funded, it was because they did not find a suitable assignment prior to applying to the program that met their personal or professional needs.

U.S. Public Health Service (USPHS) Commissioned Corps Officers have various incentives depending on the discipline. Incentives for USPHS Commissioned Corps Officers include, but not limited to: Health Professions Special Pay (HPSP), Assignment Pay and National Health Service Corps (NHSC) Loan Repayment program, and the IHS Loan Repayment Program..

Electronic Dental Record. - The Committee is concerned that the entire $2,000,000 provided in fiscal year 2020 was not directed towards EDR at additional dental centers. Therefore, the Committee directs IHS to submit an accounting of fiscal year 2020 funds and expects IHS to use the fiscal year 2021 funds only for EDR. In addition, IHS is directed to expand its efforts in planning and developing greater data and information exchange between the IHS EHR system and the EDR system.

Action taken or to be taken:
This matter was addressed in the FY 2022 CJ to illustrate inclusion of expanded EDR Implementation and Upgrade Support at Indian Health Service/Tribal/Urban (I/T/U) Sites. The +$2 million for the Electronic Dental Record appropriated in the Consolidated Appropriations Act of 2020, and the

Consolidated Appropriations Act of 2021 were used only for the Electronic Dental Record and were not distributed as tribal shares.

FY 2020 funds supported ($2 million total):

- New Electronic Dental Record Implementation at 9 I/T/U Sites ($906,000)
- Electronic Health Record Program Enhancements, including key consent forms, quality review, and other reports ($615,000)
- Electronic Dental Record Upgrade Support for 64 I/T/U sites ($400,000)
- Other activities including developing new Electronic Dental Record technology and training ($79,000)
- The FY 2020 activities include some base resources, in addition to the +$2 million increase.

FY 2021 funds supported ($2.5 million total):

- New Electronic Dental Record Implementation at 13 I/T/U Sites ($1.1 million)
- Electronic Dental Record Upgrade Support for 66 I/T/U sites ($800k) (38 sites were T/U)
    - Additional funding enabled no 'shared cost' to the clinics; thus higher 'per site' upgrade cost for FY 2021)
- Electronic Health Record Program Enhancements, including Dentrix Provider Clinical Notes transition to EHR; Dentrix scanned document QA review; and Quality of Care review reports ($500,000)
- Other activities including developing new Electronic Dental Record technology and additional Dentrix to EHR interfaces ($100,000)
- The FY 2021 activities include some base resources, in addition to the +$2.5 million increase.

FY 2022 funds are supporting ($2.5 million):

- New Electronic Dental Record Implementation at 9-11 I/T/U Sites ($1.1 million)
- Electronic Dental Record Upgrade Support for 90 I/T/U sites ($1.25 million)
- Electronic Health Record Program Enhancements, including charting, note taking, and additional patient quality of care review enhancements ($150,000)
- Other activities including developing additional new Electronic Dental Record technology and training ($200,000).

The FY 2022 expenditures are estimates as EDR funding resources are prioritized to meet the greatest needs of the IHS I/T/U clinics and these essential EDR activities always require additional DHP base resources in addition to the +$2.5 million.

H.R. 116-448/S.R. 116-123 Language. - IHS is expected to comply with the instructions and requirements at the beginning of this division and in House Report 116-448, unless otherwise specified below. Language contained in Senate Report 116-123 regarding the Alaska Comprehensive Forensic Training Academy, first aid kit enhancements, prescription drug monitoring, and teledermatology is restated.

Action taken or to be taken:
This matter was addressed in the FY 2022 CJ. IHS provided a list of all IHS facilities with pharmacies and released PDMP reporting software that reports to state PDMPs automatically, when a prescription is filled, in near real time.

First Aid Kit Enhancements - The use of hemostatic dressings is an element of the standard of care in the initial management of trauma patients and should be included, along with basic education around the

use of such materials, as standard equipment for rural EMS and ED inventories. IHS will provide a recommendation to IHS, tribal, and Urban facilities for EMS and ED to consider adding these materials for EMS and ED use. (See CJ-229)

Prescription Drug Monitoring. - Although there is no federal law requiring IHS to report to state PDMPs, in June of 2016 IHS implemented Indian Health Manual Part 3 Chapter 32 "State Prescription Drug Monitoring Program", which requires all IHS federal pharmacies to report controlled prescriptions to their respective state PDMPs.

Currently all IHS Federal Facilities, with pharmacies, report to the state PDMP, in the state where they are located. In addition, in May 2019, IHS released PDMP reporting software that reports to state PDMPs automatically, when a prescription is filled, in near real time. In 2021, the IHS allocated funding to support PDMP interoperability within the IHS EHR. Software and connectivity architecture are currently under development. (See CJ-299)

IHS does not track the participation of Tribally-operated health facilities with State PDMPs.

Teledermatology - Less than 10 percent of all dermatologists practice in rural areas while 40 percent practice in the 100 densest US areas. According to the American Academy of Dermatology, the ideal dermatologist to population ratio is 3.5 per 100,000 (although the appropriate ratio has never been validated) and the mean dermatologist to population ratio of rural counties is 423 per 100,000 people. However, 88 percent of rural counties have zero dermatologists. The 26 Native American majority counties have no dermatologists.

The IHS has considered potential options for expanding tele-dermatology. One cost-effective solution could be to expand the tele-dermatology capacity of the Phoenix Indian Medical Center as well as leveraging private dermatologists who are willing to provide tele-dermatology services pro bono. Long-term solutions like targeted recruiting efforts, and the purchase of mobile high definition cameras would likely require additional resources. (see CJ-302)

Maternal Health. - Pregnancy-related deaths have increased generally in the United States with pregnancy-related deaths for American Indian and Alaska Native women more than twice the non-Hispanic white women rate. The Committee directs IHS to submit a report to the Committee within 180 days of enactment of this Act on use of funds, updates on staff hiring, status of related standards, and the amount of training provided under this Initiative. The Committee continues to encourage IHS to establish a pilot program to determine the most effective ways to: (1) educate IHS health care providers on how to evaluate risk factors that could interfere with successfully meeting breastfeeding goals; (2) provide necessary support to AI/AN mothers to prevent or address delayed initiation of milk production during the critical period immediately following birth; and (3) provide support to AI/AN mothers to help them understand the benefits of long-term breastfeeding and improve clinically recommended rates, particularly when they return to work. The Committee also directs IHS to coordinate with employers within the community to develop breastfeeding support recommendations within the workplace that encourage job retention. (See CJ-127-128)

Action taken or to be taken:
In the OIG Report, dated 09/08/2020; OEI-06-19-00190: Instances of IHS Labor and Delivery Care Not Following National Clinical Guidelines or Best Practices, three final recommendations were made as follows:

1. Assess labor and delivery practices and consider practice improvements
2. Ensure that IHS providers employ best practices in diagnosing and treating postpartum hemorrhage

3. Encourage and support greater adoption of Alliance for Innovation on Maternal Health (AIM) bundles of maternal-safety best practices

To provide the safest care possible, IHS and Tribal sites have engaged in implementation of the Alliance for Innovation on Maternal Health (AIM) bundles, with an early emphasis on implementation of the Obstetric Hemorrhage and Hypertension bundles and other bundles as prioritized by the individual sites. Limitations on data sharing have precluded full AIM enrollment for IHS and Tribal hospitals but all sites performing planned births are otherwise engaged in AIM quality improvement efforts and in their respective State Perinatal Collaboratives where available.

Some facilities, particularly the more rural or remote sites without a planned birthing unit, or those sites with planned birth units but low volume and/or delayed transport may be faced with additional challenges in obstetrical emergency preparedness. There is currently a large body of evidence surrounding implementation of simulation drills for obstetrical emergency preparedness and thus sites are encouraged to engage in regular simulation training. Many IHS clinicians have completed the Advanced Life Support in Obstetrics (ALSO) course, and ALSO courses are offered regularly at regional sites across the I/T/U system. IHS has purchased and disseminated 50 childbirth simulation models for use in these emergency drills and in conducting local ALSO courses to enhance obstetric readiness. Further support of rural Emergency Departments (E.D.s) to ensure obstetric readiness includes working closely with individual facilities to develop and support appropriate staff training and ensuring access to necessary supplies and equipment. IHS is working with tertiary care facilities to provide telehealth support via video link for E.D.s without on-site maternity care providers. This Rural Obstetric Readiness program is following the Emergency Medicine principles of quality improvement, emphasizing attention to tools, training, and tracking.

IHS has supported self-efficacy in prenatal care and provided glucometers, continuous glucose monitors (CGMs), and blood pressure cuffs when indicated. A recent Maternal Child Health (MCH) initiative will increase blood pressure cuff access for many more prenatal patients. 825 automatic blood pressure cuffs were purchased and provided to several service units for patient home use and monitoring. Providing these cuffs to patients helps to increase access to care by removing barriers such as transportation and/or childcare. IHS will continue to explore partnerships with the Pre-Eclampsia Foundation in order to facilitate greater access to self-monitored blood pressure equipment throughout Indian Country.

IHS has had a consultative relationship with the American College of Obstetricians and Gynecologists (ACOG) Committee on American Indian and Alaska Native Women's Health for over 50 years. ACOG provides quality-benchmarking site visits, guidance on maternity care and women's health best practices, and ongoing training for IHS, Tribal, and Urban staff. ACOG, along with the Canadian SOGC, sponsors a biennial "Meeting on Indigenous Women's Health" which provides an important forum to address common themes and share solutions. The ACOG Committee work includes liaisons from the American College of Nurse Midwives (ACNM), the American Women's Health, Obstetric, and Neonatal Nurses (AWHONN) and the American Academy of Pediatrics (AAP).

All federal IHS hospitals providing planned birth services have earned the "Baby Friendly" designation by Baby-Friendly USA. Currently, one facility is pending re-designation due to staffing shortages, but is working to address this situation. Comprehensive breastfeeding education and continued lactation support are mainstays of this designation. The Baby Friendly Hospital Initiative (BFHI) designation ensures education is provided during prenatal care and lactation support is routinely offered throughout the hospital stay and postpartum. IHS further promotes breastfeeding opportunities through the Baby Friendly Hospital Initiative, building organizational capacity and practice-based resources, developing partnerships to advance breastfeeding, and incorporating breastfeeding into its robust public health programs. Breastfeeding education is included in trainings offered to IHS, Tribal, and Urban Indian

Organization health staff, including those offered in partnership with the American College of Obstetricians and Gynecologists Committee on American Indian and Alaska Native Women's Health. Baby-Friendly designation naturally leads to education and support of breastfeeding to become engrained in daily operations of the hospitals. Education on early warning signs, how to recognize these warning signs, when to return to care, whether that should be for routine or emergent care, and information on a large network of resources available for new mothers are important pieces of this breastfeeding support post-discharge. In addition to efforts specifically related to maintaining the BFHI designation, IHS continues to monitor Government Performance and Results Act (GPRA) rates and several sites have initiated intensive QI projects around breastfeeding. IHS has built partnerships between Tribes and the AIM Community Care Initiative (AIM CCI), and has enjoyed a long-standing partnership with the American Academy of Pediatrics-Committee on Native American Child Health (CONACH) and works closely with these entities in implementation of any recommendations to improve infant feeding outcomes and resultant child health indicators.

IHS partners with Tribes, urban Indian organizations, and local and state governments in order to ensure comprehensive, culturally appropriate lactation services are provided for the American Indian and Alaskan Native women and families served. One example includes linking patients with postpartum resources available to them after discharge, which include a variety of ways to access support, online, by phone, or in person including home visitation programs. Postpartum visits are also offered by public health/community health programs in many communities; offering 1:1 assistance and support, in home, which helps to remove access to care barriers such as transportation or child care for other children, and also helps to ensure cultural sensitivity for those patients practicing traditional beliefs and customs surrounding childbirth. Several certified lactation consultants and counselors are employed by IHS, and sites have offered incentives for this continued education and certification. Referrals can be placed by the public health/community health programs for additional lactation support or other resources as needed. IHS offers resources about breastfeeding promotion and support on the Baby Friendly webpage. This public facing page is available on the general website for patients, staff and other interested individuals to access freely. The page includes information about breastfeeding promotion and support, standard of care, breastfeeding benefits, common problems, clinical challenges, and a toolkit on providing breastfeeding education.

Funding from this initiative has not yet been expended; however, future actions utilizing the maternal/mortality initiative funding will provide care to better meet the health care needs of American Indian and Alaska Native communities as outlined above. IHS hired a new Maternal Child Health consultant who will be starting in May 2022 and will lead the IHS Maternal Health efforts.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2023 Performance Budget Submission to Congress

TABLE OF CONTENTS

Operating Division-Specific Requirements

Department of Health & Human Services
Indian Health Service
Number of Service Units and Facilities
Operated by IHS and Tribes, December 15, 2021

Type of Facility	TOTAL	IHS Total	TRIBAL Total	TRIBAL Title I [a]	TRIBAL Title V [b]
Service Units	172	54	118		
Hospitals	46	24	22	3	19
Ambulatory	640	88	552	131	421
Health Centers	370	51	319	98	221
School Health Centers	20	12	8	0	8
Health Stations	104	25	79	28	51
Alaska Village Clinics	146	0	146	5	141

[a] Operated under P.L. 93-638, Self Determination Contracts
[b] Operated under P.L. 106-260, Tribal Self-Governance Amendment of 2000

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2020 Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**14,350**	**23,563**	**37,913**
Alaska	*	11,488	11,488
Albuquerque	684	*	684
Bemidji	137	*	137
Billings	751	*	751
California	*	*	0
Great Plains	1,990	*	1,990
Nashville	*	749	749
Navajo	6,232	4,427	10,659
Oklahoma	1,006	5,889	6,895
Phoenix	3,550	846	4,396
Portland	*	*	0
Tucson	*	164	164

* No direct inpatient facilities in FY 2020

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	**4,455,634**	**8,726,554**	**13,182,188**
Alaska	**	1,892,761	1,892,761
Albuquerque	446,164	163,706	609,870
Bemidji	251,436	521,935	773,371
Billings	393,828	146,121	539,949
California	1,438	541,774	543,212
Great Plains	712,251	232,650	944,901
Nashville	20,550	499,069	519,619
Navajo	1,032,577	727,934	1,760,511
Oklahoma	667,015	2,548,276	3,215,291
Phoenix	684,475	554,825	1,239,300
Portland	245,900	650,230	896,130
Tucson	**	247,273	247,273

** No IHS facilities in FY 2020

INDIAN HEALTH SERVICE
Immunization Expenditures[1]

	FY 2019 Estimate	FY 2020 Estimate	FY 2021 Estimate	FY 2022 Estimate	FY 2023 Estimate	Increase or Decrease
Infants, ≤2 yrs†	$17,637,372	$16,999,814	$27,697,493	$30,729,864	$37,006,856	+$6,276,992
Children, 4 yrs*	--	--	$1,903,618	$2,181,400	$2,626,981	+$445,581
Children, 11 yrs*	--	--	$2,638,457	$3,058,125	$3,682,789	+$624,664
Children, 16 yrs*	--	--	$492,106	$592,244	$713,218	+$120,974
Influenza, 3-18 yrs*	--	--	$7,011,952	$8,208,396	$9,885,073	+$1,676,677
Adolescents, 13-17 yrs**	$14,539,873	$14,751,715	--	--	--	--
HPV vaccine, Female 19-26 yrs	$1,888,480	$2,234,867	$1,661,872	$4,362,851	$5,841,971	+$1,479,120
HPV Vaccine, Males 19-26 yrs†	$3,007,340	$3,471,040	$8,348,651	$11,371,327	$11,460,808	+$89,481
Tdap, 19+ yrs	$5,642,763	$6,881,091	$8,011,379	$14,506,783	$14,999,354	+$492,571
Hepatitis B for diabetics, 19-59 yrs	$5,001,855	$2,596,434	$983,972	$368,495	$1,152,575	+$784,079
Influenza, 19+ yrs	$26,722,962	$26,869,430	$28,389,102	$31,572,305	$39.689,513	+$8,117,208
Zoster, 50+ yrs†	$749,722	$600,430	$5,072,640	$10,710,516	$16,871,985	+$6,161,469
Pneumococcal (PPSV23), 65+ yrs	$1,263,179	$367,796	$1,766,053	$2,836,502	$3,269,807	+$433,305
Pneumococcal (PCV13), 65+ yrs§	$6,107,426	$6,676,690	$7,371,107	--	--	--
COVID-19, 5+ yrs	--	--	--	--	$36,714,324	+$36,714,324
Monitoring	$137,207	$138,579	$143,984	$149,599	$151,153	+$1,554
TOTAL	$82,698,180	$81,587,886	$101,492,384	$120,648,412	$184,066,408	+$63,417,996

†Expanded age range beginning with FY 2021 estimate
*Newly added stratified measures beginning FY 2021 for improved capture and accuracy of estimates among these patient groups
**Retired aggregate measure replaced with newly added stratified measures as indicated
§PCV13 vaccine no longer recommended beginning FY2022

The Indian Health Service (IHS) patient care data system does not calculate itemized costs for the prevention or treatment of various conditions including vaccinations. Because the cost of vaccines for children < 19 years of age is covered by the Vaccines for Children (VFC) program, only the costs for vaccine administration, which are not covered by the VFC program, are included for this age group.

Estimated immunization expenditures include projected costs for routine, on-schedule immunizations among core patient demographic groups based on current age-appropriate immunization schedules. Other individuals outside these core patient groups may be regular

1. The immunization estimates do not include the Hepatitis B and Haemophilus Immunization (AK) program; estimates for these immunizations are included under the Immunization Alaska budget.

recipients of immunizations (e.g., health care workers; patients at specific increased risk for certain vaccine-preventable diseases). However, there is not currently a methodology to accurately estimate the size or vaccination coverage rates for all of these patient groups. Therefore, some special patient groups are excluded from these expenditure estimates.

Costs for monitoring of immunization coverage were also included and represent a 1.039 percent increase over the FY 2022 estimate:

- FY 2019 Estimated Costs = FY 2017 cost plus 3.9 percent
- FY 2020 Estimated Costs = FY 2018 cost plus 1.0 percent
- FY 2021 Estimated Costs = FY 2019 cost plus 1.0 percent
- FY 2022 Estimated Costs = FY 2020 cost plus 1.0 percent
- FY 2023 Estimated Costs = FY 2021 cost plus 1.0 percent

For FY 2023, $183,915,255 is estimated for immunization costs, and $151,153 for immunization monitoring costs, for a total of $184,066,408 estimated for all immunization expenditures. This represents a $63,417,996 increase from the FY 2022 estimate attributable to changes in vaccine costs including administering COVID-19 immunizations, shifting population sizes among age categories targeted for immunization, and progress towards immunization coverage goals aligned with Healthy People 2030 targets (i.e., fewer individuals still needing vaccination which translates to reduced forecasted costs). Calculations for the costs included as part of the FY 2023 estimated immunization costs were based on the assumptions outlined in the table below:

	Estimated User Population (FY 2020)¶	Coverage Goal†	Current Coverage*	No. to be vaccinated	Vaccine costs (per dose)**	Admin fee (per dose)§§	No. of doses per patient	Total Immun. expenditures per patient	Total
Infants, ≤2 yrs	59,554	80%	NA	47,643	$0.00	$31.07	25	$776.75	$37,006,856
Children, 4 yrs	26,422	80%	NA	21,138	$0.00	$31.07	4	$124.28	$2,626,981
Children, 11 yrs	29,633	80%	NA	23,706	$0.00	$31.07	5	$155.35	$3,682,789
Children, 16 yrs	28,694	80%	NA	22,955	$0.00	$31.07	1	$31.07	$713,218
Influenza, 3-18 years	454,507	70%	NA	318,155	$0.00	$31.07	1	$31.07	$9,885,073
HPV Females, 19-26 yrs	109,720	60%	51%	10,204	$159.77	$31.07	3	$572.52	$5,841,971
HPV Males, 19-26 yrs	84,110	60%	36%	20,018	$159.77	$31.07	3	$572.52	$11,460,808
Tdap, 19+ yrs	1,153,832	90%	67%	265,381	$25.45	$31.07	1	$56.52	$14,999,354
Hepatitis B, diabetics 19-59 yrs	119,000	60%	55%	5,950	$33.50	$31.07	3	$193.71	$1,152,575
Influenza, 19+ yrs	1,153,832	70%	NA	807,682	$18.07	$31.07	1	$49.14	$39,689,513
Zoster, 50+ yrs	416,104	60%	44%	64,912	$98.89	$31.07	2	$259.92	$16,871,985
Pneumococcal (PPSV23) 65+yrs	174,988	90%	72%	30,973	$74.50	$31.07	1	$105.57	$3,269,807
COVID-19, 5+yrs[α]	1,550,436	70%	40%	458,929	$0	$40.00	2	$80.00	$36,714,324
Immunization Costs									$183,915,255
Monitoring									$151,153
Total Costs									$184,066,408

¶Reflects the most current user population counts available.

†Based on Healthy People 2030, where applicable. All targets are used for illustrative purposes only, and none reflect an official target set by the IHS.

*Coverage estimates based on most current coverage levels available (FY 2022 Quarter 1); coverage estimates for diabetics ages 19-59 years includes those patients immune to Hepatitis B for reasons other than immunization; HPV estimate is based on 3 dose series; coverage listed as 'NA' either not applicable due to age-related cohort turnover each year or recurring annual immunization requirement each year (i.e., influenza).
**Cost per dose for routine childhood vaccines administered up to and including age 18 are covered by the Vaccines for Children program; cost per dose determined from the CDC Adult Vaccine Price List dated April 1, 2022. Lowest published price is generally used where multiple products or formulations are available.
https://www.cdc.gov/vaccines/programs/vfc/awardees/vaccine-management/price-list/index.html
§Vaccine administration fees for all vaccines except COVID-19 vaccines are based on an average of CMS 2022 locality-adjusted payment amounts for administration of influenza vaccines as a proxy for all vaccines, except for COVID-19. COVID-19 vaccine administration costs are based on Medicare reimbursement rates specific to COVID-19 immunization for any vaccine doses.
[α]Due to the evolving COVID-19 vaccine landscape, estimates are preliminary and may not be reliable.

Overall, the estimated costs above reflect projected costs for routine, on-schedule immunizations but with caveats:
1. Other individuals outside these core patient groups are regular recipients of immunizations (e.g., immunization for health care workers and those at specific risk for other vaccine-preventable diseases). However, there is not currently a methodology to estimate the size of these groups to effectively track vaccination coverage rates.
2. CMS reimbursement rates for vaccine administration were used to estimate indirect costs because there is no specific methodology to estimate indirect costs or administrative overhead associated with the administration of immunizations system-wide, or operation of the overall immunization program.

FY 2021 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration										FY 2021 Enacted
	Clinical Services	Preventive Health	Indian Health Professions	Federal Administration	Tribal Mgmt Grants	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Tribal Mgmt Grants	Management Training	Self-Governance	Contract Support	Tribal Lease Payments	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																			
Hospitals & Health Clinics	920,562	0	0	0	0	0	0	920,562	1,317,071	0	0	0	0	0	0	0	0	1,317,071	2,237,633
Electronic Health Record	125,000	0	0	0	0	0	0	125,000	0	0	0	0	0	0	0	0	0	0	34,500
Dental Health	85,231	0	0	0	0	0	0	85,231	129,456	0	0	0	0	0	0	0	0	129,456	214,687
Mental Health	44,262	0	0	0	0	0	0	44,262	70,944	0	0	0	0	0	0	0	0	70,944	115,206
Alcohol & Substance Abuse	89,937	0	0	0	0	0	0	89,937	161,423	0	0	0	0	0	0	0	0	161,423	251,360
Purchased/Referred Care	395,222	0	0	0	0	0	0	395,222	580,634	0	0	0	0	0	0	0	0	580,634	975,856
IHCIF	14,904	0	0	0	0	0	0	14,904	57,376	0	0	0	0	0	0	0	0	57,376	72,280
Subtotal (CS)	1,675,118	0	0	0	0	0	0	1,675,118	2,316,904	0	0	0	0	0	0	0	0	2,316,904	3,901,522
Public Health Nursing	0	30,705	0	0	0	0	0	30,705	0	62,031	0	0	0	0	0	0	0	62,031	92,736
Health Education	0	4,085	0	0	0	0	0	4,085	0	17,304	0	0	0	0	0	0	0	17,304	21,389
Community Health Repr.	0	2,547	0	0	0	0	0	2,547	0	60,345	0	0	0	0	0	0	0	60,345	62,892
Immunization AK	0	0	0	0	0	0	0	0	0	2,127	0	0	0	0	0	0	0	2,127	2,127
Subtotal (PH)	0	37,337	0	0	0	0	0	37,337	0	141,806	0	0	0	0	0	0	0	141,807	179,144
Urban Health Project	0	0	0	0	0	0	0	0	0	0	62,684	0	0	0	0	0	0	62,684	62,684
Indian Health Professions	0	0	51,683	0	0	0	0	51,683	0	0	0	0	0	0	0	0	0	0	67,314
Tribal Management	0	0	0	0	1,461	0	0	1,461	0	0		1,004	0	0	0	0	0	1,004	2,465
Direct Operations	0	0	0	61,240	0	0	0	59,216	0	0	0	0	21,216	0	0	0	0	21,216	82,456
Self-Governance	0	0	0	0	0	5,250	0	5,250	0	0	0	0	0	556	0	0	0	556	5,806
Subtotal (OS)	0	0	51,683	61,240	1,461	5,250	0	117,610	0	0	62,684	1,004	21,216	556	0	0	0	85,460	220,725
Total, Services	1,675,118	37,337	51,683	61,240	1,461	5,250	0	1,830,065	2,316,904	141,806	62,684	1,004	21,216	556	0	0	0	2,544,171	4,301,391
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	916,000	0	0	916,000	916,000
TRIBAL LEASE PAYMENTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	101,000	0	101,000	101,000
FACILITIES																			
Maintenance & Improvement	0	0	0	0	0	0	74,727	74,727	0	0	0	0	0	0	0	0	94,225	94,225	168,952
Sanitation Facilities Constr.	0	0	0	0	0	0	68,802	68,802	0	0	0	0	0	0	0	0	127,775	127,775	196,577
Health Care Facs. Constr.	0	0	0	0	0	0	234,294	234,294	0	0	0	0	0	0	0	0	24,996	24,996	259,290
Facs. & Env. Health Sup	0	0	0	0	0	0	150,655	150,655	0	0	0	0	0	0	0	0	113,327	113,327	263,982
Equipment	0	0	0	0	0	0	13,904	13,904	0	0	0	0	0	0	0	0	15,183	15,183	29,087
Total, Facilities	0	0	0	0	0	0	542,382	542,382	0	0	0	0	0	0	0	0	375,506	375,506	917,888
TOTAL, IHS	1,675,118	37,337	51,683	61,240	1,461	5,250	542,382	2,372,447	2,316,904	141,806	62,684	1,004	21,216	556	916,000	0	375,506	3,835,677	6,236,279

FY 2022 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration									Tribal Health Administration										FY 2022 Omnibus
	Clinical Services	Preventive Health	Indian Health Professions	Federal Administration	Tribal Mgmt Grants	Self-Governance	Special Diabetes Program for Indians	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Tribal Mgmt Grants	Self-Governance	Contract Support	ISDEA 105(l) Leases	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																				
Hospitals & Health Clinics	987,018	0	0	0	0	0	0	0	987,018	1,412,151	0	0	0	0	0	0	0	0	1,412,151	2,399,169
Electronic Health Record	145,019	0	0	0	0	0	0	0	145,019	0	0	0	0	0	0	0	0	0	0	145,019
Dental Health	93,608	0	0	0	0	0	0	0	93,608	142,180	0	0	0	0	0	0	0	0	142,180	235,788
Mental Health	46,852	0	0	0	0	0	0	0	46,852	75,094	0	0	0	0	0	0	0	0	75,094	121,946
Alcohol & Substance Abuse	92,435	0	0	0	0	0	0	0	92,435	165,908	0	0	0	0	0	0	0	0	165,908	258,343
Purchased/Referred Care	398,879	0	0	0	0	0	0	0	398,879	586,008	0	0	0	0	0	0	0	0	586,008	984,887
IHCIF	15,287	0	0	0	0	0	0	0	15,287	58,851	0	0	0	0	0	0	0	0	58,851	74,138
Subtotal (CS)	1,779,097	0	0	0	0	0	0	0	1,779,098	2,440,193	0	0	0	0	0	0	0	0	2,440,192	4,219,290
Public Health Nursing	0	33,926	0	0	0	0	0	0	33,926	0	68,540	0	0	0	0	0	0	0	68,540	102,466
Community Health	0	4,441	0	0	0	0	0	0	4,441	0	18,809	0	0	0		0	0	0	18,809	23,250
Health Education	0	2,579	0	0	0	0	0	0	2,579	0	61,100	0	0	0	0	0	0	0	61,100	63,679
Immunization AK	0	0	0	0	0	0	0	0	0	0	2,174	0	0	0	0	0	0	0	2,174	2,148
Subtotal (PH)	0	40,946	0	0	0	0	0	0	40,946	0	150,623	0	0	0	0	0	0	0	150,623	191,543
Urban Health Project	0	0	0	0	0	0	0	0	0	0	0	73,424	0	0	0	0	0	0	73,424	73,424
Indian Health Professions	0	0	51,683	0	0	0	0	0	51,683	0	0	0	0	0	0	0	0	0	0	73,039
Tribal Management	0	0	0	0	1,462	0	0	0	1,462	0	0	0	0	1,004	0	0	0	0	0	2,466
Direct Operations	0	0	0	70,591	0	0	0	0	70,591	0	0	0	24,455	0	0	0	0	0	24,455	95,046
Self-Governance	0	0	0	0	0	5,290	0	0	5,290	0	0	0	0	0	560	0	0	0	560	5,850
Subtotal (OS)	0	0	51,683	70,591	1,462	5,290	0	0	129,025	0	0	73,424	24,455	1,004	560	0	0	0	98,440	249,824
Total, Services	1,779,097	40,946	51,683	70,591	1,462	5,290	0	0	1,949,069	2,440,193	150,623	73,424	24,455	1,004	560	0	0	0	2,689,254	4,660,658
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,142,000	0	0	1,142,000	880,000
ISDEAA 105(l) Leases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		150,000	0	150,000	150,000
FACILITIES																				
Maintenance & Improvement	0	0	0	0	0	0	0	75,042	75,042	0	0	0	0	0	0	0	0	94,622	94,622	169,664
Sanitation Facilities Constr.	0	0	0	0	0	0	0	69,224	69,224	0	0	0	0	0	0	0	0	128,559	128,559	197,783
Health Care Facs. Constr.	0	0	0	0	0	0	0	234,297	234,297	0	0	0	0	0	0	0	0	24,996	24,996	259,293
Facs. & Env. Health Sup	0	0	0	0	0	0	0	161,579	161,579	0	0	0	0	0	0	0	0	121,545	121,545	283,124
Equipment	0	0	0	0	0	0	0	14,562	14,562	0	0	0	0	0	0	0	0	15,902	15,902	30,464
Total, Facilities	0	0	0	0	0	0	0	554,704	554,704	0	0	0	0	0	0	0	0	385,624	385,624	940,328
TOTAL, IHS	1,779,097	40,946	51,683	70,591	1,462	5,290	0	554,704	2,503,774	2,440,193	150,623	73,424	24,455	1,004	560	1,142,000	0	385,624	4,216,878	6,630,987

FY 2023 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration										Tribal Health Administration											FY 2023 Pres Bud
	Clinical Services	Preventive Health	Indian Health Professions	Federal Administration	Tribal Mgmt Grants	Self-Governance	Special Diabetes Program for Indians	Facilities	Special Diabetes Program for Indians	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Tribal Mgmt Grants	Self-Governance	Contract Support	ISDEA 105(l) Leases	Facilities	Special Diabetes Program for Indians	TOTAL Tribal Health Admini-stration	
SERVICES																						
Hospitals & Health Clinics	1,384,687	0	0	0	0	0	0	0	0	1,384,687	1,981,105	0	0	0	0	0	0	0	0	0	1,981,105	3,365,792
Electronic Health Record	284,500	0	0	0	0	0	0	0	0	284,500	0	0	0	0	0	0	0	0	0	0	0	284,500
Dental Health	122,750	0	0	0	0	0	0	0	0	122,750	186,443	0	0	0	0	0	0	0	0	0	186,443	309,193
Mental Health	76,490	0	0	0	0	0	0	0	0	76,490	122,598	0	0	0	0	0	0	0	0	0	122,598	199,088
Alcohol & Substance Abuse	123,305	0	0	0	0	0	0	0	0	123,305	221,315	0	0	0	0	0	0	0	0	0	221,315	344,620
Purchased/Referred Care	493,314	0	0	0	0	0	0	0	0	493,314	724,745	0	0	0	0	0	0	0	0	0	724,745	1,218,059
IHCIF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal (CS)	2,485,044	0	0	0	0	0	0	0	0	2,485,045	3,236,208	0	0	0	0	0	0	0	0	0	3,236,207	5,721,251
Public Health Nursing	0	37,272	0	0	0	0	0	0	0	37,272	0	75,298	0	0	0	0	0	0	0	0	75,298	112,570
Community Health	0	4,713	0	0	0	0	0	0	0	4,713	0	19,962	0	0	0		0	0	0	0	19,962	24,675
Health Education	0	2,788	0	0	0	0	0	0	0	2,788	0	66,056	0	0	0	0	0	0	0	0	66,056	68,844
Immunization AK	0	0	0	0	0	0	0	0	0	0	0	2,174	0	0	0	0	0	0	0	0	2,174	2,221
Subtotal (PH)	0	44,773	0	0	0	0	0	0	0	44,773	0	163,490	0	0	0	0	0	0	0	0	163,490	208,310
Urban Health Project	0	0	0	0	0	0	0	0	0	0	0	0	112,513	0	0	0	0	0	0	0	112,513	112,513
Indian Health Professions	0	0	51,683	0	0	0	0	0	0	51,683	0	0	0	0	0	0	0	0	0	0	0	93,568
Tribal Management	0	0	0	0	2,659	0	0	0	0	2,659	0	0	0	0	1,827	0	0	0	0	0	0	4,486
Direct Operations	0	0	0	85,691	0	0	0	0	0	85,691	0	0	0	29,687	0	0	0	0	0	0	29,687	115,378
Self-Governance	0	0	0	0	0	5,583	0	0	0	5,583	0	0	0	0	0	591	0	0	0	0	591	6,174
Subtotal (OS)	0	0	51,683	85,691	2,659	5,583	0	0	0	145,616	0	0	112,513	29,687	1,827	591	0	0	0	0	142,791	332,119
Total, Services	2,485,044	44,773	51,683	85,691	2,659	5,583	0	0	0	2,675,434	3,236,208	163,490	112,513	29,687	1,827	591	0	0	0	0	3,542,488	6,261,680
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,142,000	0	0	0	1,142,000	1,142,000
ISDEAA 105(l) Leases	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		150,000	0	0	150,000	150,000
FACILITIES																						
Maintenance & Improvement	0	0	0	0	0	0	0	152,843	0	152,843	0	0	0	0	0	0	0	0	192,722	0	192,722	345,565
Sanitation Facilities Constr.	0	0	0	0	0	0	0	70,928	0	70,928	0	0	0	0	0	0	0	0	131,723	0	131,723	202,651
Health Care Facs. Constr.	0	0	0	0	0	0	0	493,170	0	493,170	0	0	0	0	0	0	0	0	52,614	0	52,614	545,784
Facs. & Env. Health Sup	0	0	0	0	0	0	0	211,916	0	211,916	0	0	0	0	0	0	0	0	159,410	0	159,410	371,326
Equipment	0	0	0	0	0	0	0	48,764	0	48,764	0	0	0	0	0	0	0	0	53,253	0	53,253	102,017
Total, Facilities	0	0	0	0	0	0	0	977,622	0	977,622	0	0	0	0	0	0	0	0	589,721	0	589,721	1,567,343
SDPI	0	0	0	0	0	0	0	0	37,570	37,570	0	0	0	0	0	0	0	0	0	112,430	112,430	147,000
TOTAL, IHS	2,485,044	44,773	51,683	85,691	2,659	5,583	0	977,622	37,570	3,690,625	3,236,208	163,490	112,513	29,687	1,827	591	1,142,000	0	589,721	112,430	5,274,210	9,268,023

April 13, 2022

FY 2023 Annual Facilities Planning (Five-Year Plan) a/

(Dollars in Thousands)

FACILITY	Prior to FY 22 *	FY 22 Appro	FY 23 Pres Budget	FY 24 Est.	FY 25 Est.	FY 26 Est.	Out years Est.	Total Cost **
Planning Studies	-				500	500	500	
Inpatient Facilities b/ c/ d								
PIMC, AZ, Health Care System								
Central - Hospital & ACC 1/ 8/	27,228	9,000	48,500	40,000	150,000	300,000	480,000	1,054,728
Whiteriver, AZ, Hospital 2/	85,000	50,000	100,000	250,000	241,000	0	0	726,000
Gallup, NM Hospital 3/ 8/	17,000	9,000	48,500	40,000	150,000	300,000	286,000	850,500
Outpatient Facilities b/ c/ d/								
Rapid City, SD	129,802	2,000						131,802
Alamo, NM	75,000	22,000						97,000
Pueblo Pintado, AZ	122,400	49,000						171,400
Bodaway Gap, AZ 4/	121,200		117,500					238,700
Albuquerque Health Care System								
Albuquerque West, NM 5/ 8/	164,143		40,000					204,143
Albuquerque Central, NM 6/	20,734				130,000	100,000		250,734
Sells, AZ 7/	55,750	78,293	121,284	232,100				487,427
Small Ambulatory Program (Section 306)								
Small Health Clinics		25,000	30,000	25,000				
Staff Quarters Program 25 U.S.C. 13, Snyder Act e/								
Staff Quarters		10,000	25,000	25,000				
Green Infrastructure (CWA)								
Sustainability Projects		5,000	5,000	5,000				
Demonstration Projects 25 U.S.C. § 1637 f/								
Submitted Projects			10,000					
Joint Venture Construction Program (Section 818e) g/								
* **TOTAL**		259,293	545,784	617,100	671,500	700,500	766,500	3,560,677
** **UNFUNDED (FY 2021-Outyears) Priority Projects only**								3,174,884

NOTES:

a/ All funds appropriated prior to FY 2022 are consolidated including NEF for Rapid City, Albuquerque West & Sells projects.
b/ Cost based on mid-point of construction. FY 22 and earlier are know values, FY 23 and later are estimated values.
c/ This project list includes projects from the IHS Construction Priority List of 1992.
d/ Subject to the availability of funds and does not include M&I, or staffing.
e/ An initiative to fund new and replacement energy efficient staff quarters in isolated and remote locations.
f/ An initiative to fund request for demonstration projects as outlined in the IHCIA.
g/ 24 prior year JVCP have been completed, 10 additional projects have been selected for the program.
1/ The total cost includes inpatient, outpatient, and a hostel. The budget will be updated when planning is complete.
2/ Total cost estimate includes 144 new staff quarters. The budget will be updated when planning is complete.
3/ The need for staff quarters is being evaluated. This estimate includes 100 staffing quarters units as a place holder. The cost includes the cost of land.
4/ Total estimate includes 92 staff quarters. The budget will be updated when planning is complete.
5/ The Albuquerque West Project was supplemented with $13.9 million of NEF. The budget will be updated when planning is complete.
6/ The budget will be updated when planning is complete.
7/ The Sells Project was supplemented with $15 million of NEF. The Cost includes 108 staff quarters. The budget will be updated when planning is complete.
8/ Land purchance is required for this Project

Indian Health Service

Sequestration Exemption for Indian Health Programs

Proposal: To amend current law to exempt the Indian Health Service from future sequestration cuts.

Current Law: Sequestration is the legislatively mandated process of budget control consisting of automatic, across-the-board spending reductions to enforce budget targets to limit federal spending. It was first established by the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA, Title II of P.L. 99-177, 2 U.S.C. § 900-922) to enforce deficit targets. Section 255 of BBEDCA (2 U.S.C. § 905) identifies programs that are exempt from sequestration, and Section 256 of BBEDCA (2 U.S.C. § 906) establishes special rules.

While 2 U.S.C. § 906(e) ostensibly sets IHS's discretionary funding sequester level to 2% of its total, Section 251A(5), Implementing Discretionary Reductions, does not apply the special rules of Section 256; they are only used in Implementing Direct Spending Reductions (Section 251A(6)), which results in reductions in IHS's discretionary accounts on the same basis as other nonsecurity accounts. Inclusive of the 2% sequestered from the mandatory Special Diabetes Program for Indians (SDPI, limited to a 2% reduction), a total of $2.5 million was sequestered from IHS's budget, which was 5.1% of the resources appropriated in FY 2013 for Indian health programs.

Rationale: All programs administered by the Department of Veterans Affairs are exempt from a sequestration reduction ordered under the BBEDCA and the BCA. Through this exemption Congress expressly indicated how critical it is for services provided by the VA not to be disrupted or reduced as a result of sequestration.

Section 255 of BBEDCA (codified at 2 U.S.C. § 905) identifies programs that are exempt from sequestration. These include programs providing critical support to vulnerable groups within the United States, including children (Children's Health Insurance Program (CHIP), Child Nutrition Programs, and foster care) and low income persons/families (Medicaid, TANF, Family Support Programs), health benefits to retirees, veterans and service members (Veterans Affairs, Annuitants, Employees Health Benefits, Postal Service Retiree Health Benefits Fund, Medical Benefits for Commissioned Officers, Public Health Service). Many of the exempted programs reimburse the IHS for services rendered including Medicaid, Medicare (treated under special limiting rules), CHIP, and Veterans Health program reimbursement.

The services provided by the IHS are no less critical. Budget reductions of any kind have implications for the services IHS, Tribes, and Urban Indian organizations provide to American Indian and Alaska Native patients and communities. In FY 2013, these reductions resulted in dramatic oversight and administration reductions to maintain service levels, limitations to patients being able to see outside specialists beyond Priority 1 (emergent or acutely urgent care), and reductions to services paid for through offsetting collections. Future sequesters would not only damage the lives and health of American Indians and Alaska Natives through reduced direct services and care, it would also impair IHS's efforts to improve medical quality, implement improvements/replacement to its Electronic Health Record System, and reduce critical health care staffing vacancies among other impacts.

The impact of a sequestration on the IHS will be highly variable, both based on the overall sequester level, interpretation of sequester policy (e.g., OMB's decision applying the 2% limitation only to the mandatory SDPI), as well as the availability of third party resources to ameliorate budget reductions to critical care areas. Additionally, the date in the fiscal year in which it is implemented will add to the effect of the impact. Notice earlier in the fiscal year would allow for a minimal impact, evenly reducing the reduction across 12 full months of the fiscal year, whereas later notice would impact operations more greatly.

An illustrative example is included below to demonstrate the impact of a sequestration on IHS. For the purposes of calculating the following estimate, a sequestration reduction percentage to IHS programs (excepting the SDPI program, which is capped at 2 percent) is assumed to be 7.5 percent, in the range of modest reduction levels, applied equally across IHS programs, projects or activities, as implemented in FY 2013. Using FY 2016 performance results as the base, a reduction of $267.5 million would be taken from the IHS's Appropriation, which would result in estimated impacts over the following selected measures:

Estimated Impact on Health Care Delivered by a National 7.5% Sequester Reduction

Comprehensive Cardiovascular Disease Assessment	
Number Carried out in FY 2016	30,040
Sequester Reduction	2,253
Number of Patients Who Receive Depression Screening	
Number Carried out in FY 2016	515,692
Sequester Reduction	38,677
Number of Patients Who Receive Colorectal Cancer Screening	
Number Carried out in FY 2016	165,056
Sequester Reduction	12,379
Number of Patients Who Receive Alcohol Screening: Fetal Alcohol Syndrome (FAS) Prevention Screening	
Number Carried out in FY 2016	205,952
Sequester Reduction	15,446
Number of Patients Who Receive Mammography Cancer Screening	
Number Carried out in FY 2016	55,808
Sequester Reduction	4,186
Number of AI/AN patients (age 19-35 months) who have received the combined childhood vaccination series	
Number Carried out in FY 2016	63,423
Sequester Reduction	4,757
Number of AI/AN patients (ages 18+) who have received the influenza vaccine	

Number Carried out in FY 2016	515,692
Sequester Reduction	38,677
Number of AI/AN patients who have received dental services	
Number Carried out in FY 2016	1,093,321
Sequester Reduction	81,999

Reference:

IHS FY 2016 Performance Report
https://www.ihs.gov/crs/includes/themes/responsive2017/display_objects/documents/gpra/2016_GPRAResults_CRS.pdf

IHS FY 2016 Performance Measurement Explanation
https://www.ihs.gov/crs/includes/themes/newihstheme/display_objects/documents/crsv16/GPRAMeasuresV161.pdf

Budget Impact: While resulting in no change to IHS's funding, this proposal would increase the amount of sequestered funding taken from remaining non-exempt agencies.

Effective Date: Upon enactment.

U.S. Public Health Service Commissioned Officers to be Detailed to Urban Indian Organizations to Cooperate In or Conduct Work Related to the Functions of the Department of Health and Human Services

Proposal: Amend federal law to permit U.S. Public Health Service Commissioned Officers (officers) to be detailed directly to Urban Indian Organizations (UIOs) to cooperate in or conduct work related to the functions of the Department of Health and Human Services (HHS).

Current Law: Current federal law permits HHS to detail officers or employees of the Public Health Service for particular enumerated purposes to specified entities, including State health authorities and certain nonprofit institutions (subsections (b) and (c) of section 214 of the Public Health Service Act (PHSA) (42 U.S.C. 215(b), (c)). This legislative proposal is limited to seeking authority to detail only officers to UIOs. Although UIOs are nonprofit organizations, section 214(c) of the PHSA (42 U.S.C. 215(c)) only authorizes details to nonprofit institutions engaged in health activities for special studies of scientific problems and for the dissemination of information related to public health. Because UIOs do not meet those restrictions, officers cannot be detailed directly to an UIO. The authority to detail an officer to State health authorities has been interpreted to authorize an indirect placement with an UIO by detailing an officer to a State health authority which may then designate the UIO as the officer's duty station. UIOs are part of the Indian health care system and provide health care services to eligible American Indians and Alaska Natives residing in urban centers.

Rationale: The Indian Health Service (IHS) enters into limited, competing contracts and grants with 41 501(c)(3) non-profit organizations to provide health care and referral services for Urban Indians throughout the United States. UIOs are defined in section 4(29) of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. 1603(29)) as a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a) of that Act (25 U.S.C. 1653(a)). UIOs provide unique access to culturally appropriate and quality health care for Urban Indians.

UIOs have requested that officers be detailed to them to fill many roles related to the functions of HHS, however, section 214 of the PHSA (42 U.S.C. 215) prevents IHS from detailing officers directly to UIOs. Subsection (b) of that section (42 U.S.C. 215(b)) has been interpreted as allowing IHS to detail an officer to a State health authority, which may then designate the UIO as the officer's duty station. The officer is authorized to perform work at an UIO that is related to the functions of HHS, which has been interpreted to include health care services and supportive functions. The process for such indirect details is completely dependent on the availability of a State or local health authority that is capable and willing to enter into such an arrangement. The process can be burdensome and time consuming for all involved, and State health authorities may be reluctant because of this burden, as well as their potential liability under such an arrangement.

Amending the law would provide IHS the discretionary authority to detail officers directly to an UIO to perform work related to the functions of HHS, to the same extent it may do so now through the indirect, burdensome process described above. Such authority would be comparable to the existing authority to detail officers to Indian Self Determination and Education Assistance Act (ISDEAA) contractors and compactors for the purpose of carrying out the provisions of their ISDEAA contracts (section 7 of the Act of August 5, 1954 (42 U.S.C. § 2004b).

This proposal aligns with the U.S. Public Health Service's goal to increase the number of officers. Currently, 1,614 officers of the U.S. Public Health Service are assigned to IHS. There are five officers assigned to States, whose duty stations are UIOs. See table below.

Urban Facility Name, City, State	**#Officers**	**Category**
Gerald L. Ignace Indian Health Center Milwaukee, Wisconsin	1	Pharmacy
Native American Rehabilitation Association Portland, Oregon	2	Health Services Officer – Physician Assistant Pharmacy
Oklahoma City Indian Clinic Oklahoma City, Oklahoma	3	Health Services Officer-Medical Technologist Pharmacy Therapist - Physical

Strategic Objective 1.3 in the HHS Strategic Plan addresses the need to improve Americans' access to health care and expand choices of care and service options. American Indians and Alaska Natives experience unique challenges when attempting to access care, due to factors such as inadequate supply of health care providers and other workers. Providing IHS authority to detail officers directly to UIOs will help address these shortages so that UIOs can provide health care services to eligible American Indians and Alaska Natives (AI/AN) residing in urban centers.

Budget Impact: This is a non-budget related proposal.

Personnel Requirements: This proposal does not require additional personnel to implement.

Effective Date: Upon enactment.

Equity Impact Assessment: Permitting officers to be detailed directly to UIOs will address the need to improve access to health care for AI/AN communities, who often experience unique challenges and barriers to care. Improving access to care by strengthening IHS workforce capacity will contribute to better outcomes for AI/AN, and reduce health disparities.

Indian Health Service

Provide the Indian Health Service Discretionary Use of all Title 38 Personnel Authorities

Proposal: The Indian Health Service (IHS) is seeking the discretionary use of all United States Code Title 38 authorities under Part V, Chapter 74, "Veterans Health Administration – Personnel", that are primarily available to the Department of Veterans Affairs (VA) in relation to health care positions. The term "health care occupations" refers to positions, other than positions in the Senior Executive Service, that provide direct patient-care services or services incident to direct patient-care which would normally be covered by Title 5 of the United States Code.

Current Law: Title 38 Part V, Chapter 74, governs all aspects of personnel administration for the Veterans Health Administration (VHA) unless expressly overridden by another law or regulation. In many areas of personnel administration, the VHA is exempt from Title 5 laws and regulations by virtue of Title 38. The U.S. Office of Personnel Management (OPM), under the authority of section 1104 and 5371 of Title 5 of the United States Code, has authorized the Department of Health and Human Services (HHS) to use the Title 38 provisions pertaining to pay rates and systems, premium pay, classification, and hours of work. This delegation of authority is described in a delegation of authority between OPM and HHS – the latest version of which was effective March 6, 2019. If HHS, or an HHS Operating Division under the delegation of authority, chooses to use a Title 38 provision, the comparable authority under Title 5 is waived. However, 5 U.S.C. § 5371 does not provide authority to apply all personnel provisions of Title 38 in lieu of comparable Title 5 provisions.

Rationale: The IHS, as a primarily rural health care provider, has difficulty recruiting health care professionals. The IHS has critical hiring needs for health care professionals in IHS, Tribal, and Urban Indian programs including, but not limited to physicians, dentists, nurses, pharmacists, physician assistants, and nurse practitioners. The ability to use Title 38 for pay purposes as noted above is beneficial because the IHS can offer market pay to physicians, dentists, and podiatrists as well as special salary rates to individuals in other health care occupations. However, the IHS's use of these compensation authorities is not adequate by itself to compete with other public sector agencies and private sector organizations.

Typically, the private sector and the VHA can offer candidates better scheduling options and paid time off — particularly important benefits to providers who serve in remote and rural locations. The IHS faces specific public sector competition in the area of annual leave accrual. The VHA provides 1 day of annual leave per pay period for all (including new) physicians, dentists, podiatrists, optometrists, and chiropractors and 8 hours of annual leave accrual per pay period for all (including new) nurses, physician assistants, and expanded-function dental auxiliaries. Due to the limited scope of 5 U.S.C. § 5371, the IHS does not have the authority covered by 38 U.S.C. § 7421. "Personnel Administration: in general" that includes "leaves of absence of employees". Thus, when a candidate with just a few years of experience is choosing between the IHS and the VHA, he or she will invariably choose the organization offering 1 day/8 hours of annual leave accrual per pay period, as opposed to just 4 or 6 hours of annual leave

accrual per pay period that the IHS offers. Supervisors report anecdotally that the IHS has lost many candidates due to this difference in accrual rates.

In addition to better scheduling options and paid time off, the IHS is seeking access to other Title 38 authorities to increase its competitive stance in the health care labor market and to create a more efficient and effective human resources program. This would include the potential for instituting two-year probationary periods for staff appointed under Title 38 and to have jurisdiction over appeals for adverse actions involving professional conduct or competence pertaining to direct patient care and clinical competence instead of going through the Merit Systems Protection Board. Title 38 also exempts the VHA from collective bargaining and associated grievance procedures relating to issues concerning professional conduct competence, and peer review. In contrast, Title 5 permits the establishment of grievance procedures on any issue through the collective bargaining process.

Budget Impact: This proposal is budget neutral. The IHS will accommodate funding requirements within existing resources.

Effective Date: Upon enactment.

Indian Health Service

Meet Loan Repayment/Scholarship Service Obligations on a Half-Time Basis

Proposal: Permit both Indian Health Service (IHS) scholarship and loan repayment recipients to fulfill service obligations through half-time clinical practice, under authority similar to that now available to the National Health Service Corps (NHSC) Loan Repayment Program (LRP) and Scholarship Program.

Authority similar to that provided in section 331(i) of the Public Health Service Act (42 U.S.C. 254d(i)) would allow IHS loan repayment and scholarship recipients more options and flexibility to satisfy their service obligations through half-time clinical work (a minimum of 20 hours per week) for double the amount of service time (e.g., clinician who works 20 hours a week performing clinical duties with a two-year service obligation would increase to a four-year service obligation) or to accept half the amount of loan repayment award in exchange for a two-year service obligation. This would provide parity with NHSC programs and enable IHS to make better use of these tools to recruit and retain key professionals in a highly competitive environment.

Current Law: Sections 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. 1613a, 1616a) require employees who receive IHS scholarships or loan repayments to provide clinical services on a full-time basis. Section 331(i) of the Public Health Service Act was amended by section 10501(n) of the Patient Protection and Affordable Care Act (Public Law No. 111-148; 124 Stat. 1002)to permit certain NHSC loan repayment and scholarship recipients to satisfy their service obligations through half-time clinical practice for double the amount of time or, for NHSC loan repayment recipients, to accept half the loan repayment award amount in exchange for a two-year service obligation.

Section 331(j) of the Public Health Service Act (42 U.S.C. 254d(j)) defines “full-time” clinical practice as a minimum of 40 hours per week, for a minimum of 45 weeks per year. It also defines “half-time” as a minimum of 20 hours per week (not to exceed 39 hours per week), for a minimum of 45 weeks per year.

Rationale: The IHS, as a rural health care provider, has difficulty recruiting and retaining health care professionals. Recruiting physicians and other primary care clinicians has been especially challenging. Permitting IHS scholarship and loan repayment health professional employees to fulfill their service obligations through half-time clinical practice for double the amount of time and to offer half the loan repayment award amount in exchange for a two-year service obligation could increase the number of providers interested in serving in the Indian health system. Additional half-time direct care employees could also reduce the number and cost of Purchased/Referred Care program referrals, especially at sites that do not need full-time specialty care services. There are also a number of smaller rural IHS sites where clinicians will be able to provide a minimum of half-time clinical services with the remainder of their time devoted to much needed administrative/management responsibilities. This proposal will provide flexibility for providers who might not otherwise consider service in IHS by allowing part-time practice in

IHS to coincide with a part-time private practice, as well as part-time practice in IHS combined with part-time administrative duties within the IHS.

The NHSA was authorized to establish a demonstration project permitting loan repayment recipients to meet their service obligations through less than full-time clinical service in response to requests from clinicians and sites. The Patient Protection and Affordable Care Act (Public Law No. 111-148; 124 Stat. 119) t replaced this demonstration with permanent authority for two specific kinds of NHSC options (described above under Current Law). The IHS is equally concerned with the requests from clinicians and prospective candidates for loan repayment awards for half-time service by clinicians. Having similar authority as the NHSC would increase the ability for the IHS to recruit and retain health care clinicians to provide primary health care and specialty services (e.g., Surgery, OG/GYN, Psychiatry, Radiology, and Anesthesiology) and otherwise support the IHS and HHS priorities.

The ability to provide scholarship and loan repayment awards for half-time clinical service would make these recruitment and retention tools more flexible and cost-effective, providing incentives for an additional pool of clinicians and other medical providers that otherwise may not consider a commitment to the IHS federal, Tribal, and Urban Indian sites. Having similar authority as the NHSC would increase the ability of the IHS to recruit and retain health care clinicians to provide primary health care and specialty services and otherwise support the IHS and HHS priorities.

Budget Impact: This is a budget neutral proposal. The IHS will accomodate funding requirements from within existing resources. Direct hire medical staff costs are lower than the costs to hire temporary, contractor staff.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal would increase IHS's ability to recruit and retain health care clinicians to provide primary health care and specialty services to American Indian/Alaska Native communities which disproportionately suffer from healthcare issues and lack the necessary clinical personnel to provide care to community members. The requested change will also foster equity between the IHS and NHSC loan repayment and scholarship programs which will incentivize clinicians to choose a career with IHS.

Indian Health Service

Provide Tax Exemption for Indian Health Service Health Professions Scholarship and Loan Repayment Programs

Proposal: The Indian Health Service (IHS) seeks tax treatment similar to that provided to recipients of scholarships and loan repayment from the National Health Service Corps (NHSC). The IHS seeks to allow scholarship funds for qualified tuition and related expenses received under the Indian Health Service Health Professions Scholarships to be excluded from gross income under section 117(c)(2) of the Internal Revenue Code of 1986 (IRC) and to allow participants in the IHS Loan Repayment Program to exclude from gross income, payments made by the IHS Loan Repayment Program under section 108(f)(4) of the IRC. With the above exemptions, the IHS programs would also be exempt from any Federal Employment Tax (FICA), making the IHS programs comparable to the current NHSC status.

Current Law: Generally, benefits in the form of scholarship awards and loan repayments are regarded as federal taxable income by the IRS under Title 25 of the Internal Revenue Code. However, three federal laws currently provide for the non-taxability of federal scholarship awards and loan repayment programs:

- 26 U.S.C. § 117(c)(2), provides that tuition, fee, and other related cost payments by the National Health Service Corps scholarships are not taxable. This tax exemption was made permanent by Congress in December 2012 but did not include IHS scholarships.
- 26 U.S.C. § 108(f)(4) provides that funds received through the National Health Service Corps Loan Repayment Program authorized under 338B(g) of the Public Health Service Act (42 U.S.C. 254l-1) or a state loan repayment program described in section 338I of the Public Health Service Act (42 U.S.C. 254q-1) are permanently not subject to federal income tax.
- 26 U.S.C. § 3401(a)(19) excludes NHSC loan repayment from federal employment tax.

As IHS programs are not included in the exceptions, IHS health professions scholarships and loan repayment awards are taxed under the IRC.

Rationale: The IHS, as a rural health care provider, has difficulty recruiting and retaining health care professionals. There are over 1,330 vacancies for health care professionals including: physicians, dentists, nurses, pharmacists, physician assistants, and nurse practitioners. The IHS Health Professions Scholarship Program and the Loan Repayment Program play a significant role in the recruitment and retention of the health care professionals needed to fill these vacancies. The IHS Health Professions Scholarship and IHS Loan Repayment Program are very similar to programs that receive preferred tax treatment, and should therefore receive similar tax treatment. Currently, benefits awarded through IHS in the form of loan repayment and scholarships are regarded as federal taxable income to the recipient; however, the same benefits offered under the NHSC are not taxable. This disparate tax treatment of IHS-funded scholarship and loan repayment awards increases the overall tax bracket for the participants and creates a financial

disincentive for those otherwise willing to serve American Indian and Alaska Native patients by working in Indian health facilities.

The ability to exempt scholarship and loan repayment funds from gross income would make this recruitment and retention tool more attractive to potential participants. Based on IHS' calculations, exempting the IHS Loan Repayment Program would allow IHS to award an additional 190 loan repayment contracts in a given year. Thus, the IHS would be better able to increase the number of health care providers entering and remaining within the IHS to provide primary health care and specialty services.

Budget Impact:

Federal Tax Revenue Foregone (in 2019 dollars):

Loan	$8,920,705
Scholarship	$188,773*
Total	$9,109,478

*Number indicates taxes withheld by IHS at recipient's request.

Budget impact is the amount of tax revenue withheld by IHS from IHS Health Professions Scholarship and Loan Repayment and forwarded to the Internal Revenue Service. This also includes the tax liability owed by the scholarship recipients.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal would increase IHS's ability to recruit and retain healthcare professionals to provide primary health care and specialty services to American Indian/Alaska Native communities which disproportionately suffer from healthcare issues and lack the needed clinical staff to treat community members. The requested change will also foster equity between the IHS and NHSC loan repayment and scholarship programs which will incentivize clinicians to choose a career with IHS.

Indian Health Service

Waiver of Indian Preference

Proposal: Amend Federal law to authorize the Department of Health and Human Services (HHS) Secretary to waive Indian Preference laws, and issue related regulations, applicable to IHS positions that fall under specific conditions in order to fill positions in cases where the Secretary determines there is an urgent staffing crisis or chronic persistent vacancies in health professions.

Problem: In August 2018, GAO reported that the IHS had a 25 percent vacancy rate for providers, including physicians, nurses, dentists, pharmacists, nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and physician assistants (GAO-18-580). This equates to over 1,400 current vacancies in IHS in these health professions. Long-standing vacancies have a negative effect on patient access, quality of care, and employee morale. IHS needs additional flexibilities to rapidly address chronic staffing needs. While extremely important, Indian Preference sometimes impacts the Agency's ability to hire highly competent personnel for essential provider or facility Chief Executive Officer (CEO) positions (e.g., in circumstances when an Indian Preference candidate is qualified at only the most basic level, or where an Indian Preference candidate has poor references, a record of disciplinary issues in Federal employment, or both). Allowing the HHS Secretary to waive Indian Preference as proposed may help to mitigate the persistent vacancies experienced across the Agency and improve access to highly qualified providers and CEOs.

Rationale: The proposal would allow the HHS Secretary to grant a waiver of the application of Indian Preference laws without the written waiver now required under section 2(c) of Public Law 96-135 (25 U.S.C. 5117(c)) from concerned tribal organizations, for any personnel action involving filling a vacant position at an IHS service unit in which 15 percent or more of the total positions or specific health profession positions in the service unit are not filled by a full-time employee of the IHS for a period of 6 months or longer. This flexibility will help IHS expedite recruitment and hiring for critical provider positions or a CEO position at any facility that is not able to fill vacancies for an extended period of time under the Indian Preference laws. Also, it can be impractical to obtain a Tribal waiver, as is currently required, at locations where an IHS facility serves multiple Tribes, for example the IHS Rapid City Service Unit. The IHS will provide the Secretary adequate justification for the waiver when a situation at a facility meets the criteria.

Budget Impact: IHS currently uses temporary contractors, at 2-3 times the cost of federal staff, to fill vacancies. If the proposal is approved, significant cost savings may result as federal employees and commissioned officers would be used instead of contracted personnel.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal to waive Indian Preference requirements under limited, urgent situations will enable IHS to hire and retain mission-critical healthcare staff to

provide healthcare to people in American Indian and Alaska Native (AI/AN) communities who disproportionately suffer from serious health issues and a shortage of needed healthcare providers. The requested change will allow IHS to hire the best qualified candidates and fill critical staffing shortages to ensure the highest quality of care for patients.

Indian Health Service

Withhold Annuity and Retiree Pay for Retired Civil Service Employees Convicted of Moral Turpitude

Proposal: Amend Federal law to allow for withholding or revoking of annuity and retiree pay for retired civil service employees convicted of moral turpitude, including crimes against children and rape, during the commission of their federal duties.

Current Law: Under 5 U.S.C. § 8312, a retired civilian employee's annuity and retiree pay may only be withheld for specific high crimes of treason, aiding the enemy, perjury, and subordination of perjury. The federal government needs additional authorities to address the pay of retirees who commit certain egregious and reprehensible crimes that outrage and offend the American Public's moral sensibility. Expansion of the list of offenses minimally should include crimes against children and rape perpetrated by federal employees during the commission of their federal duties, on federal property, or while otherwise using their federal position.

Rationale: In September 2018, a former U.S. Public Health Service Commissioned Corps officer and civil service employee at the IHS was convicted of sexual assault and exploitation of children for crimes committed while an active duty Corps officer assigned to the IHS facility in Browning, Montana. In September 2019, the same individual was convicted on additional charges in South Dakota for similar allegations while assigned to the IHS facility in Pine Ridge, South Dakota, and the case was appealed in February 2020. The sexual assailant's conviction exposes the limitations of current statute to fully address and adjudicate crimes of moral turpitude committed by retired federal employees during the commission of their duties while in the federal civil service.

In keeping with the limited scope of current law, e.g., 5 U.S.C. § 8312, the proposed amendment may be limited to the commission of crimes against children and rape, specifically while on duty, on federal property, or while using or misusing the authority of their federal position.

This proposed amendment is in line with the Department's mission of protecting vulnerable, underserved populations, and the Presidential Task Force on Protecting Native American Children in the Indian Health Service System.

Budget Impact: None.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal will promote equity of treatment against convicted perpetrators of egregious crimes in regards to receipt of federal retirement benefits. The American Indian/Alaska Native population is already a vulnerable and underserved population, and this proposal seeks to deny retirement benefits to those who harm children, who are the most defenseless members of this population. There are restrictions in most states' laws preventing or

limiting the receipt of a state pension for convicted felons and this proposal would make federal pensions more consistent with this model.

Indian Health Service

Provide the Indian Health Service with legislative authority to conduct mission-critical emergency hiring needs beyond 30-day appointments

Proposal: The Indian Health Service (IHS) seeks a legislative change to meet staffing needs during emergency situations. The change requested is to allow for a 60-day critical hiring need appointment authority with the possibility of a 60-day extension. In addition, the maximum number of days an employee is authorized to work in 12 months would be increased from 60 to 120 days.

Current Law: Under 5 CFR 213.3102(i)(2) agencies can appoint individuals for 30 days under an excepted service 30-day critical hiring need appointment. This type of appointment can be extended for up to 30 days if continued employment is essential to the agency's operations. The individual may not be employed for more than 60 days in 12 months. This regulation is for both senior-level and lower-level positions general schedule employees.

Rationale: Critical hiring occurs when an agency needs to fill positions to meet agency requirements brought on by natural disasters, emergencies, or threats. IHS has previously used this hiring authority to fill positions in nursing, facility management, radiology, and many other critical areas to ensure the operation of IHS facilities and quality patient care. In March 2020, the COVID-19 public health emergency emerged. This increased IHS' use of this hiring authority. The health care industry took a significant hit during the pandemic and staff shortages were a constant issue. Furthermore, the pandemic disproportionately affected American Indian and Alaska Natives across the country further stressing IHS hospitals and clinics and requiring the need for additional emergency hires.

To provide adequate services to staff health care facilities, emergency hires should have longer appointments, specifically 60 days instead of 30, with extensions possible for 60 days. This makes sense operationally and from a resource point of view. The effort to hire an individual, onboard them, and vet them through the pre-clearance and background investigation process is significant. To expend agency resources, both human and monetary, to hire someone for only 30 days is no longer the most viable solution to address staffing needs.

Budget Impact: This proposal is budget neutral. The IHS will accommodate funding requirements within existing resources.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal will enable the Indian Health Service to recruit short-term emergency staff to provide, or support the provision of, healthcare to people in American Indian and Alaska Native (AI/AN) communities who disproportionately suffer from serious health issues and a shortage of needed healthcare providers. By lengthening the period of time for critical hiring need appointments access to care will be strengthened, and as a result, better health care outcomes for American Indians and Alaska Natives will be achieved.

Impact on Other Agencies: None.

Indian Health Service

Provide the Indian Health Service with permanent authority to hire and pay experts/consultants

Proposal: The Indian Health Service (IHS) needs the ability to hire experts/consultants to address challenging tasks in a particular field beyond the usual range of achievement of competent persons (5 CFR 304.102(d)). An expert/consultant can also provide valuable and pertinent advice generally drawn from a high degree of broad administrative, professional, or technical knowledge or experience. (5 CFR 304.102(b)).

Unlike most other Department of Health and Human Services (HHS) Operating Divisions and Staff Divisions, the IHS does not have a permanent authority via the 1993 appropriations law to hire expert/consultants and pay rates not to exceed the daily rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. §5376.2. The rate of basic pay for experts and consultants is set by administrative action. An agency must determine the appropriate rate of basic pay on an hourly or daily basis. Since experts/consultants are not general schedule employees, they are automatically covered by locality payments 5 U.S.C. 5304 and 5 CFR part 531, subpart 5. The pay may not exceed the GS-15 step 10. IHS had a temporary authority through the FY 2020 annual appropriations bill; however, that authority has expired.

Current Law: Agencies may appoint experts and consultants temporarily (i.e., not to exceed one year) or on an intermittent basis (i.e., without a regularly scheduled tour of duty). These employees are not covered by the standard provisions related to an appointment in the competitive service (5 CFR part 332), position classification (5 U.S.C. chapter 51), or General Schedule pay-setting (5 U.S.C. chapter 53, subchapter III).

According to HHS Instruction 304-1: Appointment of Experts and Consultants, the Department of Interior, Environment, and Related Agencies Appropriations Act, 2020 (Public Law 116-94 div. D (Dec. 20, 2019)), authorized IHS to set pay for services authorized by 5 U.S.C. §3109 at rates not to exceed the daily rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. §5376.2. Since the end of FY 2020, IHS has not had an identified appropriation authority or other statute using 5 U.S.C. §3109, per 5 U.S.C. §3109(b).

Rationale: Hiring experts and consultants is another tool IHS can use to strengthen its workforce and better serve the American Indian/Alaska Native population. These highly specialized individuals can bring added skills, knowledge, and expertise to meet mission-critical tasks. To combat future pandemics, emergencies, and unique health-care challenges, it would be beneficial to hire experts/consultants to provide additional high-level resources to the IHS unavailable within the current workforce.

The IHS is at a disadvantage by not hiring experts/consultants that could temporarily provide specialized advice or assistance with projects or planning on a temporary or intermittent basis. IHS could benefit from experts/consultants by:

1. Gaining specialized diversity of thought needed to solve complex issues or perform tasks.

2. Obtaining advice from experts/consultants in their field of study.
3. Hiring experts/consultants from leading universities and colleges to advise on health care
4. Completing short-term mission-critical projects.
5. Filling short-term, high level positions with experts/consultants temporarily, which can be an efficient mechanism as well as a cost savings to the agency.

Budget Impact: This proposal is budget neutral. The IHS will accommodate funding requirements within existing resources.

Effective Date: Upon enactment of legislative authority and the creation of a new HR system.

Equity Impact Assessment: This proposal will enable the Indian Health Service to appoint experts and consultants to support the provision of healthcare to people in AI/AN communities who disproportionately suffer from serious health issues and a shortage of needed healthcare providers. By authorizing the use of experts and consultants, IHS can strengthen operations and patient care, and as a result, achieve better health care outcomes for American Indians and Alaska Natives.

Impact on Other Agencies: None.

Indian Health Service

Provide the Indian Health Service (IHS) with an on-call pay authority through a revision to premium pay provisions under Title 5 of the United States Code (USC)

Proposal: The Indian Health Service (IHS) needs to be able to provide on-call pay to its health care staff under the premium pay system authorized under Title 5 of the United States Code. This will enable IHS to compensate clinical staff who agree to be on call and to achieve adequate on-site staffing levels when responding to fluctuating patient care demands.

Current Law: IHS uses the premium pay provisions under Title 5 of the USC to compensate employees for working extended hours (overtime pay) or for working at certain times such as at night, on Sundays or on holidays. Premium pay is paid under Title 5 legal and regulatory provisions and is subject to biweekly and annual aggregate pay limitations, under 5 U.S.C. chapter 55, subchapter V and 5 Code of Federal Regulations (CFR) part 550, subpart A. Current Title 5 premium pay law does not allow for on-call pay.

By comparison, a major pay feature used by the United States Department of Veterans Affairs (VA) and nonfederal health care employers is the ability to provide on-call premium pay to health-care staff. Under the VA's Title 38 premium pay provisions, on-call pay is paid at ten percent of the employee's overtime rate. This type of premium pay is provided when an employee is scheduled to be on call outside of working hours in the event that the employer needs to call the employee back to the work site to provide health-care services. During the on-call period, the employee must remain ready to work and must carry a cell phone or other device in order to be easily contacted in the event the work site needs his or her services. If the employee is called back to the work site, he or she is provided, at a minimum, two hours of overtime pay or more if the employee needs to work on site longer than two hours. The ability to have employees be on call allows the VA to quickly adjust its on-site staffing and is ultimately a cost-savings measure since there is no need to schedule additional staff on-site at their full regular or overtime rate just to prepare for the possibility of increased patient care demands. On-call pay is also a standard pay option in nonfederal health care facilities that are not bound by federal pay regulations.

Rationale: The IHS is the principal federal health care provider and health advocate for American Indians and Alaska Natives (AI/ANs). The IHS provides comprehensive health services for over 500 federally recognized tribes and serves over two million AI/ANs located across 37 states every year.

For various budgetary and administrative reasons, IHS has not adopted the full suite of premium pay provisions available under the delegated Title 38 pay authorities which allow for the payment of on-call premium pay. IHS often competes with the VA and nonfederal employers for needed allied health staff, and IHS's inability to pay on-call pay is a major recruitment and retention challenge.

The success of the IHS clinical mission rests on the ready availability of the appropriate clinical staff who can best address patient needs. To achieve this, IHS needs to be able to compensate employees who are on call, with formally agreed-upon on-call restrictions in place such as continued proximity to the work site, carrying a cell phone, and remaining in a ready and able to work physical condition. A legislative change to the Title 5 premium pay provisions would place IHS on more equal footing with the VA and nonfederal employers of clinical staff that can already provide on-call pay to staff.

Budget Impact: This proposal is budget neutral. The IHS will accommodate funding requirements within existing resources.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal will enable the IHS to hire and retain mission-critical healthcare staff to provide healthcare to people in AI/AN communities who disproportionately suffer from serious health issues and a shortage of needed healthcare providers. It will enable IHS to better manage its healthcare staff by compensating employees who serve on call. The requested change will make the level of care provided to AI/AN people more on par with care provided to the country's veterans by the VA.

Impact on Other Agencies: None.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2023 Performance Budget Submission to Congress

TABLE OF CONTENTS

Self Determination

Indian Health Service

Indian Self Determination

Indian Health Service Philosophy – The Indian Health Service (IHS) implements the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law (Pub. L. No.) 93-638, as amended, which recognizes the unique legal and political relationship between the United States and American Indian and Alaska Native peoples. Accordingly, the IHS supports Tribal sovereignty: (1) by assisting Tribes in exercising their right to administer the IHS health programs, or portions thereof, and (2) by continuing to directly provide services to Tribes that choose the IHS as their health care provider. A Tribal decision to enter or not enter into ISDEAA agreements are equal expressions of self-determination.

Title I Contracts and Title V Self-Governance Compacts – Titles I and V of the ISDEAA provide Tribes the option to exercise the right to self-determination by assuming control and management of programs previously administered by the federal government. Since 1975, the IHS has entered agreements with Tribes and Tribal organizations to plan, conduct, and administer programs authorized under Section 102 of the Act. Today, over $6.2 billion of the Agency's appropriation is transferred to Tribes and Tribal Organizations through Title I contracts and Title V compacts. Under Title I, there are 244 Tribes and Tribal Organizations operating 254 contracts and annual funding agreements. Under Title V, IHS is party to 105 compacts and 131 funding agreements; through which approximately $2.6 billion of the IHS budget is transferred to Tribes and Tribal organizations. Sixty-six percent of federally recognized Tribes participate in Title V.

Indian Health Service

Self-Governance Funded Compacts FY 2021

(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALABAMA	**4,400**	**360**	**164**	**498**	**5,422**
Poarch Band of Creek Indians	4,400	360	164	498	5,422
ALASKA	**573,761**	**56,402**	**57,192**	**178,535**	**865,890**
Alaska Native Tribal Health Consortium	98,311	19,625	12,553	19,763	150,252
Aleutian Pribilof Islands Association, Inc.	1,827	36	188	1,346	3,397
Arctic Slope Native Association, Ltd	23,092	2,524	3,546	7,610	36,772
Bristol Bay Area Health Corporation	20,479	1,217	2,384	9,778	33,859
Chickaloon Native Village	58	1	16	13	89
Chugachmiut	3,641	80	241	1,822	5,785
Copper River Native Association	5,669	450	905	2,139	9,164
Council of Athabascan Tribal Governments	1,806	178	107	1,288	3,378
Eastern Aleutian Tribes, Inc.	3,079	31	192	1,890	5,192
Kenaitze Indian Tribe, I.R.A.	12,238	1,180	427	3,198	17,044
Ketchikan Indian Community	5,517	254	592	3,672	10,036
Knik Tribal Council	73	1	11	11	96
Kodiak Area Native Association	7,400	212	491	2,802	10,905
Maniilaq Association	27,383	1,300	3,043	14,671	46,397
Metlakatla Indian Community	6,280	1,064	512	1,276	9,132
Mount Sanford Tribal Consortium	730	2	81	263	1,076
Native Village of Eklutna	179	5	7	56	246
Native Village of Eyak	796	52	95	366	1,310
Norton Sound Health Corporation	44,113	4,241	4,679	12,498	65,532
Seldovia Village Tribe	1,859	46	94	699	2,698
Southcentral Foundation	89,782	4,392	10,819	33,029	138,022
SouthEast Alaska Regional Health Consortium	38,420	1,892	3,848	18,944	63,104
Tanana Chiefs Conference	62,366	4,359	6,114	18,186	91,025
Yakutat Tlingit Tribe	4,450	382	34	2,575	7,441
Yukon-Kuskokwim Health Corporation	114,211	12,876	6,213	20,641	153,941
ARIZONA	**197,964**	**19,686**	**8,248**	**50,810**	**276,707**
Ak-Chin Indian Community	52	0	7	10	70
Gila River Indian Community	76,772	9,724	1,907	22,247	110,650
Pascua Yaqui Tribe	15,527	201	198	3,336	19,262
Salt River Pima-Maricopa Indian Community	6,054	116	281	2,636	9,087
Tohono O'Odham Nation	35,064	3,897	2,617	3,479	45,056
Tuba City Regional Health Care Corporation	41,646	4,281	2,357	11,622	59,906
Winslow Indian Health Care Center, Inc.	22,848	1,468	881	7,479	32,675
CALIFORNIA	**85,044**	**4,990**	**4,237**	**28,567**	**122,839**
Chapa-De Indian Health Program, Inc.	6,778	651	193	0	7,621
Consolidated Tribal Health Project, Inc.	3,979	211	111	1,536	5,837
Feather River Tribal Health, Inc.	6,075	938	174	1,946	9,134
Hoopa Valley Tribe	5,096	139	283	2,293	7,811
Indian Health Council, Inc.	8,669	92	298	3,677	12,736
Lake County Tribal Health Consortium, Inc	6,565	1,295	179	0	8,040
Karuk Tribe of California	3,092	440	102	1,010	4,645
Northern Valley Indian Health, Inc.	4,269	10	121	1,308	5,708
Pinoleville Pomo Nation	90	0	3	12	105
Redding Rancheria Tribe	7,184	608	619	2,995	11,407
Riverside-San Bernardino County Indian Health, Inc.	21,892	214	936	9,433	32,475
Rolling Hills Clinic	534	121	1	272	928
Round Valley Indian Health Center, Inc.	2,149	198	99	528	2,976
Santa Ynez Band of Chumash Mission Indians	1,961	19	37	645	2,662
Southern Indian Health Council, Inc.	4,995	39	910	2,316	8,261
Susanville Indian Rancheria	1,715	16	171	593	2,494

Indian Health Service

Self-Governance Funded Compacts FY 2021

(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
CONNECTICUT	**2,474**	**71**	**0**	**693**	**3,239**
Mohegan Tribe of Indians of Connecticut	2,474	71	0	693	3,239
FLORIDA	**9,787**	**313**	**1,048**	**2,048**	**13,196**
Seminole Tribe of Florida	9,787	313	1,048	2,048	13,196
IDAHO	**16,136**	**1,081**	**2,006**	**6,341**	**25,564**
Coeur D'Alene Tribe	6,319	478	1,467	3,450	11,714
Kootenai Tribe of Idaho	660	38	82	138	918
Nez Perce Tribe	9,157	565	457	2,753	12,932
KANSAS	**6,893**	**203**	**198**	**3,217**	**10,511**
Iowa Tribe of Kansas and Nebraska	2,136	44	175	1,517	3,872
Prairie Band Potawatomi Nation	4,757	158	22	1,700	6,638
LOUISANA	**1,206**	**97**	**134**	**248**	**1,685**
Chitimacha Tribe of Louisiana	1,206	97	134	248	1,685
MAINE	**3,426**	**126**	**183**	**1,023**	**4,758**
Penobscot Indian Nation	3,426	126	183	1,023	4,758
MASSACHUSETTS	**708**	**41**	**236**	**0**	**985**
Wampanoag Tribe of Gay Head	708	41	236	0	985
MICHIGAN	**28,769**	**1,184**	**2,592**	**3,440**	**35,985**
Grand Traverse Band of Ottawa and Chippewa Indians	2,890	202	331	449	3,872
Keweenaw Bay Indian Community	3,433	256	868	644	5,201
Little River Band of Ottawa Indians	2,087	11	268	395	2,760
Match-E-Be-Nash-She-Wish Band of Pottawatomi	1,189	19	236	345	1,790
Nottawaseppi Huron Band Of The Potawatomi	1,772	39	57	209	2,076
Sault Ste. Marie Tribe of Chippewa Indians	17,398	657	832	1,398	20,285
MINNESOTA	**20,818**	**937**	**3,032**	**2,516**	**27,302**
Bois Forte Band of Chippewa Indians	2,677	22	430	697	3,825
Fond du Lac Band of Lake Superior Chippewa	12,129	656	1,306	984	15,075
Mille Lacs Band of Ojibwe	4,241	244	1,278	506	6,269
Shakopee Mdewakanton Sioux Community	1,771	15	18	329	2,133
MISSISSIPPI	**37,800**	**4,022**	**1,347**	**5,758**	**48,927**
Mississippi Band of Choctaw Indians	37,800	4,022	1,347	5,758	48,927
MONTANA	**33,299**	**1,327**	**2,009**	**3,960**	**40,594**
Chippewa Cree Tribe of the Rocky Boy's Reservation	10,554	370	1,127	2,378	14,430
Confederated Salish and Kootenai Tribes of the Flathead Nation	22,745	956	882	1,582	26,165
NEBRASKA	**17,663**	**3,148**	**1,822**	**3,535**	**26,168**
Winnebago Tribe of Nebraska	17,663	3,148	1,822	3,535	26,168
NEW MEXICO	**12,722**	**287**	**1,422**	**2,051**	**16,483**
Pueblo of Jemez	9,821	220	1,035	1,554	12,630
Pueblo of Sandia	1,982	59	161	254	2,456
Taos Pueblo	919	8	226	244	1,397
NEW YORK	**8,029**	**408**	**347**	**2,358**	**11,142**
St. Regis Mohawk Tribe	8,029	408	347	2,358	11,142
NEVADA	**28,943**	**1,474**	**2,357**	**5,247**	**38,022**
Duck Valley Shoshone-Paiute Tribes	6,934	523	835	1,715	10,008
Duckwater Shoshone Tribe	1,107	7	217	765	2,096
Ely Shoshone Tribe	1,348	28	68	497	1,940
Fort McDermitt Paiute and Shoshone Tribe	1,626	103	8	113	1,850
Las Vegas Paiute Tribe	3,468	87	130	322	4,006
Reno-Sparks Indian Colony	7,112	415	731	1,411	9,670
Washoe Tribe of Nevada and California	5,307	212	255	425	6,199
Yerington Paiute Tribe of Nevada	2,041	99	113	0	2,252
NORTH CAROLINA	**19,821**	**987**	**1,080**	**8,341**	**30,228**
Eastern Band of Cherokee Indians	19,821	987	1,080	8,341	30,228
NORTH DAKOTA	**11,110**	**515**	**1,660**	**2,441**	**15,726**
Spirit Lake Tribe	11,110	515	1,660	2,441	15,726

Indian Health Service

Self-Governance Funded Compacts FY 2021

(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
OKLAHOMA	**559,028**	**65,006**	**55,356**	**115,457**	**794,847**
Absentee Shawnee Tribe of Oklahoma	18,169	1,868	2,096	6,013	28,145
Cherokee Nation	239,573	22,657	25,741	37,529	325,500
Chickasaw Nation	85,946	17,701	10,980	23,144	137,771
Choctaw Nation of Oklahoma	88,106	14,188	6,902	25,177	134,373
Citizen Potawatomi Nation	22,197	1,754	1,779	9,239	34,969
Kaw Nation of Oklahoma	2,916	131	229	537	3,812
Kickapoo Tribe of Oklahoma	9,977	253	315	1,612	12,157
Modoc Tribe of Oklahoma	59	50	7	20	136
Muscogee Creek Nation	51,748	5,007	6,145	5,170	68,069
Northeastern Tribal Health System	7,545	116	166	1,175	9,003
Osage Nation	12,907	146	402	2,292	15,747
Ponca Tribe of Oklahoma	6,286	130	282	937	7,635
Quapaw Tribe of Oklahoma	223	0	37	157	417
Sac and Fox Nation of Oklahoma	9,883	101	180	1,456	11,620
Seminole Nation of Oklahoma	498	824	54	251	1,626
Wyandotte Nation	2,996	80	42	747	3,865
OREGON	**29,795**	**1,201**	**3,018**	**11,949**	**45,963**
Confederated Tribes of Grand Ronde	7,080	125	614	2,733	10,551
Confederated Tribes of Siletz Indians of Oregon	8,121	320	819	2,934	12,194
Confederated Tribes of the Coos, Lower Umpqua & Siuslaw Indians	1,847	81	320	519	2,767
Confederated Tribes of the Umatilla Reservation	6,921	331	803	2,023	10,077
Coquille Indian Tribe	2,063	139	254	3,146	5,601
Cow Creek Band of Umpqua Tribe of Indians	3,764	205	209	594	4,772
UTAH	**7,884**	**66**	**1,941**	**3,425**	**13,317**
Utah Navajo Health System, Inc.	7,884	66	1,941	3,425	13,317
WASHINGTON	**61,344**	**3,604**	**3,153**	**18,000**	**86,100**
Cowlitz Indian Tribe	6,979	213	25	2,039	9,256
Jamestown S'Klallam Indian Tribe	1,318	68	101	560	2,048
Kalispel Tribe of Indians	1,126	57	24	49	1,255
Lower Elwha Klallam Tribe	1,927	115	118	474	2,634
Lummi Indian Nation	8,279	566	294	1,786	10,926
Makah Indian Tribe	3,977	288	314	992	5,571
Muckleshoot Tribe	7,444	381	229	2,814	10,868
Nisqually Indian Tribe	2,372	195	127	441	3,134
Port Gamble S'Klallam Tribe	2,693	191	156	1,618	4,657
Quinault Indian Nation	5,751	532	251	1,876	8,410
Samish Indian Nation	1,166	7	103	458	1,734
Shoalwater Bay Indian Tribe	1,823	57	321	875	3,077
Skokomish Indian Tribe	2,122	97	128	498	2,844
Squaxin Island Indian Tribe	2,808	213	225	1,280	4,526
Suquamish Tribe	1,749	33	169	612	2,564
Swinomish Indian Tribal Community	2,314	118	203	709	3,343
Tulalip Tribes of Washington	7,496	473	364	921	9,254
WISCONSIN	**35,260**	**946**	**4,384**	**4,723**	**45,313**
Forest County Potawatomi Community	2,013	79	809	342	3,243
Ho-Chunk Nation	8,311	308	977	815	10,410
Oneida Tribe of Indians of Wisconsin	21,609	315	2,074	2,949	26,947
Stockbridge-Munsee Community	3,328	244	524	618	4,713
Grand Total	**1,814,084**	**168,481**	**159,166**	**465,182**	**2,606,912**

Indian Health Service
FY 2021 Self-Governance Funding Agreements
By Area
(Dollars in Thousands)

Area	Program Tribal Shares	Area Office Tribal Shares	Headquarters Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALASKA	607,465	13,478	9,219	57,192	178,535	865,890
ALBUQUERQUE	11,759	924	326	1,422	2,051	16,483
BEMIDJI	84,368	1,855	1,691	10,008	10,679	108,600
BILLINGS	31,902	1,806	918	2,009	3,960	40,594
CALIFORNIA	83,903	3,518	2,613	4,237	28,567	122,839
GREAT PLAINS	30,833	1,266	338	3,481	5,977	41,894
NASHVILLE	87,697	4,993	1,385	4,538	20,967	119,581
NAVAJO	74,616	1,556	2,022	5,179	22,526	105,899
OKLAHOMA	607,197	11,557	12,376	55,554	118,674	805,358
PHOENIX	119,630	1,935	1,570	4,553	30,140	157,829
PORTLAND	106,311	3,789	3,062	8,176	36,289	157,627
TUCSON	51,335	2,611	742	2,815	6,816	64,319
Total, IHS	**1,897,016**	**49,287**	**36,262**	**159,166**	**465,182**	**2,606,912**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2023 Performance Budget Submission to Congress

TABLE OF CONTENTS

Nonrecurring Expenses Fund

Nonrecurring Expenses Fund

Budget Summary
(Dollars in Thousands)

	FY 2021[1]	FY 2022[2] [4]	FY 2023[3] [4]
Information Technology	TBD	TBD	$18,000
Facilities	TBD	TBD	$20,000
Notification[4] Total	$193,700	$80,210	$38,000

Authorizing Legislation:
Authorization…….Section 223 of Division G of the Consolidated Appropriations Act, 2008
Allocation Method……..……..Direct Federal, Competitive Contract

Program Description and Accomplishments
The Nonrecurring Expenses Fund (NEF) permits HHS to transfer unobligated balances of expired discretionary funds from FY 2008 and subsequent years into the NEF account. Congress authorized use of the funds for capital acquisitions necessary for the operation of the Department, specifically information technology (IT) and facilities infrastructure acquisitions.

Information Technology

Budget Allocation FY 2023

1. Quality Measures Development and Reporting

The project will develop new data capture capabilities, measure logic, and business intelligence development to respond to mandated requirements from various quality initiative programs and public health emergency management reporting. Activities include updating measures to the current version logic, developing new measures as identified, and developing all required reporting processes that must be performed either individually at the site level or through central reporting mechanisms, such as the Association of Public Health Laboratories Information Messaging Services system.

2. IPv6 Cybersecurity Remediation

The project will upgrade the IHS Wide Area Network (WAN) to support the migration to an Internet Protocol IPv6 capable network. This upgrade is critical to support Health IT services and will provide the network hardware, tools and migration support services to enable the IHS WAN to migrate to next-generation networking capabilities and increase the overall security posture of the IHS network.

[1] Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use
[2] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on October 22, 2020.
[3] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on June 17, 2021.
[4] The NEF CJ indicates the amounts HHS intends to notify for in 2022 and 2023; these amounts are planned estimates and subject to final approval.

3. **Modernize Enterprise IT Services for Cloud and Cybersecurity**

   The proposed project will support the acquisition and implementation of cloud capabilities for the IHS enterprise infrastructure that will support the IHS Health Information Technology (HIT) modernization initiative. Leveraging cloud computing capabilities will enable the IHS to leverage five essential characteristics of cloud computing: on-demand IT services, broad network access, resource pooling, rapid elasticity, and measured services, community health department, and a full array of ancillary and support services.

Budget Allocation FY 2022 Projects

1. **Improve IT Service Management Maturity**

   This project will mature the cloud capabilities of IHS Health Information Technology (HIT) systems and improve Information Technology (IT) services that support direct patient care. IHS medical providers use IHS IT and HIT systems a

2. **Lifecycle Replacement of Critical Hardware**

   This project continues replacing end of life network and data center hardware critical to HIT services that support medical providers. IHS has thousands of devices operating beyond the lifecycle that are not covered by warranties or service agreements and cannot be updated against cybersecurity threats. This project is part of a multi-year strategy to improve lifecycle management of all IHS hardware.

3. **Cybersecurity Operations Center**

   This project will create a dedicated lab space with specific tools and equipment needed to perform several mission essential functions that aid in HHS and OIG investigations. Some of these functions include malware analysis, eDiscovery and research. This facility will give the incident responders the ability to correlate data from various sources and determine if a critical system has been impacted; provide remediation efforts and support system owners in data/system recovery.

4. **HIT Project 2: Advancing Interoperability of Health Information**

   The Interoperability project objective is to develop strategies, including the development and/or acquisition of solutions in response to the HHS requirements of the 21st Century Cures Act. IHS is required to comply with HHS mandates for Certified Health Information Technology (CHIT). Current annual appropriations are not provided at sufficient levels to support the breadth and depth of work required to maintain the current system and development work required to meet the 21st Century Cures Act program mandates.

5. **Developing and implementing supporting technology standardization through a planned Enterprise Architecture**

   While efforts are underway to transform the IHS IT and HIT major systems, ancillary and tertiary systems which provide data to major systems may also need to be upgraded or replaced. This effort would use contracted support to work to identify, develop, and implement guidance and standards for hardware and software for supporting systems in the IHS ensure technological and data sharing compatibility as well as uniformity in the IHS environment. The effort would create a holistic view of the endpoint systems which feed major data repositories to eliminate “islands of data” which require manipulation to be consumed into major systems. The effort would examine and promulgate guidance for all systems ranging from user endpoints such as PC’s and tablets to infrastructure components such as routers and switches and Wi-Fi connectivity and include network connected medical devices such as medical laboratory and diagnostic devices.

Budget Allocation FY 2021 Projects Total: $194 million

1. **ITOPS Project 2: Modernize Enterprise IT Services $3.5 million**

   This project will mature the cloud capabilities of IHS Health Information Technology (HIT) systems and improve Information Technology (IT) services that support direct patient care. IHS medical providers use IHS IT and HIT systems as fundamental tools in raising the physical, mental, social, and spiritual health of American Indian and Alaska Native people. This project is a high priority requirement on the roadmap to modernize the IHS electronic health record system, satisfies multiple Inspector General recommendations, and achieves Department data center consolidation goals. Expanding cloud capabilities enhances the cybersecurity capabilities of IHS and HIT systems and allows IHS to centralize and consolidate IT services.

2. **ITOPS Project 4: Improve IT Service Management Maturity $2 million**

   Building on ITOPS Project 3, this project will mature the IT Service Management (ITSM) capabilities of IHS and improve IT and HIT services that support medical providers, which are fundamental to raising the physical, mental, social, and spiritual health of American Indian and Alaska Native people. Building on the capabilities of the IHS ServiceNow platform, this project will improve customer experience and increase the quality of IT services provided by IHS. ITSM is fragmented in IHS because each of the 12 Areas and Headquarters operate separate IT budgets and have procured disparate ITSM tools and processes over the years. This project delivers consistent processes and centralizes ITSM capabilities to improve IHS IT services. This project also allows the IHS to develop a centralized capability to assist in stronger cybersecurity management of IHS IT and HIT systems.

3. **ITOPS Project 6: Lifecycle Replacement of Critical Hardware $2 million**

   Building on ITOPS Project 5, this project will replace end of life network and data center hardware critical to HIT services that support medical providers, which are fundamental to raising the physical, mental, social, and spiritual health of American Indian and Alaska Native people. IHS has thousands of devices operating beyond the lifecycle that are not covered by warranties or service agreements and cannot be updated against cybersecurity threats. This project is part of a multi-year strategy to improve lifecycle management of all IHS hardware.

Facilities

Budget Allocation FY 2023

1. **Fort Duchesne Health Center Modernization**

   The Fort Duchesne PHS Indian Health Center Renovations project is intended to modernize the building's mechanical, electrical, plumbing, security and information technology systems, and reconfigure the space allocation within the healthcare facility to address current healthcare needs. This amount is in addition to the $3.5 million in FY 2022 NEF resources, and will complete the project.

2. **Crow 18-Unit Apartment Building**

   The NEF funds will be used to construct an 18-Unit apartment building in Crow Agency, Montana. In 2019, the Program Justification Document for Quarters (PJDQ) was approved to justify the need for additional staff quarters at the Crow Service Unit. The project has been designed and is ready for construction, but the project has been delayed due increased construction costs related to the

COVID-19 Pandemic. The PJDQ identifies the shortage of living quarters within the area and that shortage limits IHS' ability to hire and retain staff. The project will expand the availability of living quarters at the remote location, which enables the Service Unit to hire and house the needed staff for delivering adequate health care. This project has not received NEF resources, and these funds will complete the project.

3. **Rapid City Health Center Priority Health Project**

Funds will be used to equip the health care facility to replace the Sioux San Hospital with a new 137,391sf ambulatory care center. This facility will improve access to medical care as well as improve the collaboration and partnership between the Great Plains Tribes and the IHS. The new health care facility will provide an expanded outpatient department, community health department, and a full array of ancillary and support services. This facility began construction in September 2019. This amount is in addition to the $29.5 million in FY 2016 NEF resources, and will continue the project.

Budget Allocation FY 2022

Generators for California Area Tribal Health Programs
The NEF funds will be used to support the purchase of emergency generators for California Area Tribal Health programs impacted by public safety power shutoffs in California.

IHS Chemawa Indian Health Center, Salem, OR
Based on the current service priorities and draft of the master plan, the first phase of capital improvements is anticipated to construct a new student wellness building on the Western Oregon Service Unit campus. The construction work aligns with other agency strategic initiatives specific to youth behavioral health needs. This investment will notably improve student wellness.

Yakama Dental Building and Modern Primary Care Department
Based on the current service priorities and draft of the master plan, the first phase of capital improvements is anticipated to construct a new dental and optometry building on the Yakama Service Unit campus. An updated site survey for the campus has been completed and is currently being recorded with the Yakama Nation's BIA Realty office and at the US Title Plant. Moving the dental and optometry departments to the new building will provide space to renovate and expand the existing primary care department.

White Earth Health Center Phase II Renovation
The proposed renovation plan of the White Earth Health Center in Ogema, MN, is needed to meet the demand for health services from the increase in user populations. The 35,800 sf renovation, increases space for Radiology Diagnostics, Behavioral Health, Lab, Optometry, Primary Care, Employee Facilities, Health Information Management and Administration. These funds provide continued renovation of the White Earth Health Center. Previous NEF include $10 million for renovation and expansion.

Fort Duchesne Health Center Modernization
The Fort Duchesne PHS Indian Health Center Renovations project is intended to modernize the building's mechanical, electrical, plumbing, security and information technology systems, and reconfigure the space allocation within the healthcare facility to address current healthcare needs.

Nationwide Quarters New and Replacement
The NEF funds will be used to design, construct, and equip new and replacement staff quarters. Many locations need to replace existing staff quarters due to deterioration. Staffing health centers in remote locations is difficult when quarters are limited. The shortage of staff limits IHS' ability to provide healthcare.

Sells Health Center Replacement Facility

The NEF Funds will augment the FY 2022 HHSJ funding requested for the Sells Health Center Replacement Facility for initial infrastructure and construction. Additional NEF for this facility includes $14,999,562 for a 100% design of the new facility.

Budget Allocation FY 2021 (Total: $186.2 million)

Tsaile Health Center Quarters, Tsaile, AZ **$21,500,000**

The Tsaile Health Center staff Quarters project will design and construct one 15 unit apartment building, and 15 individual staff quarters and a quarters support building to support the Navajo Area Indian Health Service (NAIHS) Tsaile Health Center (THC) located in Tsaile, Arizona.

Regional Referral Center, Seattle, WA **$164,700,000**

The proposed project plans for a design of a 173,000 SF healthcare facility on a 5.6-acre parcel of tribal trust land offered by the Puyallup Tribe in Fife, Washington (Seattle metropolitan area). The facility will be specifically designed to meet the specialty healthcare needs of the 43 tribes served in the NW regional area, and has access to multiple modes of transportation and temporary lodging.