DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year

2018

Indian Health Service

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

I present the Indian Health Service (IHS) Fiscal Year (FY) 2018 Congressional Justification. The FY 2018 budget request supports the President's goal of providing the most efficient and effective health services. This budget also invests in the Department of Health and Human Services (HHS) Secretary's priority to enhance the health and well-being of Americans, providing a patient-centered system with emphasis on fighting substance abuse and reducing the impact of childhood obesity.

The mission of the IHS is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. This FY 2018 budget submission continues support for our critical work in providing a comprehensive health service delivery system managed by IHS, Tribal and urban Indian health programs in 36 states. Our efforts align with the Administration's priorities and support the HHS' goals to help people live healthy, safe, and productive lives. This budget submission also reflects our continued partnership and consultation with Tribes and conferring with urban Indian organizations to address the health care needs of American Indians and Alaska Natives.

Our FY 2018 budget submission maintains focus on the IHS mission and maintains funding in four priorities:

- People – Recruit, develop, and retain a dedicated, competent, and caring workforce collaborating to achieve the IHS mission;
- Partnerships – Build, strengthen, and sustain collaborative relationships that advance the IHS mission;
- Quality – Excellence in everything we do to assure a high-performing Indian health system; and
- Resources – Secure and effectively manage the assets needed to promote the IHS mission.

Performance management and improvement is critical to our work and we regularly measure our progress. The IHS's priorities provide a shared vision of what needs to be accomplished with our partners and provides a consistent and effective way to measure our achievement as we continue to change and improve the IHS.

RADM Chris Buchanan, R.E.H.S., M.P.H.
Assistant Surgeon General, USPHS
Acting Director

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2018 Performance Budget Submission to Congress

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

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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 goal is to ensure that comprehensive, culturally-acceptable personal and public health services are available and accessible to American Indian and Alaska Native people. The strategic goals include building and sustaining healthy communities; providing accessible, quality health care; and fostering collaboration and innovation across the Indian health care systems.

The IHS provides a wide range of clinical, public health, community, and facilities infrastructure services to approximately 2.2 million American Indians and Alaska Natives who are primarily members of 567 federally-recognized Tribes in 36 states. Comprehensive primary health care and disease prevention services are provided through a network of over 662 hospitals, clinics, and health stations on or near Indian reservations. These 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 program direction roles that were 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 facilities where Tribes have chosen not to contract or compact health programs.

This Budget represents the President's annual report to Congress on IHS programs and its achievement of the goals of IHCIA as required by 25 USC Sec. 1671.

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INDIAN HEALTH SERVICE
FY 2018 President's Budget to Congress

Overview of Budget

The FY 2018 Budget reflects the President's support of health care services for American Indians and Alaska Natives. These programs deliver critical health care services to these uniquely vulnerable peoples. This budget focuses on the Secretary's priorities of protecting the health and well-being of Americans, investing in addressing the Nation's mental health and substance abuse crisis and supporting the fight to end childhood obesity; issues that are of particular importance to native peoples.

The Secretary is cognizant of the budget constraints, but protects medical services, holding the budget even with FY 2016, proposing one time reductions on parts of infrastructure projects and management activities in the Facilities appropriation account. This supports the President's agenda of addressing the Nation's priorities.

Tribal consultation is fundamental to the Indian Health Service (IHS) budget process. The core of the agency's formulation process consists of the priorities and recommendations developed by Tribes through an independent annual budget formulation process. This process is one the IHS is strongly committed to and believes it helps to ensure that the IHS budget is relevant to the health needs and priorities of American Indian and Alaska Native people. The tribal priorities identified in the consultation process are also instrumental in informing senior officials of other U.S. Department of Health and Human Services (HHS) agencies of the health needs of the American Indian and Alaska Native population, so that they have the opportunity to include those priorities in their individual budget requests to HHS. The Tribal budget consultation process is a key component of the IHS priority to build, strengthen, and sustain collaborative relationships that advance the IHS mission.

Summary of Budget Submission. The total discretionary budget authority for IHS is $4.7 billion, a reduction of $59 million below the FY 2017 Continuing Resolution. In order to address growing needs and access to care of the American Indian and Alaska Native population and honor the federal government's commitment made through Joint Venture Construction Program agreements entered into with the Tribes, the budget includes reductions to facilities construction in order to maintain health care services and fund staffing and operating costs for two newly-constructed facilities scheduled to open in FY 2017.

Changes:

- Staffing and Operating Costs for Newly-constructed Facilities: +$20 million above the FY 2017 Continuing Resolution for new staffing of two newly-constructed health care facilities. These funds will allow new facilities to expand the provision of health care in areas where the existing capacity is overextended, while balancing the need to maintain existing services across the country. And, the combined Tribal investments are more than $86 million in construction to expand access to care in locations where existing capacity is most over extended.

- Facilities Account: -$75 million below the FY 2017 Continuing Resolution to prioritize direct health services and funding for staffing for 2 new Joint Venture facilities. Reductions include, maintenance and improvement, sanitation facilities construction, equipment, and facility environmental health support.

Overview of Agency Performance

Since 1955, the IHS, in consultation with Tribes, Urban Indian programs, and Indian organizations, has worked diligently to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/AN people.[1]

This FY 2018 performance budget represents the IHS' progress in providing health care services to approximately 2.2 million American Indians and Alaska Natives in 36 states. In pursuing our mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level, IHS's strategic goals relate to: people, partnerships, quality and resources. The IHS operates a health services delivery system providing a range of clinical, public health, community and environmental services. This system integrates health services delivery through IHS facilities, purchased by IHS through contractual arrangements with providers in the private sector, and delivered through tribally operated programs and urban Indian health programs.

IHS performance improvement is a concerted effort by all members of the Indian health system working together to improve a comprehensive set of existing performance measures. This includes all clinic-based, hospital-based, and community-based programs administered by federal, tribal and urban programs. The IHS budget request reflects Government Performance and Results Act (GPRA) and GPRA Modernization Act (GPRAMA) measures that support our strategic goals and improvement of AI/AN health outcomes. Listed below under each goal are highlights of the Agency's achievements and performance expectations, as appropriate.

People – *Recruit, develop, and retain a dedicated, competent, caring workforce collaborating to achieve the IHS mission.*

- In FY 2016, IHS and Tribes provided 13,882,221 outpatient visits to 1,626,826 AI/ANs. While FY 2016 inpatient admission data is not yet available, IHS and Tribes provided 39,305 direct care admissions in FY 2015. In FY 2018, it is expected the IHS user population will increase by approximately 59,093 compared to FY 2016.
- In FY 2018, IHS expects to maintain current efforts to support the IHS workforce and modify the number of current health professions award for scholarships and loan repayment.
- In FY 2017, IHS is working on several recruitment and training efforts aimed at strengthening the IHS health professions workforce, including implementing a global recruitment to recruit for critical vacancies across the Agency. To reach out to health professions students, IHS has also established partnerships with the Health Resources Services Administration, Bureau of Health Workforce by participating in nationwide virtual career fairs to promote National Health Service Corps scholarship and loan repayment opportunities. IHS has also partnered with the Department of Veterans Affairs (VA) to establish a workgroup to increase capability and improve quality through training and workforce development as well as sharing of educational and training opportunities for IHS staff.

Partnerships – *Build, strengthen, and sustain collaborative relationships that advance the IHS mission.*

[1] The IHS produces statistical information and publications that measure and document the progress in assuring access to health care services and improving the health status of AI/ANs, publications are available at: https://www.ihs.gov/dps/index.cfm/publications.

- IHS has numerous partnerships with HHS sister agencies, other federal departments, and countless academic, professional, and other organizations. The bullets below represent a few examples of these important partnerships:
- The IHS and VA partnership allows eligible AI/AN veterans more choices of where to access care and VA reimbursement to the IHS and tribal facilities for direct care services. In FY 2018, IHS anticipates collection of $28 million in VA reimbursements.
- To increase access to behavioral health services for native youth, IHS partners with the Bureau of Indian Affairs (BIA) and Bureau of Indian Education (BIE) under a 10-year agreement. The agreement allows each agency to establish local partnerships between IHS federally operated mental health programs, BIE-operated elementary and secondary schools, and BIA OJS-operated juvenile detention centers to provide mental health assessment and counseling services, which includes telebehavioral health services. In FY 2018, IHS will report results for depression screening among AI/AN youth aged 12-17.
- IHS is working with the Pediatric Integrated Care Collaborative (PICC) which is part of the Johns Hopkins Center for Mental Health Services in Pediatric Primary Care. PICC works with national faculty, pediatric primary care providers, mental health professionals and families to increase the quality and accessibility of child trauma service by integrating behavioral and physical health services in Native communities. In FY 2017, 10 IHS and Tribally operated sites will participate in a new year long project to integrate trauma-informed care at IHS and tribal facilities.

Quality – *Excellence in everything we do to assure a high-performing Indian Health system.*

- In FY 2017, IHS is implementing several efforts to strengthen the delivery of high quality health care at IHS direct service facilities. The FY 2018 target is to maintain 100 percent accreditation and/or certification at IHS-operated hospitals and outpatient clinics (excluding tribally operated facilities).
- IHS is working with The Joint Commission for accreditation, training and education services to strengthen quality and patient safety.
- The Centers for Medicare & Medicaid Services (CMS) now includes IHS hospitals in the nationwide Hospital Improvement and Innovation Networks contract for public and private sector hospitals to reduce adverse health events by 20 percent and hospital readmissions by 12 percent.
- An IHS Telehealth contract will provide telehealth services at six hospitals and many health centers and other facilities throughout Iowa, Nebraska, South Dakota and North Dakota. IHS is seeking to expand telehealth services as a means of strengthening access to care at its facilities in all 14 Great Plains Area facilities, which serve 130,000 American Indians and Alaska Natives.

Resources – *Secure and effectively manage the assets needed to promote the IHS mission.*

- As of October 1, 2016, IHS and Tribes operated 170 service units, 48 hospitals and 614 ambulatory centers. Urban Indian health programs operated 42 Urban Indian organizations of which there were 21 full ambulatory care programs, 6 limited ambulatory care programs, 6 outreach and referral programs, 7 residential alcohol and addiction treatment programs and 2 hybrid programs.

Performance Management
IHS cascades performance goals and objectives and performance-related metrics Agency wide. Specific measures are cascaded from senior executive performance plans to managers to supervisors and into employee plans, which ensures that performance of all employees relates their job duties to progress on Agency priorities. Agency leadership periodically reviews progress in meeting the Agency performance measures and holds regular discussions with senior executives. The connection between performance measures and employee accountability contributes to the Agency leadership decisions on target adjustments or to take corrective actions to address obstacles that could prevent achieving the desired results.

Performance Reporting
Tribes administer over one-half of IHS resources through Indian Self-Determination and Education Assistance Act (ISDEAA) contracts and compacts and the Agency's performance management activity primarily reflects the IHS programs. However, there are several Tribal programs that choose to participate in GPRA/GPRAMA performance reporting. The IHS budget measures are focused on monitoring population health (clinical measures) and strategies to assess program trends and management (non-clinical measures).

Consistent with the GPRA/GPRAMA, IHS continues to report valid and reliable clinical measures. Additionally, IHS' measures support the following HHS performance products, including the FY 2018 Annual Performance Plan and Report (APP/R). In FY 2018, IHS proposes to report on six GPRAMA measures to be included in the HHS APP/R:

- good glycemic control among diabetic patients,
- childhood immunizations,
- depression screening among adults eighteen years and older,
- statin therapy for the prevention and treatment of cardiovascular disease among AI/ANs,
- accreditation and/or certification of all IHS-operated inpatient and outpatient facilities, and
- tribal consultation (implementation of tribal recommendations).

IHS has reported electronic population level results for GPRA/GPRAMA clinical measures since 2002. The IHS is enhancing the current clinical reporting system to a new reporting system that is able to accept data from other non-RPMS systems. Under the current system, the IHS results represent data from RPMS only sites. Beginning in FY 2018, IHS will use the Integrated Data Collection System Data Mart (IDCS DM) to report clinical measure results. This is a major performance reporting change for the Agency, as measure results can be calculated using any data (RPMS, non-RPMS or Fiscal Intermediary) submitted to the National Data Warehouse. With this change, Tribal and Urban programs will have the capability to submit their data for inclusion in IHS performance reporting. Tribal programs have the option to participate. The IDCS DM produces aggregated, clinical performance measure results at an on-demand basis.

Since the IDCS DM will use all data exported to the NDW including non-RPMS tribal and urban data, budget measures previously reported from RPMS will be revised for the following reasons:

- *User Population Estimates*: The IDCS DM will standardize the use of the User Population estimates as the denominator for the clinical GPRA/GPRAMA measures;
- *Reporting Year*: The GPRA/GPRAMA year of July 1-June 30 will change to match the User Population Estimates year of October 1-September 30.

The FY 2018 Budget Request reflects the reporting transition to the IDCS DM system and the measure performance targets. The current clinical performance measures reported in individual program narratives are displayed first with their FY 2017 target and a note in the FY 2018 target column stating this measure will retire after 2017. The replacement clinical measures with new HHS Unique Identifier numbers are added at the end of the Outputs and Outcomes table. These measures have a FY 2017 target of N/A and a FY 2018 IDCS DM target

Discretionary All Purpose Table
Indian Health Service

(Dollars in Thousands)

Program	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017 Annualized CR
SERVICES				
Hospitals & Health Clinics	1,857,225	1,853,694	1,870,405	16,711
Dental Services	178,286	177,947	179,751	1,804
Mental Health	82,100	81,944	82,654	710
Alcohol & Substance Abuse	205,305	204,915	205,593	678
Purchased/Referred Care	914,139	912,401	914,139	1,738
Subtotal, Clinical Services	3,237,055	3,230,901	3,252,542	21,641
Public Health Nursing	76,623	76,477	77,498	1,021
Health Education	18,255	18,220	18,313	93
Community Health Representatives	58,906	58,794	58,906	112
Immunization AK	1,950	1,946	1,950	4
Subtotal, Preventive Health	155,734	155,438	156,667	1,230
Urban Health	44,741	44,656	44,741	85
Indian Health Professions	48,342	48,250	43,342	-4,908
Tribal Management Grants	2,442	2,437	0	-2,437
Direct Operations	72,338	72,200	72,338	138
Self-Governance	5,735	5,724	4,735	-989
Subtotal, Other Services	173,598	173,268	165,156	-8,111
TOTAL, SERVICES	**3,566,387**	**3,559,607**	**3,574,365**	**14,760**
CONTRACT SUPPORT COSTS[1]				
CSC Need	717,970	716,605	717,970	1,365
CSC New & Expanded	0	0	0	0
TOTAL ,CONTRACT SUPPORT COSTS[2]	**717,970**	**716,605**	**717,970**	**1,365**
FACILITIES				
Maintenance & Improvement	73,614	73,474	60,000	-13,474
Sanitation Facilities Construction	99,423	99,234	75,423	-23,811
Health Care Facilities Construction	105,048	104,848	100,000	-4,848
Facilities & Environ Health Support	222,610	222,187	192,022	-30,165
Equipment	22,537	22,494	19,511	-2,983
TOTAL, FACILITIES	523,232	522,237	446,956	-75,281
TOTAL, BUDGET AUTHORITY	**4,807,589**	**4,798,450**	**4,739,291**	**-59,159**
COLLECTIONS				
Medicare	248,638	248,638	248,638	0
Medicaid	807,605	807,605	807,605	0
Subtotal, M / M	*1,056,243*	*1,056,243*	*1,056,243*	0
Private Insurance	109,272	109,272	109,272	0
VA Reimbursement	28,062	28,062	28,062	0
Total, M / M / PI	*1,193,577*	*1,193,577*	*1,193,577*	0
Quarters	8,500	8,500	8,500	0
TOTAL, COLLECTIONS	**1,202,077**	**1,202,077**	**1,202,077**	**0**
MANDATORY				
Special Diabetes Program for Indians	150,000	147,000	150,000	3,000
TOTAL, MANDATORY	**150,000**	**147,000**	**150,000**	**3,000**
TOTAL, PROGRAM LEVEL	**6,159,666**	**6,147,527**	**6,091,368**	**-56,159**

[1]CSC are maintained as discretionary with a separate, indefinite appropriation in FY 2018.

[2]The FY 2016 level includes revised estimate of $718 million for Contract Support Costs and the FY 2017 level reflects an estimated actual cost of Contract Support Costs.

INDIAN HEALTH SERVICE
FY 2018 President's Budget
Detail of Changes

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018				
Sub IHS Activity	**Final**	**Annualized CR**	**Restoration of CR[1]**	**Staffing Increases[2]**	**Program Adjustments[3]**	**President's Budget**	**+/- FY 2017 CR**
SERVICES							
CLINICAL SERVICES							
Hospitals & Health Clinics	1,857,225	1,853,694	3,531	14,738	-1,558	**1,870,405**	16,711
Dental Services	178,286	177,947	339	1,465	0	**179,751**	1,804
Mental Health	82,100	81,944	156	554	0	**82,654**	710
Alcohol & Substance Abuse	205,305	204,915	390	288	0	**205,593**	678
Purchased/Referred Care	914,139	912,401	1,738	0	0	**914,139**	1,738
Subtotal, Clinical Services	3,237,055	3,230,901	6,154	17,045	-1,558	**3,252,542**	21,641
PREVENTIVE HEALTH							
Public Health Nursing	76,623	76,477	146	875	0	**77,498**	1,021
Health Education	18,255	18,220	35	58	0	**18,313**	93
Community Health Representatives	58,906	58,794	112	0	0	**58,906**	112
Immunization AK	1,950	1,946	4	0	0	**1,950**	4
Subtotal, Preventive Health	155,734	155,438	297	933	0	**156,667**	1,230
OTHER SERVICES							
Urban Health	44,741	44,656	85	0	0	**44,741**	85
Indian Health Professions	48,342	48,250	92	0	-5,000	**43,342**	-4,908
Tribal Management Grants	2,442	2,437	5	0	-2,442	**0**	-2,437
Direct Operations	72,338	72,200	138	0	0	**72,338**	138
Self-Governance	5,735	5,724	11	0	-1,000	**4,735**	-989
Subtotal, Other Services	173,598	173,268	331	0	-8,442	**165,156**	-8,111
TOTAL, SERVICES	3,566,387	3,559,607	6,782	17,978	-10,000	**3,574,365**	14,760
CONTRACT SUPPORT COSTS							
Contract Support Costs Need	717,970	716,605	1,365	0	0	**717,970**	1,365
TOTAL, CONTRACT SUPPORT COSTS	717,970	716,605	1,365	0	0	**717,970**	1,365
FACILITIES							
Maintenance & Improvement	73,614	73,474	140	0	-13,614	**60,000**	-13,474
Sanitation Facilities Construction	99,423	99,234	189	0	-24,000	**75,423**	-23,811
Health Care Facilities Construction	105,048	104,848	200	0	-5,048	**100,000**	-4,848
Facilities & Environmental Health Support	222,610	222,187	423	2,022	-32,610	**192,022**	-30,165
Equipment	22,537	22,494	43	0	-3,026	**19,511**	-2,983
TOTAL, FACILITIES	523,232	522,237	995	2,022	-78,298	**446,956**	-75,281
TOTAL BUDGET AUTHORITY	**4,807,589**	**4,798,450**	**9,142**	**20,000**	**-88,298**	**4,739,291**	-59,159

[1]The Restoration of CR column amounts reflect the reduced spending rate (0.1901) of the initial CR. SC are maintained as discretionary with an indefinite appropriation in FY 2017.

[2]The Staffing Increases column represents the staffing and operating cost to fund two newly constructed Joint Venture (JV) facilities projects: Flandreau Health Center, Flandreau, SD and Choctaw Nation Regional Medical Center, Durant, OK

[3]The Program Adjustments column is the realignment of funds from other activities to support phased funding for Joint Venture (JV) staffing agreements.

INDIAN HEALTH SERVICE
STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES
FY 2018 Budget Request

(Dollars in Thousands)

	Durant, OK		Flandreau, SD			
	Choctaw Nation Regional Medical Center (JV)		Flandreau Health Center (JV)			
Opening Date	February 2017		August 2017		**TOTAL**	
Sub Sub Activity	Pos	Amount	Pos	Amount	**Pos**	**AMOUNT**
Hospitals & Health Clinics	91	$11,674	28	$3,064	119	$14,738
Dental Health	10	$1,135	3	$330	13	$1,465
Mental Health	4	$460	2	$94	6	$554
Alcohol & Substance Abuse	2	$186	2	$102	4	$288
Purchased/Referred Care	0	$0	0	$0	0	$0
Total, Clinical Services	107	$13,455	35	$3,590	142	$17,045
Public Health Nursing	4	$601	2	$274	6	$875
Health Education	1	$58	0	$0	1	$58
Comm. Health Representatives	0	$0	0	$0	0	$0
Total, Preventive Health	5	$659	2	$274	7	$933
Total, Services	112	$14,114	37	$3,864	149	$17,978
Facilities Support	5	$1,262	3	$466	8	$1,728
Environmental Health Support	2	$294	0	$0	2	$294
Total, FEHS	7	$1,556	3	$466	10	$2,022
Total, Facilities	7	$1,556	3	$466	10	$2,022
Grand Total[1]	**119**	**$15,670**	**40**	**$4,330**	**159**	**$20,000**

[1] Includes Utilities

Statement of Personnel Resources
INDIAN HEALTH SERVICE

	FY 2016 Final	FY 2017 Annual CR	FY 2018 PB
Direct:			
Hospitals & Health Clinics	6,077	6,078	6,078
Dental Health	571	571	571
Mental Health	196	196	196
Alcohol & Substance Abuse	173	206	206
Purchased/Referred Care	0	0	0
Total, Clinical Services	7,017	7,051	7,051
Public Health Nursing	208	208	208
Health Education	20	20	20
Community Health Reps	3	3	3
Immunization, AK	0	0	0
Total, Preventive Health	231	231	231
Urban Health	6	6	6
Indian Health Professions	22	22	22
Tribal Management	0	0	0
Direct Operations	259	259	259
Self Governance	14	14	14
Contract Support Costs	0	0	0
Total, SERVICES	7,549	7,583	7,583
Maint. & Improvement	0	0	0
Sanitation Facilities	137	137	137
Hlth Care Facs Construction	0	0	0
Facil. & Envir. Hlth Support	1,074	1,077	1,077
Equipment	0	0	0
Total, FACILITIES	1,211	1,214	1,214
Total, Direct FTE	8,760	8,797	8,797
Reimbursable:			
Buybacks	1,090	1,090	1,090
Medicare	832	832	832
Medicaid	3,790	3,790	3,790
Private Insurance	550	550	550
Quarters	37	37	37
Total, Reimbursable FTE	6,299	6,299	6,299
Trust Funds (Gift)	23	23	23
Health Reform non -add:	0	0	0
TOTAL FTE	**15,082**	**15,119**	**15,119**
Total, Civilian FTE	**13,154**	**13,191**	**13,191**
Total, Military FTE	**1,928**	**1,928**	**1,928**

FY 2016 Crosswalk
Budget Authority
Final Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2016 Enacted
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																	
Hospitals & Health Clinics	830,198	0	0	0	0	0	0	830,198	1,027,027	0	0	0	0	0	0	1,027,027	1,857,225
Dental Health	77,735	0	0	0	0	0	0	77,735	100,551	0	0	0	0	0	0	100,551	178,286
Mental Health	29,990	0	0	0	0	0	0	29,990	52,110	0	0	0	0	0	0	52,110	82,100
Alcohol & Substance Abuse	61,577	0	0	0	0	0	0	61,577	143,728	0	0	0	0	0	0	143,728	205,305
Purchased/Referred Care	424,115	0	0	0	0	0	0	424,115	490,024	0	0	0	0	0	0	490,024	914,139
Subtotal (CS)	1,423,615	0	0	0	0	0	0	1,423,615	1,813,440	0	0	0	0	0	0	1,813,440	3,237,055
Public Health Nursing	0	0	29,683	0	0	0	0	29,683	0	46,940	0	0	0	0	0	46,940	76,623
Health Education	0	0	4,852	0	0	0	0	4,852	0	13,403	0	0	0	0	0	13,403	18,255
Community Health Repr.	0	0	3,011	0	0	0	0	3,011	0	55,895	0	0	0	0	0	55,895	58,906
Immunization AK	0	0	0	0	0	0	0	0	0	1,950	0	0	0	0	0	1,950	1,950
Subtotal (PH)	0	0	37,546	0	0	0	0	37,546	0	118,188	0	0	0	0	0	118,188	155,734
Urban Health Project	0	8,164	0	0	0	0	0	8,164	0	0	36,577	0	0	0	0	36,577	44,741
Indian Health Professions	0	0	0	48,342	0	0	0	48,342	0	0	0	0	0	0	0	0	48,342
Tribal Management	0	0	0	2,442	0	0	0	2,442	0	0	0	0	0	0	0	0	2,442
Direct Operations	0	0	0	0	62,991	0	0	62,991	0	0	0	9,347	0	0	0	9,347	72,338
Self-Governance	0	0	0	0	0	5,735	0	5,735	0	0	0	0	0	0	0	0	5,735
Subtotal (OS)	0	8,164	0	50,784	62,991	5,735	0	127,674	0	0	36,577	9,347	0	0	0	45,924	173,598
Total, Services	1,423,615	8,164	37,546	50,784	62,991	5,735	0	1,588,835	1,813,440	118,188	36,577	9,347	0	0	0	1,977,552	3,566,387
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	0	0	717,970	0	717,970	717,970
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	26,548	26,548	0	0	0	0	0	0	47,066	47,066	73,614
Sanitation Facilities Constr.	0	0	0	0	0	0	34,798	34,798	0	0	0	0	0	0	64,625	64,625	99,423
Health Care Facs. Constr.	0	0	0	0	0	0	102,322	102,322	0	0	0	0	0	0	2,726	2,726	105,048
Facs. & Env. Health Sup	0	0	0	0	0	0	142,092	142,092	0	0	0	0	0	0	80,518	80,518	222,610
Equipment	0	0	0	0	0	0	7,238	7,238	0	0	0	0	0	0	15,299	15,299	22,537
Total, Facilities	0	0	0	0	0	0	312,998	312,998	0	0	0	0	0	0	210,234	210,234	523,232
TOTAL, IHS	1,423,615	8,164	37,546	50,784	62,991	5,735	312,998	1,901,833	1,813,440	118,188	36,577	9,347	0	717,970	210,234	2,905,756	4,807,589
% Federal Health Admin.								39.6%									
% Tribal and Urban Health Admin.																	60.4%

FY 2017 Crosswalk
Budget Authority
Enacted Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2017 Annual. CR
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																	
Hospitals & Health Clinics	828,620	0	0	0	0	0	0	828,620	1,025,074	0	0	0	0	0	0	1,025,074	1,853,694
Dental Health	77,621	0	0	0	0	0	0	77,621	100,326	0	0	0	0	0	0	100,326	177,947
Mental Health	29,933	0	0	0	0	0	0	29,933	52,011	0	0	0	0	0	0	52,011	81,944
Alcohol & Substance Abuse	61,460	0	0	0	0	0	0	61,460	143,455	0	0	0	0	0	0	143,455	204,915
Purchased/Referred Care	423,309	0	0	0	0	0	0	423,309	489,092	0	0	0	0	0	0	489,092	912,401
Subtotal (CS)	1,420,942	0	0	0	0	0	0	1,420,942	1,809,959	0	0	0	0	0	0	1,809,959	3,230,901
Public Health Nursing	0	0	29,626	0	0	0	0	29,626	0	46,851	0	0	0	0	0	46,851	76,477
Health Education	0	0	4,843	0	0	0	0	4,843	0	13,377	0	0	0	0	0	13,377	18,220
Community Health Repr.	0	0	3,005	0	0	0	0	3,005	0	55,789	0	0	0	0	0	55,789	58,794
Immunization AK	0	0	0	0	0	0	0	0	0	1,946	0	0	0	0	0	1,946	1,946
Subtotal (PH)	0	0	37,474	0	0	0	0	37,474	0	117,963	0	0	0	0	0	117,963	155,438
Urban Health Project	0	8,148	0	0	0	0	0	8,148	0	0	36,508	0	0	0	0	36,508	44,656
Indian Health Professions	0	0	0	48,250	0	0	0	48,250	0	0	0	0	0	0	0	0	48,250
Tribal Management	0	0	0	2,437	0	0	0	2,437	0	0	0	0	0	0	0	0	2,437
Direct Operations	0	0	0	0	62,871	0	0	62,871	0	0	0	9,329	0	0	0	9,329	72,200
Self-Governance	0	0	0	0	0	5,724	0	5,724	0	0	0	0	0	0	0	0	5,724
Subtotal (OS)	0	8,148	0	50,687	62,871	5,724	0	127,430	0	0	36,508	9,329	0	0	0	45,837	173,268
Total, Services	1,420,942	8,148	37,474	50,687	62,871	5,724	0	1,585,847	1,809,959	117,963	36,508	9,329	0	0	0	1,973,758	3,559,607
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	0	0	716,605	0	716,605	716,605
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	26,498	26,498	0	0	0	0	0	0	46,976	46,976	73,474
Sanitation Facilities Constr.	0	0	0	0	0	0	34,732	34,732	0	0	0	0	0	0	64,502	64,502	99,234
Health Care Facs. Constr.	0	0	0	0	0	0	89,048	89,048	0	0	0	0	0	0	15,800	15,800	104,848
Facs. & Env. Health Sup	0	0	0	0	0	0	141,822	141,822	0	0	0	0	0	0	80,365	80,365	222,187
Equipment	0	0	0	0	0	0	7,224	7,224	0	0	0	0	0	0	15,270	15,270	22,494
Total, Facilities	0	0	0	0	0	0	299,324	299,324	0	0	0	0	0	0	222,913	222,913	522,237
TOTAL, IHS	1,420,942	8,148	37,474	50,687	62,871	5,724	299,324	1,885,171	1,809,959	117,963	36,508	9,329	0	716,605	222,913	2,913,276	4,798,450
% Federal Health Admin.								39.3%									
% Tribal and Urban Health Admin.																	60.7%

FY 2018 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2018 PB
	Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	
SERVICES																	
Hospitals & Health Clinics	761,334	0	0	0	0	0	0	761,334	1,109,071	0	0	0	0	0	0	1,109,071	1,870,405
Dental Health	71,755	0	0	0	0	0	0	71,755	107,996	0	0	0	0	0	0	107,996	179,751
Mental Health	10,284	0	0	0	0	0	0	10,284	72,370	0	0	0	0	0	0	72,370	82,654
Alcohol & Substance Abuse	39,497	0	0	0	0	0	0	39,497	166,096	0	0	0	0	0	0	166,096	205,593
Purchased/Referred Care	389,531	0	0	0	0	0	0	389,531	524,608	0	0	0	0	0	0	524,608	914,139
Subtotal (CS)	1,272,401	0	0	0	0	0	0	1,272,401	1,980,141	0	0	0	0	0	0	1,980,141	3,252,542
Public Health Nursing	0	0	26,794	0	0	0	0	26,794	0	50,704	0	0	0	0	0	50,704	77,498
Health Education	0	0	3,950	0	0	0	0	3,950	0	14,363	0	0	0	0	0	14,363	18,313
Community Health Repr.	0	0	(1,055)	0	0	0	0	(1,055)	0	59,961	0	0	0	0	0	59,961	58,906
Immunization AK	0	0	(143)	0	0	0	0	(143)	0	2,093	0	0	0	0	0	2,093	1,950
Subtotal (PH)	0	0	29,546	0	0	0	0	29,546	0	127,121	0	0	0	0	0	127,121	156,667
Urban Health Project	0	5,137	0	0	0	0	0	5,137	0	0	39,604	0	0	0	0	39,604	44,741
Indian Health Professions	0	0	0	43,342	0	0	0	43,342	0	0	0	0	0	0	0	0	43,342
Tribal Management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Direct Operations	0	0	0	0	63,729	0	0	63,729	0	0	0	8,609	0	0	0	8,609	72,338
Self-Governance	0	0	0	0	0	4,735	0	4,735	0	0	0	0	0	0	0	0	4,735
Subtotal (OS)	0	5,137	0	43,342	63,729	4,735	0	116,943	0	0	39,604	8,609	0	0	0	48,213	165,156
Total, Services	1,272,401	5,137	29,546	43,342	63,729	4,735	0	1,418,891	1,980,141	127,121	39,604	8,609	0	0	0	2,155,474	3,574,365
CONTRACT SUPPORT COSTS	0	0	0	0	0	0	0	0	0	0	0	0	0	717,970	0	717,970	717,970
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	19,379	19,379	0	0	0	0	0	0	40,621	40,621	60,000
Sanitation Facilities Constr.	0	0	0	0	0	0	26,398	26,398	0	0	0	0	0	0	49,025	49,025	75,423
Health Care Facs. Constr.	0	0	0	0	0	0	100,000	100,000	0	0	0	0	0	0	0	0	100,000
Facs. & Env. Health Sup	0	0	0	0	0	0	109,328	109,328	0	0	0	0	0	0	82,694	82,694	192,022
Equipment	0	0	0	0	0	0	5,414	5,414	0	0	0	0	0	0	14,097	14,097	19,511
Total, Facilities	0	0	0	0	0	0	260,519	260,519	0	0	0	0	0	0	186,437	186,437	446,956
TOTAL, IHS	1,272,401	5,137	29,546	43,342	63,729	4,735	260,519	1,679,409	1,980,141	127,121	39,604	8,609	0	717,970	186,437	3,059,881	4,739,291
% Federal Health Admin.								35.4%									
% Tribal and Urban Health Admin.																	64.6%

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2018 Performance Budget Submission to Congress

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Appropriation Accounts

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INDIAN HEALTH SERVICE

Indian Health Services

For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination and Education Assistance Act, the Indian Health Care Improvement Act, and titles II and III of the Public Health Service Act with respect to the Indian Health Service, [$3,566,387,000] *$3,574,365,000*, together with payments received during the fiscal year pursuant to 42 U.S.C. 238(b) and 238b, for services furnished by the Indian Health Service: *Provided*, That funds made available to tribes and tribal organizations through contracts, grant agreements, or any other agreements or compacts authorized by the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), shall be deemed to be obligated at the time of the grant or contract award and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: *Provided further*, That, $914,139,000 for Purchased/Referred Care, including *$51,500,000* for the Indian Catastrophic Health Emergency Fund, shall remain available until expended: *Provided further*, That, of the funds provided, up to *$36,000,000* shall remain available until expended for implementation of the loan repayment program under section 108 of the Indian Health Care Improvement Act: *Provided further*, That, of the funds provided, *$2,000,000* shall remain available until expended to supplement funds available for operational costs at tribal clinics operated under an Indian Self-Determination and Education Assistance Act compact or contract where health care is delivered in space acquired through a full service lease, which is not eligible for maintenance and improvement and equipment funds from the Indian Health Service, and *$2,000,000* shall be for accreditation emergencies: *Provided further*, That the amounts collected by the Federal Government as authorized by sections 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. 1613a and 1616a) during the preceding fiscal year for breach of contracts shall be deposited to the Fund authorized by section 108A of the Act (25 U.S.C. 1616a-1) and shall remain available until expended and, notwithstanding section 108A(c) of the Act (25 U.S.C. 1616a-1(c)), funds shall be available to make new awards under the loan repayment and scholarship programs under sections 104 and 108 of the Act (25 U.S.C. 1613a and 1616a): *Provided further*, That, notwithstanding any other provision of law, the amounts made available

within this account for the Substance Abuse and Suicide Prevention Program, for the Domestic Violence Prevention Program, to improve collections from public and private insurance at Indian Health Service and tribally operated facilities, and for accreditation emergencies shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended[1]: *Provided further*, That funds provided in this Act may be used for annual contracts and grants that fall within 2 fiscal years, provided the total obligation is recorded in the year the funds are appropriated: *Provided further*, That the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act shall remain available until expended for the purpose of achieving compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act, except for those related to the planning, design, or construction of new facilities: *Provided further*, That funding contained herein for scholarship programs under the Indian Health Care Improvement Act (25 U.S.C. 1613) shall remain available until expended: *Provided further*, That amounts received by tribes and tribal organizations under title IV of the Indian Health Care Improvement Act shall be reported and accounted for and available to the receiving tribes and tribal organizations until expended: *Provided further*, That the Bureau of Indian Affairs may collect from the Indian Health Service, tribes and tribal organizations operating health facilities pursuant to Public Law 93–638, such individually identifiable health information relating to disabled children as may be necessary for the purpose of carrying out its functions under the Individuals with Disabilities Education Act (20 U.S.C. 1400, et seq.): *Provided further*, That the Indian Health Care Improvement Fund may be used, as needed, to carry out activities typically funded under the Indian Health Facilities account.

Note.—A full-year 2017 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Further Continuing Appropriations Act, 2017 (P.L. 114–254). The amounts included for 2017 reflect the annualized level provided by the continuing resolution.

Indian Health Contract Support Costs

For payments to tribes and tribal organizations for contract support costs associated with Indian Self-Determination and Education Assistance Act agreements with the Indian Health Service for fiscal year 2018, such sums as may be necessary: *Provided*, That amounts obligated but not expended by a tribe or tribal organization for contract support costs for such agreements for the current fiscal year shall be applied to contract support costs otherwise due for such agreements for subsequent fiscal years: *Provided further*, That, notwithstanding any other provision of law, no amounts made available under this heading shall be available for transfer to another budget account.

Note.—A full-year 2017 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Further Continuing Appropriations Act, 2017 (P.L. 114–254). The amounts included for 2017 reflect the annualized level provided by the continuing resolution.

Indian Health Facilities

For construction, repair, maintenance, improvement, and equipment of health and related auxiliary facilities, including quarters for personnel; preparation of plans, specifications, and drawings; acquisition of sites, purchase and erection of modular buildings, and purchases of trailers; and for provision of domestic and community sanitation facilities for Indians, as authorized by section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), the Indian Self-Determination Act, and the Indian Health Care Improvement Act, and for expenses necessary to carry out such Acts and titles II and III of the Public Health Service Act with respect to environmental health and facilities support activities of the Indian Health Service, [$523,232,000] *$456,956,000*, to remain available until expended: *Provided*, That, notwithstanding any other provision of law, funds appropriated for the planning, design, construction, renovation or expansion of health facilities for the benefit of an Indian tribe or tribes may be used to purchase land on which such facilities will be located: *Provided further*, That not to exceed *$500,000* may be used by the Indian Health Service to purchase TRANSAM equipment from the Department of Defense for distribution to the Indian Health Service and tribal facilities: *Provided further*, That none of the funds appropriated to the Indian Health

Service may be used for sanitation facilities construction for new homes funded with grants by the housing programs of the United States Department of Housing and Urban Development: *Provided further*, That not to exceed *$2,700,000* from this account and the "Indian Health Services" account may be used by the Indian Health Service to obtain ambulances for the Indian Health Service and tribal facilities in conjunction with an existing interagency agreement between the Indian Health Service and the General Services Administration: *Provided further*, That not to exceed *$500,000* may be placed in a Demolition Fund, to remain available until expended, and be used by the Indian Health Service for the demolition of Federal buildings.

Note.—A full-year 2017 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Further Continuing Appropriations Act, 2017 (P.L. 114–254). The amounts included for 2017 reflect the annualized level provided by the continuing resolution.

Administrative Provisions, Indian Health Service

Appropriations provided in this Act to the Indian Health Service shall be available for services as authorized by 5 U.S.C. 3109 at rates not to exceed the per diem rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. 5376; hire of passenger motor vehicles and aircraft; purchase of medical equipment; purchase of reprints; purchase, renovation and erection of modular buildings and renovation of existing facilities; payments for telephone service in private residences in the field, when authorized under regulations approved by the Secretary; uniforms or allowances therefor as authorized by 5 U.S.C. 5901–5902; and for expenses of attendance at meetings that relate to the functions or activities of the Indian Health Service: *Provided*, That in accordance with the provisions of the Indian Health Care Improvement Act, non-Indian patients may be extended health care at all tribally administered or Indian Health Service facilities, subject to charges, and the proceeds along with funds recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2651–2653) shall be credited to the account of the facility providing the service and shall be available without fiscal year limitation: *Provided further*, That notwithstanding any other law or regulation, funds

transferred from the Department of Housing and Urban Development to the Indian Health Service shall be administered under Public Law 86–121, the Indian Sanitation Facilities Act and Public Law 93–638: *Provided further*, That funds appropriated to the Indian Health Service in this Act, except those used for administrative and program direction purposes, shall not be subject to limitations directed at curtailing Federal travel and transportation: *Provided further*, That none of the funds made available to the Indian Health Service in this Act shall be used for any assessments or charges by the Department of Health and Human Services unless identified in the budget justification and provided in this Act, or the House and Senate Committees on Appropriations are notified through the reprogramming process: Provided further, That notwithstanding any other provision of law, funds previously or herein made available to a tribe or tribal organization through a contract, grant, or agreement authorized by title I or title V of the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), may be deobligated and reobligated to a self-determination contract under title I, or a self-governance agreement under title V of such Act and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: *Provided further*, That none of the funds made available to the Indian Health Service in this Act shall be used to implement the final rule published in the Federal Register on September 16, 1987, by the Department of Health and Human Services, relating to the eligibility for the health care services of the Indian Health Service until the Indian Health Service has submitted a budget request reflecting the increased costs associated with the proposed final rule, and such request has been included in an appropriations Act and enacted into law: *Provided further*, That with respect to functions transferred by the Indian Health Service to tribes or tribal organizations, the Indian Health Service is authorized to provide goods and services to those entities on a reimbursable basis, including payments in advance with subsequent adjustment, and the reimbursements received therefrom, along with the funds received from those entities pursuant to the Indian Self-Determination Act, may be credited to the same or subsequent appropriation account from which the funds were originally derived, with such amounts to remain available until expended: *Provided further*, That reimbursements for training, technical assistance, or services provided by the Indian Health Service will contain total costs, including direct, administrative, and

overhead associated with the provision of goods, services, or technical assistance: *Provided further,* That, notwithstanding any other provision of law, for any lease under section 105(l) of the Indian Self-Determination and Education Assistance Act, as amended, no additional compensation is required by the Act above the amount provided to the tribe or tribal organization under section 106(a)(1), except the Secretary, in the discretion of the Secretary, may award compensation for such leases, above the section 106(a)(1) amount, and if the Secretary awards such additional compensation the amount of such compensation may be based on such reasonable expenses, if any, as the Secretary determines to be appropriate, which may include the expenses described in section 105(l)(2), and the exercise of this discretion to award additional compensation and determine its amount is not subject to sections 102(a)-(b), (e) or 507(b)-(d) of the Act[4].

General Provisions

Contract Support Costs, Fiscal Year 2018 Limitation

Sec. 406. Amounts provided by this Act for fiscal year [2016] *2018* under the headings "Department of Health and Human Services, Indian Health Service, Contract Support Costs" and " Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Contract Support Costs" are the only amounts available for contract support costs arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements for fiscal year [2016] *2018* with the Bureau of Indian Affairs or the Indian Health Service: *Provided,* That such amounts provided by this Act are not available for payment of claims for contract support costs for prior years, or for repayments of payments for settlements or judgments awarding contract support costs for prior years[5]. *(Consolidated Appropriations Act, 2017)*

Language Analysis

Language Provision	Language Provision
SERVICES PROVISIONS	
Provided further, That, notwithstanding any other provision of law, the amounts made available within this account for the [methamphetamine and suicide prevention and treatment initiative] *Substance Abuse and Suicide Prevention Program*, for the [domestic violence prevention initiative] *Domestic Violence Prevention Program*, to improve collections from public and private insurance at Indian Health Service and tribally operated facilities, and for accreditation emergencies shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended[1]	Methamphetamine language is changed to better reflect broader use of the funds
ADMINISTRATIVE PROVISIONS	
Provided further, That the appropriation structure for the Indian Health Service may not be altered without advance notification to the House and Senate Committees on Appropriations[2]:	Language is struck to maximize operational flexibility and is no longer needed for the Urban Indian Health Program
Provided further, That the Indian Health Service shall develop a strategic plan for the Urban Indian Health program in consultation with urban Indians and the National Academy of Public Administration, and shall publish such plan not later than one year after the date of enactment of this Act[3]	Language is struck to maximize operational flexibility and is no longer needed for the Urban Indian Health Program
Provided further, That, notwithstanding any other provision of law, for any lease under section 105(l) of the Indian Self-Determination and Education Assistance Act, as amended, no additional compensation is required by the Act above the amount provided to the tribe or tribal organization under section 106(a)(1), except the Secretary, in the discretion of the Secretary, may award compensation for such leases, above the section 106(a)(1) amount, and if the Secretary awards such additional compensation the amount of such compensation may be based on such reasonable expenses, if any, as the Secretary determines to be appropriate, which may include the expenses described in section 105(l)(2), and the exercise of this discretion to	Language is added to ensure that the FY 2018 appropriation includes clarity regarding compensation, expenses and awards related to leases.

award additional compensation and determine its amount is not subject to sections 102(a)-(b), (e) or 507(b)-(d) of the Act[4].	
GENERAL PROVISIONS	
SEC.406. Amounts provided by this Act for fiscal year [2016] *2018* under the headings "Department of Health and Human Services" Indian Health Service*, Contract Support Costs*" and "Department of the Interior, Bureau of Indian Affairs and Bureau of Indian Education, Contract Support Costs" are the only amounts available for contract support costs arising out of self-determination or self-governance contracts, grants, compacts, or annual funding agreements for fiscal year [2016] 2018 with the Bureau of Indian Affairs or the Indian Health Service: Provided, That such amounts provided by this Act are not available for payment of claims for contract support costs for prior years, or for repayments or payments for settlements or judgments awarding contract support costs for prior years[5].	Added to ensure that the FY 2018 appropriation for Contract Support Costs will not be used to pay prior year contract support costs claims or to repay the Judgment Fund for payments on prior year claims.

INDIAN HEALTH SERVICE
Amounts Available for Obligations

SERVICES

	FY 2016	FY 2017	FY 2018
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$3,566,387,000	$3,566,387,000	$3,574,365,000
Across-the-board reductions (Interior)	$0	($6,780,000)	$0
Subtotal, Appropriation (Interior)	$3,566,387,000	$3,559,607,000	$3,574,365,000
Mandatory Appropriation:			
Appropriation	$150,000,000	$150,000,000	$150,000,000
Offsetting Collections:			
Federal sources	($231,000,000)	($271,000,000)	($276,000,000)
Non-federal sources	($1,196,000,000)	($1,151,000,000)	($1,174,000,000)
Subtotal, Offsetting Collections	($1,427,000,000)	($1,422,000,000)	($1,450,000,000)
Unobligated Balances:			
Discretionary, Start of Year	$741,000,000	$828,000,000	$1,027,000,000
Mandatory, Start of Year	$87,000,000	$199,000,000	--
End of Year	$828,000,000	$1,027,000,000	$1,133,000,000
Total Obligations, Services	$2,289,387,000	$2,287,607,000	$2,168,365,000

INDIAN HEALTH SERVICE
Amounts Available for Obligations

FACILITIES

	FY 2016	FY 2017	FY 2018
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$523,232,000	$523,232,000	$446,956,000
Across-the-board reductions (Interior)	$0	($995,000)	$0
Subtotal, Appropriation (Interior)	$523,232,000	$522,237,000	$446,956,000
Offsetting Collections:			
Federal sources	(31,000,000)	($56,000,000)	(57,000,000)
Subtotal, Offsetting Collections	(31,000,000)	($56,000,000)	(57,000,000)
Unobligated Balances:			
Discretionary, Start of Year	$236,000,000	$284,000,000	$388,000,000
End of Year	$284,000,000	$388,000,000	$445,000,000
Total Obligations, Facilities	$444,232,000	$362,237,000	$332,956,000

INDIAN HEALTH SERVICE
Amounts Available for Obligations

CONTRACT SUPPORT COSTS

	FY 2016	FY 2017	FY 2018
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$717,970,000	$717,970,000	$717,970,000
Across-the-board reductions (Interior)	$0	($1,365,000)	$0
Subtotal, Appropriation (Interior)	$717,970,000	$716,605,000	$717,970,000
Total Obligations, CSC	$717,970,000	$716,605,000	$717,970,000

INDIAN HEALTH SERVICE

SERVICES

Summary of Changes

FY 2017 Annualized CR	3,559,607,000
Total estimated budget authority	3,559,607,000
Less Obligations	(3,559,607,000)
FY 2018 Estimate	3,574,365,000
Less Obligations	(3,574,365,000)
Net Change	14,760,000
Less Obligations	(14,760,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	497,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	1,515,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	3,288,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	9,281,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	23,772,000
7	Increased Cost of Travel	--	43,644,000	--	1,534,000
8	Increased Cost of Transportation & Things	--	6,140,000	--	140,000
9	Increased Cost of Printing	--	40,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	28,414,000	--	546,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	559,809,000	--	20,341,000
12	Increased Cost of Supplies	--	92,804,000	--	3,447,000
13	Increased Cost of Medical or other Equipment	--	12,089,000	--	294,000
14	Increased Cost of Land & Structure	--	352,000	--	2,000
15	Increased Cost of Grants	--	2,085,380,000	--	55,979,000
16	Increased Cost of Insurance / Indemnities	--	247,000	--	9,000
17	Increased Cost of Interest / Dividends	--	43,000	--	1,000
18	Population Growth	--	n/a	--	61,757,000
	Subtotal, Built-In	--	2,828,962,000	--	182,403,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	166	17,978,000
C. Program Increases		--	0	--	6,782,000
	TOTAL INCREASES	--	2,828,962,000	166	207,163,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(182,404,000)
B. Program Decreases		--	0	--	(10,000,000)
	TOTAL DECREASES	--	0	--	(192,404,000)
NET CHANGE		--	**2,828,962,000**	**166**	**14,760,000**

INDIAN HEALTH SERVICE
CLINICAL Services
Summary of Changes

FY 2017 Annualized CR	3,230,901,000
Total estimated budget authority	3,230,901,000
Less Obligations	(3,230,901,000)
FY 2018 Estimate	3,252,542,000
Less Obligations	(3,252,542,000)
Net Change	21,641,000
Less Obligations	(21,641,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2014 CO Pay Raise (3months)	--	n/a	--	451,000
2	FY 2015 Pay Raise CO (9months)	--	n/a	--	1,373,000
3	Annualization of FY 2014 CS Pay Raise (3months)	--	n/a	--	2,965,000
4	FY 2015 Pay Raise CS (9months)	--	n/a	--	8,367,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	21,424,000
7	Increased Cost of Travel	--	39,184,000	--	1,433,000
8	Increased Cost of Transportation & Things	--	5,101,000	--	116,000
9	Increased Cost of Printing	--	33,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	26,720,000	--	514,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	525,682,000	--	19,331,000
12	Increased Cost of Supplies	--	86,592,000	--	3,263,000
13	Increased Cost of Medical or other Equipment	--	6,325,000	--	156,000
14	Increased Cost of Land & Structure	--	352,000	--	2,000
15	Increased Cost of Grants	--	1,881,445,000	--	48,853,000
16	Increased Cost of Insurance / Indemnities	--	221,000	--	8,000
17	Increased Cost of Interest / Dividends	--	38,000	--	1,000
18	Population Growth	--	n/a	--	58,155,000
	Subtotal, Built-In	--	2,571,693,000	--	166,412,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	158	17,045,000
C. Program Restoration		--	0	--	6,154,000
TOTAL INCREASES		--	2,571,693,000	158	189,611,000
DECREASES					
A. Built-In					
Absorption of Built-In Increases		--	0	--	(166,412,000)
B. Adjustments		--	0	--	(1,558,000)
TOTAL DECREASES		--	0	--	(167,970,000)
NET CHANGE		**--**	**2,571,693,000**	**158**	**21,641,000**

INDIAN HEALTH SERVICE
Hospitals & Health Clinics
Summary of Changes

FY 2017 Annualized CR	1,853,694,000
Total estimated budget authority	1,853,694,000
Less Obligations	(1,853,694,000)
FY 2018 Estimate	1,870,405,000
Less Obligations	(1,870,405,000)
Net Change	16,711,000
Less Obligations	(16,711,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	372,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	1,131,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	2,539,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	7,160,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	16,625,000
7	Increased Cost of Travel	--	4,742,000	--	109,000
8	Increased Cost of Transportation & Things	--	4,617,000	--	106,000
9	Increased Cost of Printing	--	32,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	26,377,000	--	509,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	142,338,000	--	4,450,000
12	Increased Cost of Supplies	--	62,302,000	--	2,330,000
13	Increased Cost of Medical or other Equipment	--	3,649,000	--	90,000
14	Increased Cost of Land & Structure	--	283,000	--	0
15	Increased Cost of Grants	--	1,047,927,000	--	16,348,000
16	Increased Cost of Insurance / Indemnities	--	6,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	33,366,000
	Subtotal, Built-In	--	1,292,273,000	--	85,135,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	135	14,738,000
C. H&HC Restoration		--	0	--	3,531,000
TOTAL INCREASES		--	1,292,273,000	135	103,404,000
DECREASES					
A. Built-In					
Absorption of Built-In Increases		--	0	--	(85,135,000)
B. Adjustments		--	0	--	(1,558,000)
TOTAL DECREASES		--	0	--	(86,693,000)
NET CHANGE		--	**1,292,273,000**	**135**	**16,711,000**

INDIAN HEALTH SERVICE
Dental Health
Summary of Changes

FY 2017 Annualized CR	177,947,000
Total estimated budget authority	177,947,000
Less Obligations	(177,947,000)
FY 2018 Estimate	179,751,000
Less Obligations	(179,751,000)
Net Change	1,804,000
Less Obligations	(1,804,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	61,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	185,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	245,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	694,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	1,628,000
7	Increased Cost of Travel	--	441,000	--	10,000
8	Increased Cost of Transportation & Things	--	279,000	--	6,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	77,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	8,047,000	--	270,000
12	Increased Cost of Supplies	--	6,681,000	--	250,000
13	Increased Cost of Medical or other Equipment	--	1,727,000	--	43,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	101,525,000	--	3,959,000
16	Increased Cost of Insurance / Indemnities	--	2,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	3,203,000
	Subtotal, Built-In	--	118,779,000	--	10,554,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	15	1,465,000
C. Dental Restoration		--	0	--	339,000
	TOTAL INCREASES	--	118,779,000	15	12,358,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(10,554,000)
	TOTAL DECREASES	--	0	--	(10,554,000)
NET CHANGE		--	**118,779,000**	**15**	**1,804,000**

INDIAN HEALTH SERVICE
Mental Health
Summary of Changes

FY 2017 Annualized CR	81,944,000
Total estimated budget authority	81,944,000
Less Obligations	(81,944,000)
FY 2018 Estimate	82,654,000
Less Obligations	(82,654,000)
Net Change	710,000
Less Obligations	(710,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	9,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	29,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	107,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	302,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	844,000
7	Increased Cost of Travel	--	343,000	--	8,000
8	Increased Cost of Transportation & Things	--	148,000	--	3,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	103,000	--	2,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	3,757,000	--	145,000
12	Increased Cost of Supplies	--	1,562,000	--	59,000
13	Increased Cost of Medical or other Equipment	--	98,000	--	2,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	53,495,000	--	2,086,000
16	Increased Cost of Insurance / Indemnities	--	27,000	--	1,000
17	Increased Cost of Interest / Dividends	--		--	0
18	Population Growth	--	n/a	--	1,475,000
	Subtotal, Built-In	--	59,533,000	--	5,072,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	5	554,000
C. Mental Health Restoration		--	0	--	156,000
	TOTAL INCREASES	--	59,533,000	5	5,782,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(5,072,000)
	TOTAL DECREASES	--	0	--	(5,072,000)
NET CHANGE		--	**59,533,000**	**5**	**710,000**

INDIAN HEALTH SERVICE
Alcohol and Substance Abuse
Summary of Changes

FY 2017 Annualized CR	204,915,000
Total estimated budget authority	204,915,000
Less Obligations	(204,915,000)
FY 2018 Estimate	205,593,000
Less Obligations	(205,593,000)
Net Change	678,000
Less Obligations	(678,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	9,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	28,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	74,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	211,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	2,327,000
7	Increased Cost of Travel	--	423,000	--	10,000
8	Increased Cost of Transportation & Things	--	55,000	--	1,000
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	159,000	--	3,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	13,676,000	--	509,000
12	Increased Cost of Supplies	--	1,415,000	--	53,000
13	Increased Cost of Medical or other Equipment	--	849,000	--	21,000
14	Increased Cost of Land & Structure	--	69,000	--	2,000
15	Increased Cost of Grants	--	172,060,000	--	6,709,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	3,688,000
	Subtotal, Built-In	--	188,707,000	--	13,645,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	3	288,000
C. ASA Restoration		--	0	--	390,000
	TOTAL INCREASES	--	188,707,000	3	14,323,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(13,645,000)
	TOTAL DECREASES	--	0	--	(13,645,000)
NET CHANGE		**--**	**188,707,000**	**3**	**678,000**

INDIAN HEALTH SERVICE
Purchased/Referred Care
Summary of Changes

FY 2017 Annualized CR	912,401,000
Total estimated budget authority	912,401,000
Less Obligations	(912,401,000)
FY 2018 Estimate	914,139,000
Less Obligations	(914,139,000)
Net Change	1,738,000
Less Obligations	(1,738,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	33,235,000	--	1,296,000
8	Increased Cost of Transportation & Things	--	2,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	4,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	357,864,000	--	13,957,000
12	Increased Cost of Supplies	--	14,632,000	--	571,000
13	Increased Cost of Medical or other Equipment	--	2,000	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	506,438,000	--	19,751,000
16	Increased Cost of Insurance / Indemnities	--	186,000	--	7,000
17	Increased Cost of Interest / Dividends	--	38,000	--	1,000
18	Population Growth	--	n/a	--	16,423,000
	Subtotal, Built-In	--	912,401,000	--	52,006,000
B. PRC Restoration		--	0	--	1,738,000
	TOTAL INCREASES	--	912,401,000	--	53,744,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(52,006,000)
	TOTAL DECREASES	--	0	--	(52,006,000)
NET CHANGE		--	**912,401,000**	--	**1,738,000**

INDIAN HEALTH SERVICE
PREVENTIVE Health
Summary of Changes

FY 2017 Annualized CR	155,438,000
Total estimated budget authority	155,438,000
Less Obligations	(155,438,000)
FY 2018 Estimate	156,667,000
Less Obligations	(156,667,000)
Net Change	1,230,000
Less Obligations	(1,230,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	26,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	80,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	102,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	290,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	1,914,000
7	Increased Cost of Travel	--	231,000	--	5,000
8	Increased Cost of Transportation & Things	--	569,000	--	13,000
9	Increased Cost of Printing	--	6,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	85,000	--	2,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	3,064,000	--	115,000
12	Increased Cost of Supplies	--	2,636,000	--	102,000
13	Increased Cost of Medical or other Equipment	--	237,000	--	9,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	123,726,000	--	4,826,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	2,798,000
	Subtotal, Built-In	--	130,554,000	--	10,282,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	8	933,000
C. Program Restoration		--	0	--	297,000
	TOTAL INCREASES	--	130,554,000	8	11,512,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(10,282,000)
	TOTAL DECREASES	--	0	--	(10,282,000)
NET CHANGE		--	**130,554,000**	**8**	**1,230,000**

INDIAN HEALTH SERVICE
Public Health Nursing
Summary of Changes

FY 2017 Annualized CR	76,477,000
Total estimated budget authority	76,477,000
Less Obligations	(76,477,000)
FY 2018 Estimate	77,498,000
Less Obligations	(77,498,000)
Net Change	1,021,000
Less Obligations	(1,021,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	24,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	73,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	89,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	251,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	760,000
7	Increased Cost of Travel	--	166,000	--	4,000
8	Increased Cost of Transportation & Things	--	548,000	--	13,000
9	Increased Cost of Printing	--	5,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	76,000	--	2,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	1,981,000	--	74,000
12	Increased Cost of Supplies	--	2,083,000	--	81,000
13	Increased Cost of Medical or other Equipment	--	177,000	--	7,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	49,657,000	--	1,937,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	1,377,000
	Subtotal, Built-In	--	54,693,000	--	4,692,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	7	875,000
C. PHN Restoration		--	0	--	146,000
	TOTAL INCREASES	--	54,693,000	7	5,713,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(4,692,000)
	TOTAL DECREASES	--	0	--	(4,692,000)
NET CHANGE		--	**54,693,000**	**7**	**1,021,000**

INDIAN HEALTH SERVICE
Health Education
Summary of Changes

FY 2017 Annualized CR	18,220,000
Total estimated budget authority	18,220,000
Less Obligations	(18,220,000)
FY 2018 Estimate	18,313,000
Less Obligations	(18,313,000)
Net Change	93,000
Less Obligations	(93,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	1,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	4,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	12,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	35,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	217,000
7	Increased Cost of Travel	--	57,000	--	1,000
8	Increased Cost of Transportation & Things	--	18,000	--	0
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	7,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	420,000	--	16,000
12	Increased Cost of Supplies	--	346,000	--	13,000
13	Increased Cost of Medical or other Equipment	--	55,000	--	2,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	14,687,000	--	573,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	328,000
	Subtotal, Built-In	--	15,591,000	--	1,202,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	1	58,000
C. Health Education Restoration		--	0	--	35,000
	TOTAL INCREASES	--	15,591,000	1	1,295,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,202,000)
	TOTAL DECREASES	--	0	--	(1,202,000)
NET CHANGE		--	**15,591,000**	**1**	**93,000**

INDIAN HEALTH SERVICE
Community Health Representatives
Summary of Changes

FY 2017 Annualized CR	58,794,000
Total estimated budget authority	58,794,000
Less Obligations	(58,794,000)
FY 2018 Estimate	58,906,000
Less Obligations	(58,906,000)
Net Change	112,000
Less Obligations	(112,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	1,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	3,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	1,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	4,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	905,000
7	Increased Cost of Travel	--	8,000	--	0
8	Increased Cost of Transportation & Things	--	3,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	2,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	663,000	--	25,000
12	Increased Cost of Supplies	--	207,000	--	8,000
13	Increased Cost of Medical or other Equipment	--	5,000	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	57,436,000	--	2,240,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	1,058,000
	Subtotal, Built-In	--	58,324,000	--	4,245,000
B. CHR Restoration		--	0	--	112,000
	TOTAL INCREASES	--	58,324,000	--	4,357,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(4,245,000)
	TOTAL DECREASES	--	0	--	(4,245,000)
NET CHANGE		--	**58,324,000**	--	**112,000**

INDIAN HEALTH SERVICE
Immunization AK
Summary of Changes

FY 2017 Annualized CR	1,946,000
Total estimated budget authority	1,946,000
Less Obligations	(1,946,000)
FY 2018 Estimate	1,950,000
Less Obligations	(1,950,000)
Net Change	4,000
Less Obligations	(4,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	32,000
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	1,946,000	--	76,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	35,000
	Subtotal, Built-In	--	1,946,000	--	143,000
B. Immunization AK Restoration		--	0	--	4,000
	TOTAL INCREASES	--	1,946,000	--	147,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(143,000)
	TOTAL DECREASES	--	0	--	(143,000)
NET CHANGE		**--**	**1,946,000**	**--**	**4,000**

INDIAN HEALTH SERVICE
OTHER Services
Summary of Changes

FY 2017 Annualized CR	173,268,000
Total estimated budget authority	173,268,000
Less Obligations	(173,268,000)
FY 2018 Estimate	165,156,000
Less Obligations	(165,156,000)
Net Change	(8,111,000)
Less Obligations	8,111,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	20,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	62,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	221,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	624,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	434,000
7	Increased Cost of Travel	--	4,229,000	--	96,000
8	Increased Cost of Transportation & Things	--	470,000	--	11,000
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	1,609,000	--	30,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	31,063,000	--	895,000
12	Increased Cost of Supplies	--	3,576,000	--	82,000
13	Increased Cost of Medical or other Equipment	--	5,527,000	--	129,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	80,209,000	--	2,300,000
16	Increased Cost of Insurance / Indemnities	--	26,000	--	1,000
17	Increased Cost of Interest / Dividends	--	5,000	--	0
18	Population Growth	--	n/a	--	804,000
	Subtotal, Built-In	--	126,715,000	--	5,709,000
B. Program Restoration		--	0	--	331,000
	TOTAL INCREASES	--	126,715,000	--	6,040,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(5,709,000)
B. Program Adjustments		--	0	--	(8,442,000)
	TOTAL DECREASES	--	0	--	(14,151,000)
NET CHANGE		--	**126,715,000**	--	**(8,111,000)**

INDIAN HEALTH SERVICE
Urban Indian Health
Summary of Changes

FY 2017 Annualized CR	44,656,000
Total estimated budget authority	44,656,000
Less Obligations	(44,656,000)
FY 2018 Estimate	44,741,000
Less Obligations	(44,741,000)
Net Change	85,000
Less Obligations	(85,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	3,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	9,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	6,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	19,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	283,000
7	Increased Cost of Travel	--	119,000	--	3,000
8	Increased Cost of Transportation & Things	--	15,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	16,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	13,838,000	--	479,000
12	Increased Cost of Supplies	--	167,000	--	4,000
13	Increased Cost of Medical or other Equipment	--	140,000	--	5,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	28,519,000	--	1,112,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	804,000
	Subtotal, Built-In	--	42,814,000	--	2,727,000
B. Urban Restoration		--	0	--	85,000
	TOTAL INCREASES	--	42,814,000	--	2,812,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(2,727,000)
	TOTAL DECREASES	--	0	--	(2,727,000)
NET CHANGE		--	**42,814,000**	--	**85,000**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2017 Annualized CR	48,250,000
Total estimated budget authority	48,250,000
Less Obligations	(48,250,000)
FY 2018 Estimate	43,342,000
Less Obligations	(43,342,000)
Net Change	(4,908,000)
Less Obligations	4,908,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	1,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	3,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	11,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	30,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	41,000	--	0
8	Increased Cost of Transportation & Things	--	0	--	1,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	24,000	--	0
12	Increased Cost of Supplies	--	4,000	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	45,933,000	--	1,056,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	46,002,000	--	1,102,000
B. IHP Restoration		--	0	--	92,000
	TOTAL INCREASES	--	46,002,000	--	1,194,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,102,000)
B. Adjustments		--	0	--	(5,000,000)
	TOTAL DECREASES	--	0	--	(6,102,000)
NET CHANGE		--	**46,002,000**	--	**(4,908,000)**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2017 Annualized CR	2,437,000
Total estimated budget authority	2,437,000
Less Obligations	(2,437,000)
FY 2018 Estimate	0
Less Obligations	0
Net Change	(2,437,000)
Less Obligations	2,437,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,437,000	--	56,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	2,437,000	--	56,000
B. TMG Restoration		--	0	--	5,000
	TOTAL INCREASES	--	2,437,000	--	61,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(56,000)
B. Adjustments		--	0	--	(2,442,000)
	TOTAL DECREASES	--	0	--	(2,498,000)
NET CHANGE		--	**2,437,000**	--	**(2,437,000)**

INDIAN HEALTH SERVICE
Direct Operations
Summary of Changes

FY 2017 Annualized CR	72,200,000
Total estimated budget authority	72,200,000
Less Obligations	(72,200,000)
FY 2018 Estimate	72,338,000
Less Obligations	(72,338,000)
Net Change	138,000
Less Obligations	(138,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	16,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	50,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	192,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	542,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	151,000
7	Increased Cost of Travel	--	3,883,000	--	89,000
8	Increased Cost of Transportation & Things	--	454,000	--	10,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	1,572,000	--	30,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	16,686,000	--	405,000
12	Increased Cost of Supplies	--	3,388,000	--	78,000
13	Increased Cost of Medical or other Equipment	--	5,329,000	--	123,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	671,000	--	15,000
16	Increased Cost of Insurance / Indemnities	--	26,000	--	1,000
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	32,009,000	--	1,702,000
B. Direct Operations Restoration		--	0	--	138,000
	TOTAL INCREASES	--	32,009,000	--	1,840,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,702,000)
	TOTAL DECREASES	--	0	--	(1,702,000)
NET CHANGE		--	**32,009,000**	--	**138,000**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2017 Annualized CR	5,724,000
Total estimated budget authority	5,724,000
Less Obligations	(5,724,000)
FY 2018 Estimate	4,735,000
Less Obligations	(4,735,000)
Net Change	(989,000)
Less Obligations	989,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	12,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	33,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	186,000	--	4,000
8	Increased Cost of Transportation & Things	--	1,000	--	0
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	21,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	515,000	--	11,000
12	Increased Cost of Supplies	--	17,000	--	0
13	Increased Cost of Medical or other Equipment	--	58,000	--	1,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,649,000	--	61,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	5,000	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	3,453,000	--	122,000
B. Self-Governance Restoration		--	0	--	11,000
	TOTAL INCREASES	--	3,453,000	--	133,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(122,000)
B. Adjustments		--	0	--	(1,000,000)
	TOTAL DECREASES	--	0	--	(1,122,000)
NET CHANGE		--	**3,453,000**	--	**(989,000)**

INDIAN HEALTH SERVICE
Contract Support Costs
Summary of Changes

FY 2017 Annualized CR	716,605,000
Total estimated budget authority	716,605,000
Less Obligations	(716,605,000)
FY 2018 Estimate	717,970,000
Less Obligations	(717,970,000)
Net Change	1,365,000
Less Obligations	(1,365,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	716,605,000	--	0
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	716,605,000	--	0
B. CSC Restoration		--	0	--	1,365,000
	TOTAL INCREASES	--	716,605,000	--	1,365,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**716,605,000**	--	**1,365,000**

INDIAN HEALTH SERVICE

FACILITIES

Summary of Changes

FY 2017 Annualized CR	522,237,000
Total budget authority	522,237,000
Less Obligations	(522,237,000)
FY 2018 Estimate	446,956,000
Less Obligations	(446,956,000)
Net Change	(75,281,000)
Less Obligations	75,281,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	156,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	477,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	392,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	1,012,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	1,303,000
7	Increased Cost of Travel	--	2,685,000	--	61,000
8	Increased Cost of Transportation & Things	--	3,334,000	--	78,000
9	Increased Cost of Printing	--	59,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	16,046,000	--	361,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	101,617,000	--	2,337,000
12	Increased Cost of Supplies	--	6,636,000	--	152,000
13	Increased Cost of Medical or other Equipment	--	13,310,000	--	389,000
14	Increased Cost of Land & Structure	--	106,842,000	--	2,456,000
15	Increased Cost of Grants	--	165,714,000	--	4,461,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	n/a	--	7,513,000
	Subtotal, Built-In	--	416,243,000	--	21,148,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	8	2,022,000
C. Program Restoration		--	0	--	795,000
	TOTAL INCREASES	--	416,243,000		23,965,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(21,148,000)
B. Adjustments		--	0	--	(78,098,000)
	TOTAL DECREASES	--	0	--	(99,246,000)
NET CHANGE		**--**	**416,243,000**	**8**	**(75,281,000)**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2017 Annualized CR	73,474,000
Total budget authority	73,474,000
Less Obligations	(73,474,000)
FY 2018 Estimate	60,000,000
Less Obligations	(60,000,000)
Net Change	(13,474,000)
Less Obligations	13,474,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	58,000	--	1,000
8	Increased Cost of Transportation & Things	--	27,000	--	1,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	352,000	--	8,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	18,713,000	--	431,000
12	Increased Cost of Supplies	--	4,018,000	--	92,000
13	Increased Cost of Medical or other Equipment	--	360,000	--	8,000
14	Increased Cost of Land & Structure	--	6,106,000	--	140,000
15	Increased Cost of Grants	--	43,840,000	--	1,008,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	1,323,000
	Subtotal, Built-In	--	73,474,000	--	3,012,000
B. M&I Restoration		--	0	--	140,000
	TOTAL INCREASES	--	73,474,000	--	3,152,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(3,012,000)
B. Adjustments		--	0	--	(13,614,000)
	TOTAL DECREASES	--	0	--	(16,626,000)
NET CHANGE		**--**	**73,474,000**	**--**	**(13,474,000)**

INDIAN HEALTH SERVICE
Sanitation Facilities Construction
Summary of Changes

FY 2017 Annualized CR	99,234,000
Total budget authority	99,234,000
Less Obligations	(99,234,000)
FY 2018 Estimate	75,423,000
Less Obligations	(75,423,000)
Net Change	(23,811,000)
Less Obligations	23,811,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	102,000	--	2,000
8	Increased Cost of Transportation & Things	--	689,000	--	16,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	12,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	66,763,000	--	1,536,000
12	Increased Cost of Supplies	--	149,000	--	3,000
13	Increased Cost of Medical or other Equipment	--	7,000	--	0
14	Increased Cost of Land & Structure	--	1,499,000	--	34,000
15	Increased Cost of Grants	--	23,397,000	--	538,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	1,786,000
	Subtotal, Built-In	--	92,618,000	--	3,915,000
B. SFC Restoration		--	0	--	189,000
	TOTAL INCREASES	--	92,618,000	--	4,104,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(3,915,000)
B. Adjustments		--	0	--	(24,000,000)
	TOTAL DECREASES	--	0	--	(27,915,000)
NET CHANGE		**--**	**92,618,000**	**--**	**(23,811,000)**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2017 Annualized CR	104,848,000
Total budget authority	104,848,000
Less Obligations	(104,848,000)
FY 2018 Estimate	100,000,000
Less Obligations	(100,000,000)
Net Change	(4,848,000)
Less Obligations	4,848,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2018 Pay Raise CS (9months)	--	n/a		0
5	One Days Pay	--	n/a		0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	12,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	20,000	--	0
12	Increased Cost of Supplies	--	57,000	--	1,000
13	Increased Cost of Medical or other Equipment	--	5,585,000	--	128,000
14	Increased Cost of Land & Structure	--	99,174,000	--	2,281,000
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	0
	Subtotal, Built-In	--	104,848,000	--	2,410,000
B. HCFC Restoration		--	0	--	0
	TOTAL INCREASES	--	104,848,000	--	2,410,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(2,410,000)
B. Adjustments		--	0	--	(4,848,000)
	TOTAL DECREASES	--	0	--	(7,258,000)
NET CHANGE		**--**	**104,848,000**	**--**	**(4,848,000)**

INDIAN HEALTH SERVICE
Facilities & Environmental Health Support
Summary of Changes

FY 2017 Annualized CR	222,187,000
Total budget authority	222,187,000
Less Obligations	(222,187,000)
FY 2018 Estimate	192,022,000
Less Obligations	(192,022,000)
Net Change	(30,165,000)
Less Obligations	30,165,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	156,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	477,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	392,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	1,012,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	1,303,000
7	Increased Cost of Travel	--	2,520,000	--	58,000
8	Increased Cost of Transportation & Things	--	2,362,000	--	55,000
9	Increased Cost of Printing	--	59,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	15,421,000	--	349,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	15,104,000	--	347,000
12	Increased Cost of Supplies	--	2,341,000	--	54,000
13	Increased Cost of Medical or other Equipment	--	2,041,000	--	46,000
14	Increased Cost of Land & Structure	--	62,000	--	1,000
15	Increased Cost of Grants	--	82,899,000	--	2,307,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	n/a	--	3,999,000
	Subtotal, Built-In	--	122,809,000	--	10,556,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	8	2,022,000
C. HCFC Restoration		--	0		423,000
	TOTAL INCREASES	--	122,809,000	--	13,001,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(10,556,000)
B. Adjustments		--	0	--	(32,610,000)
	TOTAL DECREASES	--	0	--	(43,166,000)
NET CHANGE		**--**	**122,809,000**	**8**	**(30,165,000)**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2017 Annualized CR	22,494,000
Total budget authority	22,494,000
Less Obligations	(22,494,000)
FY 2018 Estimate	19,511,000
Less Obligations	(19,511,000)
Net Change	(2,983,000)
Less Obligations	2,983,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	5,000	--	0
8	Increased Cost of Transportation & Things	--	244,000	--	6,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	261,000	--	4,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	1,017,000	--	23,000
12	Increased Cost of Supplies	--	71,000	--	2,000
13	Increased Cost of Medical or other Equipment	--	5,317,000	--	207,000
14	Increased Cost of Land & Structure	--	1,000	--	0
15	Increased Cost of Grants	--	15,578,000	--	608,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	405,000
	Subtotal, Built-In	--	22,494,000	--	1,255,000
B. Equipment Restoration		--	0	--	43,000
	TOTAL INCREASES	--	22,494,000	--	1,298,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,255,000)
B. Adjustments		--	0	--	(3,026,000)
	TOTAL DECREASES	--	0	--	(4,281,000)
NET CHANGE		**--**	**22,494,000**	**--**	**(2,983,000)**

INDIAN HEALTH SERVICE
Budget Authority by Activity

(Dollars in Thousands)

	2016 Final		2017 Annualized CR		2018 President's Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES						
Hospitals & Health Clinics	6,077	$1,857,225	6,078	$1,853,694	6,078	$1,870,405
Dental Services	571	178,286	571	177,947	571	179,751
Mental Health	196	82,100	196	81,944	196	82,654
Alcohol & Substance Abuse	173	205,305	206	204,915	206	205,593
Contract Health Services	0	914,139	0	912,401	0	914,139
Total, Clinical Services	7,017	3,237,055	7,051	3,230,901	7,051	3,252,542
Public Health Nursing	208	76,623	208	76,477	208	77,498
Health Education	20	18,255	20	18,220	20	18,313
Comm. Health Reps.	3	58,906	3	58,794	3	58,906
Immunization AK	0	1,950	0	1,946	0	1,950
Total, Preventive Health	231	155,734	231	155,438	231	156,667
Urban Health	6	44,741	6	44,656	6	44,741
Indian Health Professions	22	48,342	22	48,250	22	43,342
Tribal Management	0	2,442	0	2,437	0	0
Direct Operations	259	72,338	259	72,200	259	72,338
Self-Governance	14	5,735	14	5,724	14	4,735
Total, Other services	301	173,598	301	173,268	301	165,156
Total, Services	7,549	3,566,387	7,583	3,559,607	7,583	3,574,365
CONTRACT SUPPORT COSTS	0	717,970	0	716,605	0	717,970
FACILITIES						
Maintenance & Improvement	0	73,614	0	73,474	0	60,000
Sanitation Facilities Constr.	137	99,423	137	99,234	137	75,423
Health Care Facs. Constr.	0	105,048	0	104,848	0	100,000
Facil. & Envir. Health Supp.	1,074	222,610	1,077	222,187	1,077	192,022
Equipment	0	22,537	0	22,494	0	19,511
Total, Facilities	1,211	523,232	1,214	522,237	1,214	446,956
Total IHS	8,760	$4,807,589	8,797	$4,798,450	8,797	$4,739,291

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

Indian Health Service

Authorizing Legislation

(Dollars in Thousands)

	FY 2017		FY 2018	
	Amount Authorized	Amount Appropriated	Amount Authorized	President's Budget
1. Services Appropriation:	3,559,607	3,559,607	3,574,365	3,574,365
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:	716,605	716,605	717,970	717,970
Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.*				
3. Facilities Appropriation:	522,237	522,237	446,956	446,956
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).	8,500	8,500	8,500	8,500
4. Public and Private Collections:	1,193,577	1,193,577	1,193,577	1,193,577
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:	147,000	147,000	150,000	150,000
42 U.S.C. 245c-3.				
Unfunded authorizations:	0	0	0	0
Total appropriations:	6,147,527	6,147,527	6,091,368	6,091,368
Total appropriations against Definite authorizations:	6,147,527	6,147,527	6,091,368	6,091,368

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
Recission (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	-	-	-

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	-	-	-

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	-	-	-

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2018 Performance Budget Submission to Congress

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

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$3,237,055	$3,230,901	$3,252,542	+$21,641
FTE*	7,017	7,051	7,051	0

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

SUMMARY OF THE BUDGET REQUEST

The FY 2018 Budget submission for Clinical Services of $3.252 billion is $21.641 million above the FY 2017 Annualized Continuing Resolution (CR) level. Included in the budget is $17.045 million for Staffing of New Facilities. 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 critical health care needs.

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

- **Hospitals and Health Clinics**, which 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 HIV/AIDS, tuberculosis, and hepatitis; women's and men's health; geriatric health; disease surveillance; and healthcare quality improvement. The Budget proposes an increase of $16.711 million for a total of $1.870 billion for Hospitals and Health Clinics.

- **Dental Health**, which 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 the high dental caries rate in American Indian and Alaska Native (AI/AN) children; however, a continuing emphasis on community oral health promotion/disease prevention is essential to impact long-term improvement of the oral health of AI/AN people. The Budget proposes an increase of $1.804 million for a total of $179.751 million for Dental Health.

- **Mental Health**, which 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. The Budget proposes an increase of $710,000 for a total of $82.654 million for Mental Health.

- **Alcohol and Substance Abuse**, which supports an integrated behavioral health approach to collaboratively reduce the incidence of alcoholism and other drug dependencies in AI/AN communities. The Budget proposes an increase of $678,000 for a total of $205.593 million for Alcohol and Substance Abuse.

- **Purchased/Referred Care (PRC)**, which 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, colonscopies, 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 Budget proposes an increase of $1.738 million for a total of $914.139 million for Purchased/Referred Care.

The bulk of clinical services funds are provided to 12 Area (regional) Offices which distribute resources, monitor and evaluate activities, and provide administrative and technical support to 170 Federal and Tribal Service Units (local level) for 662 healthcare facilities providing care to approximately 2.2 million AI/ANs primarily 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.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
28 Unintentional Injury Rates: Age-Adjusted Unintentional injuries mortality rate in AI/AN population (Outcome)	FY 2008: 94.5 (Target Not In Place)	TBD	94.5	N/A
31 Childhood Weight Control: Proportion of children, ages 2-5 years, with a BMI at or above the 95th percentile. IHS - All (Outcome)	FY 2016: 22.3 % Target: 22.8 % (Target Exceeded)	TBD	Retire after 2017	N/A
71 Childhood Weight Control: Proportion of children, ages 2-5 years with a BMI at or above the 95th percentile. IHS-All (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 22.6 % (Pending)	N/A	22.6 %	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 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$1,857,225	$1,853,694	$1,870,405	+$16,711
FTE*	6,077	6,078	6,078	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

FY 2018 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 2.2 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 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/ANs such as diabetes, maternal and child health, and communicable diseases including influenza, HIV/AIDS, and hepatitis. Although the health status of AI/ANs has improved significantly in the past 60 years since the inception of the IHS, the average life expectancy at birth is 73.7 years (data years 2007-2009) compared to the U.S. all races life expectancy of 78.1 years[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, 289 health centers, 73 health stations, 150 Alaska village clinics, and 15 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 26 hospitals, 53 health centers, 30 health stations and 4 school health centers.

[1] *Life Expectancy: American Indians and Alaska Natives, Data Years 2007-2009*. Indian Health Service Division of Program Statistics, Indian Health Service, United States Department of Health and Human Services, (Advance Data).

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 and Improving Patient Care) that are primarily funded through the H&HC budget.

PROGRAM ACCOMPLISHMENTS

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

Improving Patient Care (IPC) Program 2.0 - 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 Patient Centered Medical Home (PCMH) model of care to improve the health and wellness of AI/ANs. The IPC program provides a regional model of collaborative learning to develop proficiency in quality improvement. Data management and analysis are used drive improvements. Success will be measured in FY 2018 and beyond by achievement of clinical and process industry-benchmarks, as well as ultimate recognition or certification of participating sites as PCMHs. Participating teams report on clinical outcome measures aligned with the Government Performance and Results Act (GPRA) measures and some additional clinical process measures

In 2016, the IPC program provided training cohorts related to quality improvement skill building including regional training in 8 IHS areas and a national web based training series. Data reporting by IHS, Tribal and Urban (I/T/U) participating health care facilities has demonstrated an increase in patient empanelment to almost 90 percent by the end of 2016. Patient empanelment supports population health management, care coordination, and continuity with the care team and providers. However, clinical measures reported such as blood pressure control and diabetes control rates were unchanged. In January 2015, the IPC program began working with 16 I/T/U facilities regarding patient satisfaction. The results from reported data as of the end of 2016, demonstrates that 80 percent of the patients were satisfied with their care.

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. According to the 2016 IHS Nurse Position Report, there are 2,195 Registered Nurses (RNs) and 354 Licensed Practical Nurses (LPNs) employed in I/T/U programs. The FY 2016 IHS Nurse Position Report identified a RN/Advanced Practice Nurse (APN) vacancy rate of 21 percent and a LPN vacancy rate of 11 percent. Nurses are actively engaged in the transformation of the health care system by placing more emphasis on prevention, wellness, and coordination of care.

IHS nurses are instrumental in promoting and sustaining the IHS Baby Friendly Hospital Initiative (BFHI). This IHS initiative promotes breastfeeding to reduce the risk that children will develop obesity, diabetes, and other obesity-related conditions in the future.[2] Nationally, fewer than 13.8 percent of all U.S. hospitals are Baby-Friendly designated. The IHS adopted Baby-Friendly as the official standard of care for AI/AN mothers and babies in 2011. IHS received 100 percent Baby Friendly designation of all its obstetric care hospitals in 2014 and has sustained 100

[2] Ip, S. Chung M., Raman G., et al. *Breastfeeding and Maternal Infant Health Outcomes in Developed Countries*. Evid Rep Technol Assess. 2007 (153): 1-186.

percent (n=10) Baby-Friendly designation at all IHS hospitals that provided obstetric services in FY 2016. IHS is committed to sustaining Baby-Friendly practices in FY 2017, and enhancing team-based care, self-management support, and integration with primary care services. IHS is committed to maintaining Baby Friendly practices and designation into FY 2018 and beyond.

In FY 2016, the Childhood immunization GPRA measure was 72.3 percent and did not meet the FY 2016 goal of 76.8 percent. The measure checks for coverage with 4 doses of DTaP, 3 doses of polio, 1 dose of MMR, 3 doses of Hepatitis B, 3 or 4 dose of Hib vaccine (depending on formulation), 1 dose of varicella and 4 doses of PCV13. The 4th dose of PCV13 is dependent on the age of receipt and is recommended to be given at 2, 4, 6 and 12 months. Children past the age of 12 months could not receive the 4th does causing the measure to not be met.

Trauma Care – Trauma is the leading cause of death and disability among the AI/AN population under age 45, and AI/AN trauma death rates are three times higher than U.S. all races rates.[3] Local IHS hospitals are frequently the nearest emergency medical facility that can receive patients with traumatic injuries from emergency medical services providers (Paramedics, EMTs). Of the 26 IHS emergency departments (EDs), 24 of which are located at inpatient facilities and 2 are in health centers; 74 percent are more than 50 miles from the nearest designated trauma center at any level and 52 percent are more than 100 miles. According to the FY 2016 IHS emergency department memo, there were 396,766 direct outpatient ED visits and 15,100 direct inpatient ED visits for the 26 IHS facilities. Recruitment and retention of competent and proficient staff for EDs at certain facilities has posed a significant challenge to continuity of emergency services in FY 2016 and FY 2017. A coordinated effort to address this challenge across all levels of the agency in FY 2017 is aimed at improving recruitment and retention activities.

Trauma Center designation is determined by state and local municipalities based on unique criteria such as: trauma readiness, resources available, policies, patient care, and performance improvement. Currently, out of 24 IHS hospitals with an ED, only one is designated a Level III (provides prompt assessment, resuscitation, surgery, intensive care, and stabilization of injured patients and emergency operations) and one other is designated a Level IV (provides evaluation, stabilization, and diagnostics for injured patients prior to the transfer of the patient to a higher Level Trauma Center).

Adequate staffing levels and capabilities, as well as state of the art equipment, are essential for quality care. Emergency medicine physicians, RNs, APNs, and other highly trained staff are essential for crisis and disaster management to improve patient outcomes. For RNs from rural IHS emergency departments and critical care areas, the IHS Capstone program develops critical thinking skills, competence and confidence in trauma nurses in the emergency department setting. This program includes population specific services, pediatric emergency services, and geriatric trauma. In FY 2016, the IHS Capstone program trained eight registered nurses; 6 registered nurses are scheduled to complete training in FY 2017.

HIV/AIDS Program – HIV is a significant public health concern for AI/AN people. Compared to other groups, AI/AN people ranked fifth in estimated new HIV infection diagnoses in 2013[4]. In 2014, the proportion of AI/AN persons surviving more than 36 months following diagnosis of an HIV infection was 88 percent,[5] the lowest rate among all racial groups. The HIV/AIDS Program

[3] U.S. Department of Health and Human Services, Indian Health Service, Trends in Indian Health 2014 Edition (Released March 2015), ISSN 1095-2896

[4] http://www.cdc.gov/hiv/group/racialethnic/aian/index.html for more.
[5] http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-us.pdf

goal is to ensure access to quality health services for AI/ANs living with HIV/AIDS and those at risk of contracting HIV and commonly co-occurring infections. The IHS has shown recent improvements in screening and HIV/AIDS care. As of FY 2016, 100 percent of IHS sites have served patients living with an HIV diagnosis. To improve access to care in remote areas, IHS has provided technical support to sites on screening and treatment, and extended the use of tele-health. IHS hosts a monthly secure webinar clinic for IHS HIV/AIDS care providers in partnership with the University of New Mexico.

Hepatitis C virus (HCV) infections can result in illness varying in severity from mild, lasting a few weeks, to serious, a lifelong illness. The likelihood of liver damage is related to the duration and severity of untreated infection. New treatment medications that became available in FY 2015 are more effective than in the past, but are much more expensive. In the general U.S. population, people born from 1945-1965 ("Baby Boomers") have recently been identified to be at risk of infection with Hepatitis C. The Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force recommend a one-time HCV screening of all Baby Boomers in the United States. In addition to the Baby Boomer population, CDC estimates that the highest rate of acute infections in the United States is among AI/ANs. IHS anticipates higher costs associated with HCV care in FY 2016 and 2017 associated with the increased rate of diagnosis (based on increased screening of Baby-Boomers) and the substantially higher cost of newer, curative medications.

Domestic Violence Prevention Program (DVPP) (formerly known as the Domestic Violence Prevention Initiative) – Domestic and intimate partner violence has a disproportionately large impact on AI/AN communities. According to the CDC, 45.9 percent of AI/AN woman have experienced intimate partner violence – the highest rate of any race or ethnicity in the U.S.[6] In addition, one out of every three AI/AN women will be sexually assaulted in her lifetime,[7] and AI/AN victims of intimate and family violence are more likely than victims of all other races to be injured and need hospital care.[8]

DVPP is 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 DVPP focuses on domestic and sexual violence prevention, advocacy, and coordinated community responses, as well as providing forensic healthcare services to victims of domestic and sexual violence.

In FY 2015, IHS established a new five-year funding cycle for the DVPP that will operate from 2015-2020. A total of 57 grantees and federal awardees work to meet the following goals:

- Build Tribal, Urban Indian Health Programs and Federal capacity to provide coordinated community responses to AI/AN victims of domestic and sexual violence,
- Increase access to domestic and sexual violence prevention, advocacy, crisis intervention, and behavioral health services for AI/AN victims and their families,
- Promote trauma-informed services for AI/AN victims of domestic and sexual violence and their families,

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[6] *National Intimate Partner and Sexual Violence Survey. 2010.* Centers for Disease Control and Prevention. Available at, http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf

[7] *Restoration of Native Sovereignty, 5*. Restoration of Safety for Native Women .Sacred Circle and the National Congress of American Indians Task Force on Violence Against Women in Indian Country. (2006, September).

[8] *American Indians and Crime, 1992-96 Report*. Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice.

- Offer health care provider and community education on domestic violence and sexual violence,
- Respond to the health care needs of AI/AN victims of domestic and sexual violence, and
- Incorporate culturally appropriate practices and/or faith-based services for AI/AN victims of domestic and sexual violence.

The first year concluded on September 29, 2016, and 100 percent of projects submitted their progress reports. Evaluation of the data is currently being conducted.

TRIBAL SHARES

H&HC funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities. A portion of the overall H&HC budget line is reserved for federally inherent functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

FUNDING HISTORY

Fiscal Year	Amount	DVPP
2014	$1,773,931,000	($8,967,278)
2015	$1,836,789,000	($8,967,278)
2016	$1,857,225,000	($8,967,278)
2017 Annualized CR	$1,853,694,000	($8,967,278)
2018 President's Budget	$1,870,405,000	($8,967,278)

BUDGET REQUEST

The FY 2018 budget submission for Hospitals and Health Clinics of $1,870,405,000 is $16,711,000 above the FY 2017 Annualized Continuing Resolution (CR) level.

FY 2017 Base Funding of $1,853,694,000 - 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. In addition, an amount of H&HC funding that initially is allocated to Headquarters each year is reallocated on a non-recurring basis to Areas during the fiscal year and supports national activities. Also included in the base is funding to provide technical assistance to IHS facilities to promote efficient, effective, high quality care to the AI/AN population. The IHS will strengthen its quality system to ensure alignment with and attainment of national standards for quality and patient safety for inpatient and outpatient facilities. This will include accreditation preparation, readiness, and survey activities; bringing health care quality expertise to IHS; and development and/or dissemination of education tools and experiential opportunities to ensure staff competencies in quality assurance and quality improvement.

FY 2018 Funding Increase of $16,711,000 includes:

- Staffing for New Facilities FY (2018) +$14,738,000 - 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 critical health care needs. The following table displays this request.

New Facilities	Amount	FTE/Tribal Positions
Choctaw Nation Regional Medical Center (JV), Durant, OK	$11,674,000	91
Flandreau Health Center (JV), Flandreau, SD	$3,064,000	28
Grand Total:	**$14,738,000**	**119**

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2017 Target**	**FY 2018 Target**	**FY 2018 Target +/-FY 2017 Target**
5 Diabetes: Nephropathy Assessment: Proportion of patients with diagnosed diabetes assessed for nephropathy. IHS-All (Outcome)	FY 2016: 63.3 % Target: 61.1 % (Target Exceeded)	63.3 %	Retire after 2017	N/A
5 Tribally Operated Health Programs (Outcome)	FY 2016: 57.7 % Target: 58.9 % (Target Not Met)	59.2 %	Retire after 2017	N/A
6 Diabetic Retinopathy: Proportion of patients with diagnosed diabetes who receive an annual retinal examination. (Outcome)	FY 2016: 59.1 % Target: 61.6 % (Target Not Met)	63.1 %	Retire after 2017	N/A
6 Tribally Operated Health Programs (Outcome)	FY 2016: 56.8 % Target: 59.6 % (Target Not Met)	61.7 %	Retire after 2017	N/A
7 Pap Screening Rates: Proportion of eligible women who have had cervical cancer screening appropriate for their age (Outcome)	FY 2016: 54.8 % Target: 55.6 % (Target Not Met)	56.1 %	Retire after 2017	N/A
7 Tribally Operated Health Programs (Outcome)	FY 2016: 54.7 % Target: 56.1 % (Target Not Met but Improved)	55.5 %	Retire after 2017	N/A
8 Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. (Outcome)	FY 2016: 54.8 % Target: 55.9 % (Target Not Met but Improved)	56.7 %	Retire after 2017	N/A
8 Tribally Operated Health Programs (Outcome)	FY 2016: 55 % Target: 57.1 % (Target Not Met)	57.3 %	Retire after 2017	N/A
9 Colorectal Cancer Screening Rates: Proportion of eligible patients who have had	FY 2016: 39.6 % Target: 38.7 % (Target Exceeded)	40.2 %	Retire after 2017	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
appropriate colorectal cancer screening. (Outcome)				
9 Tribally Operated Health Programs (Outcome)	FY 2016: 40.4 % Target: 40.9 % (Target Not Met but Improved)	41.7 %	Retire after 2017	N/A
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 2015: 99 % Target: 100 % (Target Not Met)	100 %	100 %	Maintain
24 American Indian and Alaska Native 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)	FY 2016: 72.3 % Target: 76.8 % (Target Not Met)	74.8 %	Retire after 2017	N/A
24 Tribally Operated Health Programs (Outcome)	FY 2016: 66 % Target: 71 % (Target Not Met)	68.5 %	Retire after 2017	N/A
26 Pneumococcal vaccination rates among adult patients aged 65 years and older. IHS-All (Outcome)	FY 2016: 86.4 % Target: 87.3 % (Target Not Met but Improved)	86.7 %	Retire after 2017	N/A
26 Tribally Operated Health Programs (Outcome)	FY 2016: 82.1 % Target: 83.3 % (Target Not Met but Improved)	82.2 %	Retire after 2017	N/A
30 American Indian and Alaska Native patients, 22 and older, with Coronary Heart Disease are assessed for four cardiovascular disease (CVD) risk factors. (Outcome)	FY 2016: 65.7 % Target: 53.3 %[9] (Target Exceeded)	Retire after 2016	Retire after 2016	N/A
30 Tribally Operated Health Programs (Outcome)	FY 2016: 60.4 % Target:	Retire after 2016	Retire after 2016	N/A

[9]In FY 2015 the CVD measure included five risk factors. In FY 2016 the measure will include four risk factors.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
	49.3 % (Target Exceeded)			
32 Tobacco Cessation Intervention: Proportion of tobacco-using patients that receive tobacco cessation intervention. IHS-All (Outcome)	FY 2016: 50.4 % Target: 49.1 % (Target Exceeded)	53.2 %	Retire after 2017	N/A
32 Tribally Operated Health Programs (Outcome)	FY 2016: 43.2 % Target: 43.9 % (Target Not Met)	45.8 %	Retire after 2017	N/A
43 Proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed (Outcome)	FY 2016: 35.2 % Target: 35.8 % (Target Not Met)	36.4 %	Retire after 2017	N/A
43 Tribally Operated Health Programs (Outcome)	FY 2016: 36.4 % Target: 38.6 % (Target Not Met but Improved)	37 %	Retire after 2017	N/A
44 Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native population (Outcome)	FY 2008: 89.3 years (Target Not In Place)	TBD	89.3 years	N/A
45 Hospital admissions per 100,000 service population for long-term complications of diabetes (Efficiency)	FY 2015: 56 Target: 83.62 (Target Exceeded)	TBD	74.6	N/A
46 Controlling High Blood Pressure (Outcome)	FY 2016: 59.2 % Target: 60.6 % (Target Not Met but Improved)	59.7 %	Retire after 2017	N/A
46 Tribally Operated Health Programs (Outcome)	FY 2016: 58 % Target: 60.2 % (Target Not Met but Improved)	58.5 %	Retire after 2017	N/A
47 HIV Screening Ever: Percentage of 13-64 year olds screened for HIV (Outcome)	FY 2016: 41.9 % Target: 41.9 % (Baseline)	41.9 %	Retire after 2017	N/A
47 TOHP HIV Screening Ever (Outcome)	FY 2016: 31.3 % Target: 31.3 % (Baseline)	31.3 %	Retire after 2017	N/A
48 Influenza Vaccination Rates Among Children 6 months to 17 years (Outcome)	FY 2016: 37.1 % Target:	37.1 %	Retire after 2017	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
	37.1 % (Baseline)			
48 TOHP Influenza 6 months to 17 years (Outcome)	FY 2016: 29.4 % Target: 29.4 % (Baseline)	29.4 %	Retire after 2017	N/A
49 Influenza Vaccination Rates Among Adults 18 years and older (Outcome)	FY 2016: 38.7 % Target: 38.7 % (Baseline)	38.7 %	Retire after 2017	N/A
49 TOHP Influenza 18 years and older (Outcome)	FY 2016: 33.6 % Target: 33.6 % (Baseline)	33.6 %	Retire after 2017	N/A
51 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives (Outcome)	FY 2017: Result Expected Jan 31, 2018 Target: Set Baseline (Pending)	Baseline	Retire after 2017	N/A
51 TOHP Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives (Outcome)	FY 2017: Result Expected Jan 31, 2018 Target: Set Baseline (Pending)	Baseline	Retire after 2017	N/A
55 Nephropathy Assessed (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 34.0 % (Pending)	N/A	34.0 %	N/A
56 Retinopathy Exam (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 49.7 % (Pending)	N/A	49.7 %	N/A
57 Pap Smear Rates (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 35.9 % (Pending)	N/A	35.9 %	N/A
58 Mammogram Rates (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 42.0 % (Pending)	N/A	42.0 %	N/A
59 Colorectal Cancer Screening Rates (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 32.6 % (Pending)	N/A	32.6 %	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
64 TOHP IPV/DV Screening (Output)	FY 2016: 64.3 % Target: 64.3 % (Baseline)	64.3 %	Retire after 2017	N/A
64 IPV/DV Screening (Output)	FY 2016: 65.3 % Target: 65.3 % (Baseline)	65.3 %	Retire after 2017	N/A
66 American Indian and Alaska Native 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)	FY 2018: Result Expected Jan 31, 2019 Target: 45.6 % (Pending)	N/A	45.6 %	N/A
67 Influenza Vaccination Rates among children 6 months to 17 years (Outcome)	FY 2018: Result Expected Jan 31, 2019 (TargetNot In Place)	N/A	TBD	N/A
68 Influenza vaccination rates among adults 18 years and older (Outcome)	FY 2018: Result Expected Jan 31, 2019 (Target Not In Place)	N/A	TBD	N/A
69 Adult Composite Immunization (Output)	FY 2018: Result Expected Jan 31, 2019 Target: Set Baseline (Pending)	N/A	TBD	N/A
70 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives (Outcome)	FY 2018: Result Expected Jan 31, 2019 (Target Not In Place)	N/A	TBD	N/A
72 Tobacco Cessation Intervention (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 27.5 % (Pending)	N/A	27.5 %	N/A
73 HIV Screening Ever (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 17.3 % (Pending)	N/A	17.3 %	N/A
74 Breastfeeding Rates (Outcome)	FY 2018: Result Expected Jan 31, 2019	N/A	39.0 %	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
	Target: 39.0 % (Pending)			
75 Controlling High Blood Pressure - MH (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 42.3% (Pending)	N/A	42.3%	N/A
81 IPV/DV Screening (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 41.6 % (Pending)	N/A	41.6 %	N/A
H&HC-4 Inpatient Admissions - IHS Direct (Output) (Output)	FY 2015: 17,254 admissions Target: 19,500 admissions (Target Exceeded)	Retire after 2016	Retire after 2016	N/A
TOHP-2 Number of designated annual clinical performance goals met. (Outcome)	FY 2016: 10[10] Target: 13[11] (Target Not Met but Improved)	16[12]	Retire after 2017	N/A

GRANTS AWARDS - H&HC funds support the Healthy Lifestyles in Youth Grant[13], a $1,000,000 limited 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 57 DVPP grants.

(whole dollars)	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Number of Awards	58	58	58
Average Award	$148,207	$148,207	$148,207
Range of Awards	$49,750-$1,000,000	$49,750-$1,000,000	$49,750-$1,000,000

[10]FY 2016 result is 10 of 21 clinical performance goals met.
[11]FY 2016 target is for 13 of 18 annual clinical performance goals to be met.
[12]FY 2017 target is for 16 of 22 annual clinical performance goals to be met.
[13] The current Healthy Lifestyles in Youth cooperative agreement expires August 2017.

AREA ALLOCATION

Hospital and Health Clinics

(dollars in thousands)

DISCRETIONARY	FY 2016 Final			FY 2017 Estimated			FY 2018 Estimated			FY '18 +/- FY '17
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$4,667	$316,083	$320,750	$4,689	$313,776	$318,465	$4,698	$314,374	$319,072	$607
Albuquerque	49,522	27,457	76,979	49,759	27,256	77,015	49,853	27,308	77,162	147
Bemidji	21,379	77,044	98,423	21,481	76,482	97,962	21,522	76,627	98,149	187
Billings	50,774	12,640	63,413	51,016	12,547	63,564	51,113	12,571	63,685	121
California	4,853	66,525	71,378	4,876	66,039	70,916	4,886	66,165	71,051	135
Great Plains	134,568	32,747	167,315	135,211	32,508	167,719	135,468	35,634	171,102	3,383
Nashville	12,327	60,186	72,514	12,386	59,747	72,133	12,410	59,861	72,271	137
Navajo	157,968	82,321	240,289	158,722	81,720	240,442	159,025	81,876	240,900	458
Oklahoma	106,040	229,036	335,076	106,546	227,364	333,910	106,749	239,471	346,221	12,310
Phoenix	107,229	69,088	176,317	107,741	68,584	176,325	107,946	68,715	176,661	336
Portland	22,915	51,613	74,528	23,024	51,237	74,261	23,068	51,334	74,402	141
Tucson	17,542	2,288	19,830	1,918	17,912	19,830	1,922	17,946	19,868	38
Headquarters	140,414	0	140,414	141,151	0	141,151	139,862	0	139,862	-1,289
Total, H&HC	**$830,198**	**$1,027,027**	**$1,857,225**	**$818,522**	**$1,035,172**	**$1,853,694**	**$818,523**	**$1,051,882**	**$1,870,405**	**+$16,711**

Note: FY 2016 are actual amounts. FY 2017 and FY 2018 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 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$1,857,225	$1,853,694	$1,870,405	+$16,711
*Epi Centers**	*$4,433*	*$4,433*	*$4,433*	*0*

**Amount updated based on FY 2016 actuals.*

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 2018 Authorization.....Permanent

Allocation Method.....Cooperative Agreements

PROGRAM DESCRIPTION

The Indian Health Service (IHS) Tribal Epidemiology Center (TEC) Program was first authorized and funded by Congress in FY 1996. The intent has been 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, 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 critical 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 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 testing the effectiveness of implemented health interventions. The TEC Program supports Tribal communities by providing technical training in public health practice and prevention-oriented research, and promoting public health career pathways for Tribal members.

Over 90 percent of the TEC Program budget is distributed through cooperative agreements based on a 5-year competitive award cycle. In the current award cycle, all 12 TECs were awarded an annual average of $341,000 (beginning FY 2016). The next 5-year competitive award cycle will encompass FYs 2021-2026 and projected at similar funding levels for each TEC.

The TECs are fundamental to the IHS' partnership with Tribes by supporting epidemiology and public health functions critical to the delivery of 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 (i.e., surveillance of disease and control programs and collecting epidemiological data for use in determining health status of Tribal communities).

PROGRAM ACCOMPLISHMENTS

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 to designate the TECs as public health authorities. To ensure the security of the agency data access, data sharing agreements are required, before TECs access IHS-generated data sets.

TECs assist Tribes with projects such as conducting behavioral risk factor surveys to establish a base of measurement for successfully evaluating intervention and prevention activities related to behavioral health needs. Because national surveys (e.g., Behavioral Risk Factor Surveillance System Survey, Youth Risk Behavior Survey) do not consistently capture representative data for AI/AN populations, TECs have had an essential role in piloting adapted versions of these national surveys to include AI/AN populations. These surveys provide baseline and trend data used by Tribes and Urban Indian Health organizations (UIHOs) to identify health-related needs and to prioritize interventions and prevention services. For example, one TEC combines these surveys and other data to generate reports on the health disparities of urban Indians and distributes nationally to all UIHOs to identify health priorities, seek opportunities for new data collection, and support competitive, evidence-driven applications for funding opportunities to address these priorities.

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 develop recommendations for the targeting of services needed by the populations served.

Collaboration
The DEDP collaborates with the National Institutes of Health, the Centers for Disease Control and Prevention (CDC), and other federal agencies 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 2020 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.

FUNDING HISTORY

Fiscal Year	Amount*
2014	*$4,433,361*
2015	*$4,433,361*
2016	*$4,433,361*
2017 Annualized CR	*$4,433,361*
2018 President's Budget	*$4,433,361*

*Funded under the H&HC budget.

BUDGET REQUEST

The FY 2018 budget submission for the TECs under Hospitals and Health Clinics is $4,433,361, which is the same as the FY 2017 Annualized Continuing Resolution (CR) level. Current funding, an average of $341,000 per TEC, covers the salaries of a Director, one full-time Epidemiologist, administrative assistance/support, and the execution of one or two pressing disparity projects or tribal priorities. The table below identifies the twelve TECs and their respective locations.

Tribal Epidemiology Centers and Locations		
1	Alaska Native Tribal Health Consortium	Anchorage, AK
2	Albuquerque American Indian Health Board	Albuquerque, NM
3	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI
4	Inter-Tribal Council of Arizona	Phoenix, AZ
5	Montana/Wyoming Tribal Leaders Council	Billings, MT
6	Navajo Nation Division of Health	Window Rock, AZ
7	Northern Plains – Great Plains Area	Rapid City, SD
8	Northwest Portland Area Indian Health Board	Portland, OR
9	Oklahoma City Area Inter-Tribal Health Board	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

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2017 Target**	**FY 2018 Target**	**FY 2018 Target +/-FY 2017 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 2016: 850 Target: 850 (Baseline)	850	850	Maintain
EPI-5 Number of TEC-sponsored trainings and technical assistance provided to build tribal public health capacity. (Output)	FY 2016: 89 Target: 89 (Baseline)	89	89	Maintain

New measures adopted by Tribal Epidemiology Centers Consortium during mid-FY 2016

GRANTS AWARDS

(whole dollars)	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Number of Awards	12	12	12
Average Award	$341,000	$341,000	$341,000
Range of Awards	$265,250 -$412,000	$265,250 -$412,000	$265,250 -$412,000

* Administrative and technical support of the TEC's is provided by the Division of Epidemiology and Disease Prevention (DEDP) and is included in the average award amount.

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 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$1,857,225	$1,853,694	$1,870,405	+$16,711
HIT	*$182,149*	*$182,149*	*$182,149*	*0*

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 2018 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) Program 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 critical support for the IHS, Tribal, and Urban (I/T/U) programs that care for 2.2 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 a comprehensive health information solution that includes an Electronic Health Record (EHR) which has received 2014 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 and is pursuing 2015 certification. The IHS HIT program directly supports better ways to 1) pay providers, 2) deliver care, and 3) distribute information, resulting in better care, wiser spending of our health dollars, and healthier communities, economy, and country.

The HIT Program is dedicated to providing the most innovative, effective, cost-efficient, and secure HIT system in the federal government. The HIT program is comprised of four major strategic IT investments: 1) the Resource and Patient Management System (RPMS); 2) Infrastructure, Office Automation, and Telecommunications (IOAT); 3) the National Patient Information Reporting System (NPIRS); and 4) Security and Compliance (IT Security). These investments support tribal priorities for improving the delivery of healthcare and are fully integrated with the Agency's programs and are critical to carrying out the IHS mission and priorities (see IHS Investment table below).

1) **RPMS** is the key enterprise health information system that underlies the clinical, practice management and revenue cycle business processes at I/T/U facilities across the country. The RPMS EHR is certified according to criteria published by the ONC and is in use at

approximately 400 health care facilities across the country. RPMS continued the deployment of new health information sharing and patient engagement features, collectively called the RPMS Network, through FY 2016 and began its planning efforts for the IHS implementation of the IT requirements for the Medicare Access & Children's Health Insurance Program (Reauthorization Act (MACRA) of 2015) and other quality improvement initiatives.

2) **IOAT** provides the technical infrastructure for federal and some tribal healthcare facilities and is the foundation upon which all health IT services are delivered. The IOAT investment includes a highly available and secure wide-area network which 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. The IT infrastructure incorporates government and industry standards for the collection, processing, storage, and transmission of information and is poised to respond to new and pioneering opportunities.
3) **NPIRS** is an enterprise-wide data warehouse and business intelligence environment that produces 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. This investment, is evolving to add rigor to the analytic platform, is extending standards and best practices and exploiting the capabilities of Business Intelligence, and is enabling IHS to produce and make more informed, quality decisions against agency-level measurement, performance and enterprise data.
4) **Security and Compliance investment** is an enterprise-wide IT Security Program which creates information security policy, manages centralized resources, and provides cybersecurity training for employees and contractors.

In addition, the HIT Program includes mature Capital Planning and Investment Control, and Enterprise Architecture Programs that support the four major strategic IT investments. These programs serve to promote compliance with federal laws and mandates and improve the efficiency and security of the HIT investments.

PROGRAM ACCOMPLISHMENTS

The Office of Information Technology (OIT) achieved numerous accomplishments during FY 2017, some examples follow:

FY 2017 Accomplishments and Progress to Date

- Continued deployment of the new health information sharing and patient engagement capabilities in support of improving how we deliver services.
- Implemented a predictable, quarterly release schedule for the IHS electronic health records system, to improve the efficiency of the development and release processes and to continuously demonstrate value for end-users.
- Realigned HIT software development contracts to improve on the efficiency and effectiveness of the development contracts, to move to a responsive, agile development process, and to leverage the benefits of performance-based contracting.
- Continued implementation of a Department of Veterans Affairs (VA)-developed Bar Code Medication Administration (BCMA) solution, which is designed to prevent medication errors in healthcare settings and improve the quality and safety of medication administration, across the Indian health system. The overall goals of BCMA are to improve accuracy, prevent errors, and generate online records of medication administration. IHS will complete deployments to all 21 of its priority hospitals.

- Continued planning for the deployment of systems changes needed in support of the proposed Meaningful Use (MU) 3 initiative.
- Continued planning for the system changes required to support the implementation of Medicare Access and CHIP Reauthorization Act.
- Completed initial deployment of the new Integrated Data Collection System (IDCS), which will improve the quality, effectiveness, and utility of GPRA reporting. Supported quality improvement initiatives for the Great Plains Area.
- Implemented a new system to facilitate the improved Uniform Data System (UDS) reporting capabilities for the Urban Indian Health Program. UDS reporting is required performance reporting for HRSA-funded health centers.
- Implemented network circuit upgrades to provide additional bandwidth at over 50 IHS hospital and clinics to improve access to the Health IT and administrative applications essential to support daily operations.
- Implemented a new Microsoft Active Directory domain to support secured centralized authentication of IHS Health IT applications.
- Implemented high-density blade server environment and upgraded Storage Area Network (SAN) to improve IHS HQ data center hosting capabilities of Health IT, infrastructure and administrative applications and in support of the OMB Data Center Optimization Initiative (DCOI).
- IHS Cybersecurity Program was selected as one of 50 organizations (and people within them) to win a CSO Magazine's CS050 award for developing and implementing security initiatives that drive business value. IHS was selected due to the quality of our cybersecurity program and security initiatives that demonstrate outstanding business value and thought leadership. IHS will be recognized at the CSO50 Security Conference + Awards on May 1-3, 2017, focusing on "Aligning Proactive Security with Modern Threats", in Scottsdale, Arizona.
- IHS Cybersecurity Program reached award winning status from the Federal Information Systems Security Educator's (FISSEA) for the second year in a row for training and awareness efforts. Additionally, IHS received an award for the best newsletter and a peer choice award for best security training.
- Performed nine system security assessments resulting in Authorizations to Operate (ATOs). To comply with HHS policy, all weaknesses from security assessments are captured and reported to HHS on a monthly basis.
- Implemented a comprehensive Plan of Action and Milestones (POA&M) process. All weaknesses from previous assessments and audits are now formally tracked and updated. Quarterly reviews are now occurring which requires staff to provide remediation updates to their reported weaknesses.

Collaboration with Tribal health programs and other federal agencies is key to the success of the HIT Program. IHS works closely with the ONC, CMS, Agency for Healthcare Research and Quality, VA, and other federal entities on IT initiatives to ensure that 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. IHS considers the RPMS suite, built on the shared technology with the Department of Veteran's Affairs' VistA system, to be a public utility and collaboration with the Open Source Electronic Health Record Alliance will facilitate making the innovations and advances that IHS has made in HIT available to the broader public.

Immediate Priorities and Challenges

The IHS HIT Program continues to face increased demand for systems improvements and enhancements, rising costs, and increased IT security requirements because of ever-growing and more complex requirements for health information technology capabilities. These requirements come from government and industry initiatives, program needs of health programs, and operational requests of I/T/U health care facilities. Virtually any new program initiative has information technology requirements for data collection or reporting which then must be added to the HIT portfolio. IHS forecasts all of the above to be major workload and cost drivers for HIT in FY 2018 and beyond.

The HIT Program also faces significant challenges implementing centralized IT solutions due to lack of access to the Broadband Internet and sufficient bandwidth to support modernization and advances in the delivery of care for I/T/U health programs located in the rural and remote settings.

FUNDING HISTORY

Fiscal Year	Amount[1]
2014	$172,149,000
2015	$182,149,000
2016	$182,149,000
2017 Annualized CR	$182,149,000
2018 President's Budget	$182,149,000

TRIBAL SHARES

H&HC (IT is funded out of H&HC) funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities. A portion of the overall H&HC 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 2018 budget submission for Health Information Technology is $182,149,000, which is the same as the FY 2017 Annualized Continuing Resolution (CR) level.

This funding will continue progress made in the past several years by keeping infrastructure costs as low as possible 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 and is reducing use of more costly assisted acquisition providers such as the General Services Administration. The success of HIT in completing the 2014 EHR certification initiative was the direct result of IHS Service Units contributing a portion of Stage 1 MU incentive payments to enable development for Stage 2. Diminution of the MU incentive funding, together with inflationary costs will constrain the ability of the HIT investments to maintain current services or to enhance systems in response to the

[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.

requirements described in the previous paragraphs. The request includes funding to support the President's information technology initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process. Performance and project milestones will be monitored through normal Enterprise Performance Life Cycle processes. The following initiatives will continue as part of the base funding in FY 2017:

- Certified 2014 EHR – FY 2016 saw expanded costs for operational support and training on new capabilities delivered with the 2014 Certified EHR. Operational and maintenance costs have risen and exceed historical levels because the breadth and complexity of new capabilities in the IHS HIT systems. RPMS in particular, has been increasing exponentially over the past several years.
- Certified 2015 EHR - Analysis and development of the expected 2015 Certification standards for EHR must be completed by 2017 in order for IHS facilities to continue to participate in the MU initiative. However, the software development required to meet the standards may not be complete until 2019. This work is expected to be no less complex and no less costly than the 2014 Certification experience.
- Meaningful Use Stage 3 - Analysis and field/provider preparation for the expected Meaningful Use Stage 3 rule in order for IHS facilities to continue to participate in the MU initiative.
- NPIRS expansion - Continued expansion of the NPIRS national data warehouse to serve as the enterprise data analytics and performance measurement hub for IHS. NPIRS includes data from non-RPMS systems, which requires additional processing for data integration.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
HIT-1 OMB IT Dashboard - All IHS Major Investments will Maintain a score of 4/5 or greater (Outcome)	FY 2016 4.0 Target: 4.0 (Target Met)	4.0[2]	4.0	Maintain
HIT-2 HHS CIO Workplan - The IHS will score 90% or greater on the annual scoring of the HHS CIO Workplan (Outcome)	FY2016: Result "Achieved Expected". Target: "Achieved More than Expected" (See Note)	Achieved More Than Expected	Achieved More Than Expected	N/A
RPMS-2 Derive all clinical measures from RPMS and integrate with EHR. (Output)	FY 2016: 66 Measures / 12 IHS Areas Target: 75 Measures / 12 IHS Areas (Target Not Met)	75 Measures / 12 IHS Areas	Retire after 2017	N/A

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

[2]>= out of 5 for all investments

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

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$178,286	$177,947	$179,751	+$1,804
FTE*	571	571	571	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 2018 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 2016, the dental program provided a total of 3,870,490 basic dental services. More complex rehabilitative care (e.g., root canals, crowns and bridges, dentures, and surgical extractions) is provided where resources allow and account for the additional 263,565 dental services provided in FY 2016.

The demand for dental treatment remains high due to the high incidence of dental caries in AI/AN children. Over 80 percent of AI/AN children ages 6-9 and 13-15 years suffer from dental caries, while less than 50 percent of the U.S. population in the same age cohort have experienced cavities.[1][2] In addition to this disparity in prevalence, there is a significant disparity in severity of dental disease. AI/AN children ages 2-5 years exhibit an average of four decayed teeth, while the same age group in the U.S. population averages one decayed tooth.[3] A continuing emphasis on community oral health promotion/disease prevention is essential in order to address the current high prevalence, reduce the severity of oral disease and improve the oral health of AI/AN people. 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] Phipps KR, Ricks TL, Blahut P. The oral health of 6-9 year old American Indian and Alaska Native children compared to the general U.S. population and Healthy People 2020 targets. Indian Health Service data brief. Rockville, MD: Indian Health Service. 2014[1]).
[2] Phipps KR, Ricks TL, Blahut P, The oral health of 13-15 year old American Indian and Alaska Native children compared to the general U.S. population and Healthy People 2020 targets. Indian Health Service data brief, Rockville, MD: Indian Health Service, 2014.
[3] Indian Health Service. The 2010 Indian Health Service Oral Health Survey of American Indian and Alaska Native Preschool Children. Rockville, M.D.: U.S. Department of Health and Human Services, Indian Health Service, 2014

1) Increase the number of dental sealants placed in 2-15 year-olds;
2) Increase the number of patients that receive at least one topical fluoride application in 1-15 year-olds; and
3) Increase access to care across all age groups.

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.[4] In the 6-9 year-old age group, 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.[5] In the 13-15 year-old age group, eight out of 10 AI/AN dental clinic patients have a history of tooth decay, compared to just 44 percent in the general U.S. population, and almost five times as many 13-15 year-old AI/AN youth have untreated decay compared to the general U.S. population.[6] 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.[7]

PROGRAM ACCOMPLISHMENTS

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.[8] 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.[9] 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. By the end of this initiative, 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

[4] Indian Health Service. The 2010 Indian Health Service Oral Health Survey of American Indian and Alaska Native Preschool Children. Rockville, MD: U.S. Department of Health and Human Services. Indian Health Service, 2014.
[5] Phipps KR, Ricks TL, Blahut P. The Oral Health of 6-9 year old American Indian and Alaska Native children compared to the general U.S. population and Healthy People 2020 targets. Indian Health Service data brief. Rockville, MD: Indian Health Service 2014.
[6] Phipps KR, Ricks TL, Blahut P. The Oral Health of 13-15 year old American Indian and Alaska Native children compared to the general U.S. population and Healthy People 2020 targets. Indian Health Service data brief. Rockville, MD: Indian Health Service 2014.
[7] 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.
[8] 1. US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, US Public Health Service. Oral Health in America: Report of the US Surgeon General. NIH publication no. 00-213. Washington, DC: DHHS, NIDCR, USPHS; 2000
[9] Indian Health Service. The 2010 Indian Health Service. The 2010 Indian Health Service Oral Health Survey of American Indian and Alaska Native Preschool Children. Rockville, MD: U.S. Department of Health and Human Services, Indian Health Service, 2013. Available at http://www.ihs.gov/doh .

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), resulting in a net decrease of dental caries prevalence from 54.9 percent in 2010 to 52.6 percent in 2014, and an even more dramatic decrease in dental caries experience from 33.4 percent to 27.1 percent in 1-2 year-olds, one of the largest decreases in caries experience evident in dental literature over such a short time span.[10] To support this initiative, the IHS conducted a nationwide surveillance of 1-5 year-old AI/AN children through two coordinated efforts of 8,451 children in 2010[3] and 11,873 in 2014 – the largest oral health surveillance sample size ever of this age group in the AI/AN population.[11] While the national initiative has since ended, the IHS DHP continues to promote evidence-based best practices in ECC primary and secondary prevention including early access to dental services, dental sealants in primary and permanent teeth, fluoride varnish applications, and secondary prevention tactics such as interim therapeutic restorations and silver ion antimicrobials aimed at reducing the spread of dental caries once it has begun.

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 and IHS Area initiatives. The DSCs were designed and implemented in FY 1999 and FY 2000 to augment the dental public health infrastructure necessary to best meet the oral health needs of AI/AN communities. A new five-year cycle began September 15, 2015 with eight DSCs, three are funded by program awards and five are funded through grants. 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 has increased significantly in recent years. For example, the number of dental sealants placed per year has tripled in the last decade, and the number of patients receiving topical fluoride treatments has more than doubled in the last five years. In FY 2013, the DHP began tracking the coverage or prevalence of children and adolescents receiving sealants and topical fluoride, rather than simply counting procedures. These assessments allow improved comparisons with data from the U.S. population compiled by the Healthy People 2020 initiative.

Congressional appropriations created initial funding for the DSCs in FYs 1999 and 2000. In the ensuing years, these DSCs had an immediate positive impact on the direct delivery of dental care in a number of ways:

- All centers advocated for an appropriate focus on the dental Government Performance and Results Act (GPRA) performance objectives to increase specific clinical services.
- All centers provided continuing education opportunities to enhance the quality of care delivered.
- Several centers provided on-site clinical and community based program reviews to enhance the quality of care, assuring that field programs maintained a high level of expertise with respect to challenges such as infection control, preparing for accreditation and certification reviews, and patient scheduling practices aimed at maximizing access to care.
- Several centers 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 of IHS oral health education efforts throughout Indian Country.

[10] Ricks TL, Phipps KR, Bruerd BB. The Indian Health Service Early Childhood Caries Collaborative: A Five-year Summary. Ped Dent 2015, 37;3: 275-80.

[11] Phipps KR and Ricks TL. The Oral Health of American Indian and Alaska Native Children aged 1-5 years; results of the 2014 IHS oral health survey. Indian Health Service data brief. Rockville, MD: Indian Health Service. 2015. Available at http://www.ihs.gov/doh .

- Several centers provided or arranged for direct clinical services that otherwise would not have been provided.
- The aggregate accomplishments of the DSCs have resulted in an increase in clinical preventive care, an increase in overall clinical services, and an enhancement of the quality of clinical and community based care delivered by the dental field programs.

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 currently aligned with Healthy People 2020 methodology as a percentage of patients who have visited the dentist within the previous 12 months. The access to care goal in FY 2016 was 29.3 percent and the performance was 28.7 percent. This performance is the second highest access rate in the IHS since dental access first began being measured in the 1990's. The dentist to population ratio in our system compared to the ratio in the U.S. private sector continues to be very low. 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.

Topical fluorides and dental sealants have been extensively researched and documented in the dental literature as safe and effective preventive interventions to reduce tooth decay. In FY 2013, the tracking of dental sealants and the tracking of patients receiving topical fluoride measures changed from simple counts of procedures or patients to the percentage of children receiving either sealants or topical fluorides. New annual targets were set for these two objectives as of July 1, 2013. In FY 2016, 31.1 percent of children ages 1-15 received topical fluoride, while 18.1 percent of 2-15 year-olds received dental sealants; both of these measures far surpassed the annual GPRA goal and represent the highest rates ever recorded for these two measures. This high number of young patients with sealants represents a notable accomplishment for the IHS DHP as significant numbers of susceptible tooth surfaces are now protected by dental sealants.

The DHP continues to assess the care provided by its programs. Through an annual continuous surveillance program, the DHP monitors disease burden and progress across all age groups, a process that began in its current form in 2010 with a combination of community-based, school-based, and clinic-based surveillance methodologies. For the first time since 1999, the DHP assessed the oral health status of AI/AN adults 35 years of age and older, with 11,462 adults surveyed in 84 IHS and tribal dental clinics, our largest sampling ever of this age group. Through this assessment, the DHP was able to conclude that AI/AN adult dental patients have almost twice the prevalence of severe periodontal disease (17 percent vs. 10 percent) and more than double the prevalence of untreated tooth decay (64 percent vs. 27 percent) than the general U.S. population.

A second way the DHP assessed care was through a collaboration between the DHP and the IHS Division of Planning, Evaluation, and Research, in which a data analysis was conducted in FY 2016 of eight selected programs to measure the true impact of the IHS Early Childhood Caries (ECC) Collaborative. Using a matrix to evaluate participation level and adherence to the ECC Collaborative core components, the DHP was able to establish that one site that fully implemented all aspects of the ECC Collaborative had a 17 percent improvement in decay experience and a 27 percent improvement in untreated decay rates, leading to the conclusion that the impact and improvement of the ECC Collaborative was mostly seen at the local program level in those sites that fully embraced the initiative.

A third way the DHP has assessed dental services was an evaluation of dental amalgam use in the IHS. In response to external inquiries, the IHS DHP conducted an analysis of the use of dental amalgam and dental composite, two of the most common restorative materials in use. The results of the analysis showed that beginning in 2012, composites outnumbered amalgams in terms of

use in the IHS system, with 61.2 percent of all restorations being composite by 2015. This analysis helps show that there is an increase in the trend of using composite restorative materials in the IHS (https://www.ihs.gov/DOH/index.cfm?fuseaction=home.amalgam).

The DHP has also made significant improvements in the way dental services are delivered. Through the implementation of an electronic dental record, over 90 percent of IHS and Tribal dental programs have been transformed to and electronic system that will improve the quality and delivery of dental services. A second improvement was the release of 20 new dental clinic efficiency and effectiveness standards by which IHS and Tribal dental programs can measure clinical productivity, staffing ratios, and specific clinical efficiency indicators against national averages. A third way the DHP has improved the delivery of care is through the development of new national protocols for the early screening and treatment of periodontal disease in adults. A fourth way the DHP has improved the delivery of care is through ongoing support of long-term training (LTT) of general dentist to build the cadre of dental specialists in the IHS and Tribal dental programs. 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 2 years, an Oral Maxillofacial Surgeon, an endodontist, and periodontist have returned from LTT to serve AI/AN patients. A fifth 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. A final way 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 American Dental Association Commission for Continuing Education Provider Recognition approved quality education with over 200 clinical and public health courses to IHS and Tribal dentists, dental hygienists, dental assistants, and dental public health leadership.

FUNDING HISTORY

Fiscal Year	Amount
2014	$165,290,000
2015	$173,982,000
2016	$178,286,000
2017 Annualized CR	$177,947,000
2018 President's Budget	$179,751,000

TRIBAL SHARES

Dental funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities. A portion of the overall Dental 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 2018 budget submission for Dental Health of $179,751,000 is $1,804,000 above the FY 2017 Annualized Continuing Resolution (CR) level.

FY 2017 Base Funding of $177,947,000 –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 2018 Funding Increase of $1,804,000 includes:

- Staffing for New Facilities FY (2018) +$1,465,000 - 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 critical health care needs. The following table displays this request.

New Facilities – FY 2018	Amount	FTE/Tribal Positions
Choctaw Nation Regional Medical Center (JV), Durant, OK	$1,135,000	10
Flandreau Health Center (JV), Flandreau, SD	$330,000	3
Grand Total:	**$1,465,000**	**13**

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
12 Topical Fluorides: Percentage of patients, ages 1 to 15, who received one or more topical fluoride application during the report period (Outcome)	FY 2016: 31.1 % Target: 28.3 % (Target Exceeded)	29.9 %	Retire after 2017	N/A
13 Dental Access: Percent of patients who receive dental services. (Outcome)	FY 2016: 28.7 % Target: 29.3 % (Target Not Met)	29.7 %	Retire after 2017	N/A
14 Dental Sealants: Percentage of patients, ages 2 to 15, with at least one or more intact dental sealant (Outcome)	FY 2016: 18.1 % Target: 14.8 % (Target Exceeded)	16.6 %	Retire after 2017	N/A
61 Topical Fluorides (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 30.0 % (Pending)	N/A	30.0 %	N/A
62 Access to Dental Services (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 27.2 % (Pending)	N/A	27.2 %	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
63 Dental Sealants (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 16.0 % (Pending)	N/A	16.0 %	N/A

GRANTS AWARDS

The purpose of the 5 grant awards is to support the Dental Preventive and Clinical Support Centers program (aka Dental Support Centers or DSCs). The 5 DSCs combine IHS and Tribal resources and infrastructure in order to address broad challenges and opportunities associated with preventive and clinical dental programs. Centers also rigorously measure and evaluate their work with the goal of demonstrably improving dental health outcomes through the technical assistance and services they provide. 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 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Number of Awards	5	5	5
Average Award	$250,000	$250,000	$250,000
Range of Awards	$250,000	$250,000	$250,000

AREA ALLOCATION

Dental Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2016 Final			FY 2017 Estimated			FY 2018 Estimated			FY '18 +/- FY '17
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$30,096	$30,096	$0	$29,827	$29,827	$0	$29,884	$29,884	$57
Albuquerque	4,933	3,199	8,132	4,969	3,170	8,139	4,978	3,176	8,155	16
Bemidji	1,994	2,170	4,164	2,009	2,150	4,159	2,012	2,155	4,167	8
Billings	6,081	1,202	7,282	6,125	1,191	7,316	6,136	1,193	7,329	14
California	360	1,644	2,003	362	1,629	1,991	363	1,632	1,995	4
Great Plains	10,466	6,236	16,701	10,541	6,180	16,721	10,561	6,522	17,083	362
Nashville	655	5,474	6,129	660	5,425	6,085	661	5,435	6,096	12
Navajo	21,149	11,227	32,375	21,301	11,126	32,428	21,342	11,147	32,489	62
Oklahoma	9,122	28,463	37,585	9,187	28,208	37,396	9,205	29,397	38,602	1,206
Phoenix	8,493	7,723	16,216	8,555	7,654	16,209	8,571	7,669	16,239	31
Portland	4,331	3,113	7,444	4,362	3,085	7,447	4,371	3,091	7,461	14
Tucson	1,810	5	1,815	0	1,815	1,815		1,819	1,819	3
Headquarters	8,342	0	8,342	8,415	0	8,415	8,431	0	8,431	16
Total, Dental	**$77,735**	**$100,551**	**$178,286**	**$76,486**	**$101,461**	**$177,947**	**$76,632**	**$103,119**	**$179,751**	**+$1,804**

Note: FY 2016 are actual amounts. FY 2017 and FY 2018 are estimates.

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

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$82,100	$81,944	$82,654	+$710
FTE*	196	196	196	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 2018 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) 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 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.

PROGRAM ACCOMPLISHMENTS

Specific focus areas that meet the Agency's priority relating to People, Partnerships and Quality for the IHS MH/SS program are:

Suicide Prevention: In 2015, the suicide rate for AI/AN adolescents and young adult ages 15 to 34 (19.5 per 100,000) was 1.5 times than the national average for that age group (12.9 per 100,000). [1] Suicide is the eighth leading cause of death among all AI/AN across all ages. [1] Strategies to address behavioral health, alcohol, substance use disorder, and suicide prevention require comprehensive clinical strategies, and approaches. The IHS utilizes and promotes collaborations and partnerships with patients and their families, including Tribes and Tribal organizations, Urban Indian health programs, federal, state, and local agencies, as well as public and private organizations. The 2017 – 2022 National AI/AN Suicide Prevention Strategic Plan

advances the 2012 National Suicide Strategic Plan with culturally relevant approaches and strategies specific for AI/AN communities.[1]

The IHS utilizes a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion. The suicide surveillance tool captures data related to a specific incident of suicide, including date and location of act, method, contributing factors, and other useful epidemiological information to better understand the issue, identified risk factors and target resources appropriately.

In FY 2015, IHS launched the Zero Suicide Initiative in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), an approach developed by the Education Developmental Center's (EDC) Suicide Prevention Resource Center. Zero Suicide is a priority to transform health systems to significantly reduce suicides for those individuals under our care. The initiative includes educating healthcare providers on screening for suicide, conducting suicide risk assessments, and ensuring the infrastructure exists to support evidence-based suicide care. During FY 2016, ten pilot sites attended the AI/AN Zero Suicide Training Academy and worked over the year to implement the model in their health care facilities. IHS awarded the EDC a contract in September 2016 that will bring tailored technical assistance to IHS and tribal health care facilities who are working to implement Zero Suicide and a second AI/AN Zero Suicide Training Academy in 2017.

Trauma-Informed Care: 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. 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.

In September 2016, the MH/SS and Improving Patient Care and the Johns Hopkins University partnered to develop a tribal specific Pediatric Integrated Care Collaborative (PICC), a pilot project to increase the quality and accessibility of child trauma services by integrating behavior and physical health services in patient centered medical homes. The PICC pilot sites will attend in person and virtual quality improvement learning collaborative sessions to receive tailored technical assistance to integrate pediatric trauma informed care into primary care. The goal of the pilot site project is to harvest lessons learned to apply for screening of trauma in the pediatric population, engaging families, and developing policy recommendations for the Indian health system.

In 2016, IHS contracted with the University of New Mexico (UNM) to develop an online training curriculum related to trauma and trauma-informed care tailored for IHS staff, clinical staff, and supervisors. UNM will also adapt the Creating Cultures of Trauma Informed Care (CCTIC) model to be culturally appropriate and used in AI/AN communities. UNM will pilot the online training in 2017 and provide recommendations, including cost estimates, of providing the training system wide for the Indian health system, along with recommendations for online technical assistance.

[1] Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2013, 2011) National Center for Injury Prevention and Control, CDC (producer). Available from http://www.cdc.gov/injury/wisqars/index.html

Additionally, IHS is examining policies and practices to ensure its processes reflect trauma informed care and are supported with activities such as screening, early intervention, assessments, home visiting, and treatment. The UNM training and Johns Hopkins PICC will be used by IHS to incorporate into a standalone trauma informed care policy in the Indian Health Manual.

Behavioral Health Integration with Primary Care: IHS supports changing the paradigm of mental health and substance abuse disorder services from being episodic, fragmented, specialty, and/or disease focused to incorporating it into the patient-centered medical home. 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 launched an Improving Patient Care learning intensive focused on behavioral health integration with primary care. The intensive focused on the key areas of the Behavioral Health Integration Initiative (BH2I): formalizing integration across the system, developing care teams, strengthening infrastructure, and enhancing clinical processes. The goal was increased depression screening in primary care clinics through utilization of the Public Health Questionnaire (PHQ) (PHQ-2 and PHQ-9). Despite setting the goal of improving screening rates, the learning intensive did not result in significant improvements. The seven participating teams reported progress in advancing their organizational strategy for behavioral health integration. IHS will plan to include additional measures that reflect organizational change for behavioral health integration outside of focusing solely on screening rates.

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, our patients face many issues surrounding access to care, particularly specialty care. Providers working in these remote areas often face barriers in maintaining the required continuing education (CE) credits required for licensure and up to date on current clinical guidelines. The TBHCE assists IHS, Tribal, and Urban Indian healthcare providers and facilities in overcoming these challenges by providing a range of telebehavioral health services and training. There are 25 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 2016, the TBHCE provided more than 3100 hours of behavioral health services to over 5800 patients. Additionally, the TBHCE hosts a robust weekly schedule designed to meet the specific training needs of IHS, Tribal, and Urban Indian health care providers. In FY 2016, the TBHCE awarded more than 4800 hours of CE credits and over 15,900 hours of training during 176 online seminars.

FUNDING HISTORY

Fiscal Year	Amount
2014	$77,980,000
2015	$81,145,000
2016	$82,100,000
2017 Annualized CR	$81,944,000
2018 President's Budget	$82,654,000

TRIBAL SHARES

Mental Health funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities. A portion of the overall Mental Health 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 2018 budget submission for Mental Health of $82,654,000 is $710,000 above the FY 2017 Annualized Continuing Resolution (CR) level.

FY 2017 Base Funding of $81,944,000 – 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 2018 Funding Increase of $554,000 includes:

- Staffing for New Facilities FY (2018) +$554,000 - 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 critical health care needs. The following table displays this request.

New Facilities – FY 2018	Amount	FTE/Tribal Positions
Choctaw Nation Regional Medical Center (JV), Durant, OK	$460,000	4
Flandreau Health Center (JV), Flandreau, SD	$94,000	2
Grand Total:	**$554,000**	**6**

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
18 Proportion of American Indian and Alaska Native adults 18 & over who are screened for depression (Outcome)	FY 2016: 67.9 % Target: 67.2 % (Target Exceeded)	70 %	Retire after 2017	N/A
18 Tribally Operated Health Programs (Outcome)	FY 2016: 65 % Target: 62.2 % (Target Exceeded)	65 %	Retire after 2017	N/A
29 Suicide Surveillance: Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals (Outcome)	FY 2016: 2,109 completed reporting forms Target: 1,798 completed reporting	2,536 completed reporting forms	2,561 completed reporting forms	+25 completed reporting forms

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
	forms (Target Exceeded)			
65 Proportion of American Indian and Alaska Native adults 18 and over who are screened for depression (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 42.2 % (Pending)	N/A	42.2 %	N/A
77 Anti-Depressant Medication Management: Acute Treatment (Intermediate Outcome)	FY 2017: Result Expected Jan 31, 2018 Target: Set Baseline (Pending)	Baseline	Retire after 2017	N/A
77 TOHP Anti-Depressant Medication Management: Acute Treatment (Intermediate Outcome)	FY 2017: Result Expected Jan 31, 2018 Target: Set Baseline (Pending)	Baseline	Retire after 2017	N/A
78 Anti-Depressant Medication Management: Continuous Treatment (Intermediate Outcome)	FY 2017: Result Expected Jan 31, 2018 Target: Set Baseline (Pending)	Baseline	Retire after 2017	N/A
78 TOHP Anti-Depressant Medication Management: Continuous Treatment (Intermediate Outcome)	FY 2017: Result Expected Jan 31, 2018 Target: Set Baseline (Pending)	Baseline	Retire after 2017	N/A
79 Depression Screening of American Indians and Alaska Natives ages 12-17. (Output)	FY 2017: Result Expected Jan 31, 2018 Target: Set Baseline (Pending)	Baseline	Retire after 2017	N/A
79 TOHP Depression Screening of American Indian and Alaska Native patients ages 12-17. (Output)	FY 2017: Result Expected Jan 31, 2018 Target: Set Baseline (Pending)	Baseline	Retire after 2017	N/A
83 Antidepressant Medication Management: Acute Treatment (Outcome)	FY 2018: Result Expected Jan 31, 2019 (Target Not In Place)	N/A	TBD	N/A
84 Antidepressant Medication Management: Continuous Treatment (Outcome)	FY 2018: Result Expected Jan 31, 2019 (Target Not In Place)	N/A	TBD	N/A
85 Depression Screening ages 12-17 (Outcome)	FY 2018: Result Expected Jan 31, 2019 (Target Not In Place)	N/A	TBD	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
MH-1 Increase Tele-behavioral health encounters nationally (Output)	FY 2016: 10,388 Target: 8,901 (Target Exceeded)	10,359	11,600	+1,241

GRANTS AWARDS

The proposed FY 2018 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. Grants will be publicly competed. The actual number of grants to be awarded is to be determined.

AREA ALLOCATION

Mental Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2016 Final			FY 2017 Estimated			FY 2018 Estimated			FY'18 +/- FY'17
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$11,259	$11,259	$0	$11,154	$11,154	$0	$11,175	$11,175	$21
Albuquerque	1,813	2,419	4,231	1,832	2,396	4,229	1,836	2,401	4,237	8
Bemidji	308	1,908	2,216	311	1,891	2,202	311	1,894	2,206	4
Billings	2,637	1,123	3,760	2,666	1,113	3,779	2,671	1,115	3,786	7
California	97	2,017	2,114	98	1,998	2,096	98	2,002	2,100	4
Great Plains	7,199	2,190	9,389	7,278	2,170	9,447	7,291	2,268	9,559	112
Nashville	304	2,207	2,510	307	2,186	2,493	308	2,191	2,498	5
Navajo	7,643	7,512	15,156	7,727	7,442	15,170	7,742	7,457	15,199	29
Oklahoma	2,994	11,655	14,649	3,027	11,547	14,574	3,033	12,029	15,062	488
Phoenix	3,266	5,418	8,685	3,302	5,368	8,670	3,308	5,378	8,687	17
Portland	465	3,537	4,002	470	3,504	3,974	471	3,510	3,982	8
Tucson	554	865	1,418	0	1,418	1,418		1,421	1,421	3
Headquarters	2,711	0	2,711	2,739	0	2,739	2,744	0	2,744	5
Total, Mental	**$29,990**	**$52,110**	**$82,100**	**$29,757**	**$52,187**	**$81,944**	**$29,814**	**$52,840**	**$82,654**	**+$710**

Note: FY 2016 are actual amounts. FY 2017 and FY 2018 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 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$205,305	$204,915	$205,593	+$678
FTE*	173	206	206	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 2018 Authorization.....Permanent

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

PROGRAM DESCRIPTION

Alcoholism, addiction, and alcohol and substance abuse 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 behavioral 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 the Agency's priorities of People, Partnerships, and Quality through these collaborative activities, and works to integrate substance abuse treatment into primary care. For instance, the Substance Abuse and Suicide Prevention Program (SASP) (formerly known as the Methamphetamine and Suicide Prevention Initiative - MSPI) provides community developed and delivered prevention and intervention resources to address the dual crises of methamphetamine and suicide in AI/AN communities.

In general, AI/AN populations suffer disproportionately from substance abuse disorders compared with other racial groups in the United States. The age-adjusted AI/AN drug-related death rate is 4.1 deaths per 100,000 population for the three-year period 1979-1981, as compared to the AI/AN death rate of 22.7 in 2007-2009. This is an increase of 454 percent since drug-related death rates were first introduced for AI/AN populations in 1979. The 2007-2009 AI/AN rate is 1.8 times greater than the U.S. all races rate of 12.6 for 2008.[1]

PROGRAM ACCOMPLISHMENTS

As alcohol and substance abuse treatment and prevention have transitioned from IHS direct care services to local community control via Tribal contracting and compacting, IHS' role has transitioned to providing support to enable communities to plan, develop, and implement

[1] U.S. Department of Health and Human Services, Indian Health Service. Trends in Indian Health 2014 Edition. Released March 2015. ISSN 1095-286

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 emergency services. Integrating treatment into health care offers immediate and same-day opportunities for health care providers to identify patients with substance use disorders, provide them with medical advice, help them understand the health risks and consequences, obtain substance abuse consultations, and refer patients with more severe substance use-related problems to treatment.[2] One integration activity is Screening, Brief Intervention, 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 is broadly promoting SBIRT as an integral part of a sustainable, primary care-based, behavioral health program through reimbursement from the Centers for Medicare and Medicaid Services (CMS). IHS has incorporated screening and SBIRT as national measures to be tracked and reported. IHS provided national training on SBIRT in FY 2016 and will continue through FY 2017. Guidelines for clinical documentation in the electronic health record have also been instituted.

Medication Assisted Treatment (MAT): MAT is an approach that uses Food and Drug Administration approved pharmacological treatments, often in combination with psychosocial treatments, for patients with opioid use disorders.[3] In FY 2016, IHS, in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), provided waiver training for physicians to prescribe MAT. IHS provided waiver training in the Bemidji area and plans to host additional onsite waiver trainings in FY 2017.

Proper Opioid Prescriber Training: IHS provides a mandatory five-hour training course for its providers on proper opioid prescribing. As of January 2017, IHS trained 96 percent of its workforce on proper opioid prescribing with the goal to have all prescribers trained by April 2017. IHS will continue to offer the training on a regular basis to capture new employees who require training, as well as offer refresher courses every three years.

Pain and Opioid Use Disorder Case Consultation Services: To provide clinical support for providers, IHS launched weekly Pain and Addiction consultations, in partnership with the University of New Mexico. Healthcare providers may receive a no-cost consultation from an expert panel on the most challenging pain and addiction cases.

Youth Regional Treatment Centers (YRTCs): YRTCs provide residential substance abuse and mental health treatment services to AI/AN youth. Congress authorized the establishment of these YRTCs in each of the 12 IHS Areas, with two (northern and southern) specifically authorized for the California Area. The Southern California facility was completed in FY 2016 and expected to begin accepting patients by the end of 2017. Recruitment of licensed clinical staff have impacted the timeline. IHS is actively seeking clinical staff in an effort to begin accepting patients at the facility. In Bemidji and Billings, youth treatment services are contracted out. The Alaska and Portland Areas divided their funds to provide residential treatment services for two programs. The second treatment facility for the Portland Area is under renovation and is scheduled to be complete in FY 2017.

[2] U.S. Office of National Drug Control Policy. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.
[3] U.S. Office of National Drug Control Policy. Medication Assisted Treatment for Opioid Addiction. *Available at* http://www.whitehouse.gov/sites/default/files/ondcp/recovery/medication_assisted_treatment_9-21-20121.pdf.

Indian Children's Program (formerly, Fetal Alcohol Spectrum Disorders (FASD)): Screening with intervention has been shown to be effective in reducing alcohol misuse during pregnancy and to reduce the incidence of FASD. The IHS increased the alcohol screening rate since 2004 until this fiscal year. Training and technical assistance on FASD is provided through the IHS TeleBehavioral Health Center of Excellence (TBHCE). In FY2016, the TBHCE began revamping the Indian Children's Program (ICP) into a nation-wide resource center. The focus of the ICP is training clinicians on developmental and neurobiological issues that can affect AI/AN children, and providing expert consultation to help clinicians successfully diagnose, manage, and/or treat these conditions. In FY2016, the TBHCE ICP provided 152 hours training on Autism Spectrum Disorders. Regarding FASD, several trainings were provided and for a total of 369 hours of training via six webinars. A formal, FASD training series will start in FY 2017 in addition to the expert consultation clinic. Recordings of these trainings are available here: https://www.ihs.gov/telebehavioral/seminararchive/. Additionally, more information regarding the TBHCE ICP can be found here: https://www.ihs.gov/telebehavioral/icp/.

Substance Abuse and Suicide Prevention Program (SASP): The SASP, formerly known as the Methamphetamine and Suicide Prevention Initiative, is a nationally-coordinated program providing funds for culturally appropriate substance use and suicide prevention programming in AI/AN communities. The program operates on a five-year funding cycle from September 30, 2015 to September 29, 2020.

The goals of SASP are to: 1) increase IHS, Tribal, and Urban (I/T/U) capacity to operate successful methamphetamine 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 methamphetamine 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 methamphetamine 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 for 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) Support.

In FY 2016, IHS received an additional $10 million to fund more projects under Purpose Area 4) Gen-I Support and awarded a total of 56 projects. In total, there are 91 Gen-I projects, including the FY 2015 awarded projects, working to increase resiliency, promote positive youth development and family engagement, and increase the number of behavioral health professionals focused on children and adolescents.

In year 1, 100 percent of projects submitted progress reports as a requirement of funding. Target population of awarded projects ranges from age 5 to 55+, indicating projects are targeting a wide range of children, youth, adults, and elders in all purpose areas. The largest target populations

being focused on are youth, ages 12-24, which is expected given that largest purpose area is focused on youth.

Projects in purpose areas 2, 3, and 4 are asked to report the culturally appropriate evidence-based and practice-based approaches being implemented specific to their purpose area. The most frequently reported approaches in year 1 are Question, Persuade, Refer, Mental Health First Aide, Cognitive Behavioral Therapy, and Motivational Interviewing.

In Year 1, projects funded in Purpose Area 1 conducted activities specifically related to planning and resource identification, seeking partnerships with local, regional or national organizations, hiring and training of staff, and identifying models to be used for the community and organizational needs assessment and strategic planning. For example, one project has chosen to utilize the Mobilizing for Action through Planning and Partnerships (MAPP), a community-driven strategic planning process for improving community health, which was developed by the National Association of Country and City Health Officials (NACCHO) (NACCHO, http://www.naccho.org/programs/public-health-infrastructure/mapp).

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 (BH) providers and support BH-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 substance disorders such as SAMHSA, Veterans Health Administration, Health Resources and Services Administration, Office of National Drug Control Policy, and 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 Department of the Interior (DOI) through the Bureau of Indian Affairs (BIA), 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), Department of Justice (Office of Justice Programs/Office of Tribal Justice), and the Office of the Attorney General. The leverage and 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 and 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 FY 2016, the IHS and BIA entered into a formal partnership to reduce deaths from prescription drug and heroin overdoses by providing naloxone, a medication that reverses the effects of heroin or prescription opioid overdose and saves lives. As of December 2016, IHS trained 284 BIA law enforcement officers and provided approximately $20,000 worth of emergency naloxone kits to officers. The BIA reported one overdose reversal in the first year of the partnership. IHS and BIA will continue this partnership in FY 2017.

FUNDING HISTORY

Fiscal Year	Amount	SASP	Gen I
2014	$186,378,000	($15,512,557)	N/A
2015	$190,981,000	($15,475,000)	N/A
2016	$205,305,000	($15,475,000)	($10,000,000)
2017 Annualized CR	$204,915,000	($15,475,000)	($10,000,000)
2018 President's Budget	$205,593,000	($15,475,000)	($10,000,000)

TRIBAL SHARES

Alcohol and Substance Abuse funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities. A portion of the overall Alcohol and Substance Abuse 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 2018 budget submission for Alcohol & Substance Abuse of $205,593,000 is $678,000 above the FY 2017 Annualized Continuing Resolution (CR) level.

FY 2017 Base Funding of $204,915,000 – 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 2018 Funding Increase of $678,000 includes:

- Staffing for New Facilities FY (2018) +$288,000 - 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 critical health care needs. The following table displays this request.

New Facilities FY 2018	**Amount**	**Tribal Positions**
Choctaw Nation Regional Medical Center (JV), Durant, OK	$186,000	2
Flandreau Health Center (JV), Flandreau, SD	$102,000	2
Grand Total:	**$288,000**	**4**

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
10 YRTC Improvement/Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more). (Outcome)	FY 2016: 100 % Target: 100 % (Target Met)	100 %	100 %	Maintain
11 Alcohol Screening (FAS Prevention): Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients. (Outcome)	FY 2016: 67.2 % Target: 67.2 % (Baseline)	Retire after 2016	Retire after 2016	N/A
11 Tribally Operated Health Programs (Outcome)	FY 2016: 66 % Target: 66 % (Baseline)	Retire after 2016	Retire after 2016	N/A
60 Universal Alcohol Screening (Outcome)	FY 2017: Result Expected Jan 31, 2018 Target: Set Baseline (Pending)	Baseline	Retire after 2017	N/A
60 TOHP Tribally Operated Health Programs (Outcome)	FY 2017: Result Expected Jan 31, 2018 Target: Set Baseline (Pending)	Baseline	Retire after 2017	N/A
76 Screening, Brief, Intervention, and Referral Treatment (SBIRT) (Outcome)	FY 2017: Result Expected Jan 31, 2018 Target: Set Baseline (Pending)	Baseline	Retire after 2017	N/A
76 TOHP Screening, Brief, Intervention and Referral to Treatment (SBIRT) (Outcome)	FY 2017: Result Expected Jan 31, 2018 Target: Set Baseline (Pending)	Baseline	Retire after 2017	N/A
80 Universal Alcohol Screening (Outcome)	FY 2018: Result Expected Jan 31, 2019 (Target Not In Place)	N/A	TBD	N/A
82 Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Outcome)	FY 2018: Result Expected Jan 31, 2019 (Target Not In Place)	N/A	TBD	N/A

GRANTS AWARDS

(whole dollars)	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Number of Awards	143	143	143
Average Award	$150,000	$150,000	$150,000
Range of Awards	n/a	n/a	n/a

AREA ALLOCATION

Alcohol and Substance Abuse

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2016 Final			FY 2017 Estimated			FY 2018 Estimated			FY'18 +/- FY'17
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$331	$31,251	$31,582	$330	$31,189	$31,519	$331	$31,248	$31,579	$60
Albuquerque	2,724	9,262	11,986	2,719	9,244	11,963	2,724	9,261	11,986	23
Bemidji	1,704	8,178	9,882	1,701	8,162	9,863	1,704	8,177	9,881	19
Billings	246	10,662	10,909	246	10,641	10,887	246	10,661	10,908	21
California	1,147	12,601	13,748	1,145	12,575	13,721	1,147	12,599	13,747	26
Great Plains	3,452	10,315	13,768	3,447	10,295	13,741	3,453	10,416	13,869	128
Nashville	2,823	6,128	8,951	2,818	6,116	8,934	2,823	6,127	8,951	17
Navajo	3,469	15,794	19,263	3,464	15,762	19,226	3,470	15,792	19,262	37
Oklahoma	4,017	11,839	15,856	4,010	11,815	15,825	4,018	12,024	16,041	216
Phoenix	6,697	10,395	17,092	6,686	10,375	17,060	6,698	10,394	17,093	32
Portland	953	14,998	15,951	952	14,968	15,919	953	14,996	15,950	30
Tucson	764	2,304	3,069	25	3,044	3,069	25	3,050	3,074	6
Headquarters	33,250	0	33,250	33,189	0	33,189	33,252	0	33,252	63
Total, ASA	**$61,577**	**$143,728**	**$205,305**	**$60,730**	**$144,184**	**$204,915**	**$60,846**	**$144,747**	**$205,593**	**+$678**

Note: FY 2016 are actual amounts. FY 2017 and FY 2018 are estimates.

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

PURCHASED / REFERRED CARE

(Dollars in thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$914,139	$912,401	$914,139	+$1,738
FTE*	0	0	0	0

* PRC Funds are not used for Federal or 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 2018 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 providing comprehensive health care services to eligible American Indians and Alaska Natives (AI/AN). 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. The general purpose of the PRC Program is for I/T/U 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 supplemental funds are necessary to provide comprehensive care to eligible Indian people.

[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.

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 service delivery Area; authorization of payment for the 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, 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 service delivery area of the local facility, IHS PRC regulations require I/T/U 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 Medicare-like rate is used to purchase all hospital-based health care services and allows IHS to purchase care at a lower cost than if each service were negotiated individually. Physician and non-hospital provider based services are paid at the PRC rate unless providers refuse this rate and then contracts are negotiated with individual providers of care. 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 PRC Program also administers the Catastrophic Health Emergency Fund (CHEF). Created in 1988, 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 accidents, high risk obstetrics, cardiology, etc.) after a threshold payment amount of $25,000 is met. The CHEF is centrally managed at IHS Headquarters and is available to IHS and Tribally-managed PRC programs annually on a first come basis.

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. All IHS-managed PRC programs and some Tribally-managed PRC programs use the FI to ensure the use of Medicare-like rates for inpatient services and PRC and negotiated rates for physician and non-hospital providers.

[5] 25 U.S.C. § 1621e, 1623; 42 CFR 136.61 (2010)
[6] 25 U.S.C. § 1621a

PRC funding provides critical access to essential health care services and remains a top priority for Tribes in the budget formulation recommendations.

PROGRAM ACCOMPLISHMENTS

Purchased/Referred Care (PRC) Rates – On March 21, 2016, the IHS published in the Federal Register the Final Rule with comment period for Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated with Non-Hospital Based Care. The Final Rule became effective on May 20, 2016, with an implementation date of March 21, 2017. The regulation is consistent with the recommendations from the Government Accountability Office (GAO)[7] and the HHS Office of Inspector General[8] and could potentially achieve substantial PRC savings that may be used to expand IHS beneficiary access to care. The rates were originally referred to as Medicare-like rates (MLR) for hospital based services but are now being called PRC rates for physician and non-hospital services to differentiate from the 2007 MLR for hospital based services. The Final Rule established payment rates that are consistent across federal health care programs; aligns IHS provider payments with inpatient services rates; and enables the I/T/U health programs to expand beneficiary access to medical care. Changes to the rule include: an applicability provision to specify that the rule applies to I/T/Us but only to the extent the tribally-operated programs agree to "opt-in" in their ISDEAA contract or compact; a definition section to include Notification of a Claim, Provider, Supplier, Referral and Repricing Agent; flexibility that allows PRC programs to negotiate rates that are higher than Medicare-rates but equal to or less than the rates accepted by the provider or supplier's most favored customer; and, in the absence of a negotiated amount, the amount the provider or supplier accepts from its most favored customer will be accepted.

Purchased/Referred Care – Recent program funding increases have allowed some 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 2016, 70 percent of IHS-operated PRC programs were able to purchase services beyond Medical Priority I – Emergent or Acutely Urgent Care Services. Prior funding increases as well as alternate resources, increased third-party collections and Medicaid expansion ensure programs can purchase preventive care beyond emergency care services, such as mammograms or colonoscopies.

The IHS PRC Workgroup helped IHS develop a more accurate form for reporting denied and deferred PRC services each year. In FY 2016, PRC denied an estimated $371,521,000 for an estimated 80,000 services needed by eligible AI/ANs. Due to the fact that Tribally-managed programs are not required to report on denials, it is difficult to provide a verifiable and complete measure of the total unmet need for the entire 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 2016, 1,362 high cost cases were reimbursed from the CHEF funds on a rolling basis at a total cost of $51,500,000. It is estimated that more cases may qualify for CHEF reimbursement but were not reported by the local IHS and Tribally-managed PRC programs. When CHEF funds are depleted, requests for reimbursements from IHS Headquarters are denied. Prior funding increases as well as alternate resources and

[7] Government Accountability Office, *Indian Health Service: Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services* (April 2013)

[8] Department of Health and Human Services, Office of Inspector General, *IHS Contract Health Services Program: Overpayments and Potential Savings* (Sept. 2009).

increased third-party collections helped ensure the CHEF funds were depleted later than in previous years; in FY 2016 funding was able to cover the CHEF cases submitted for reimbursement through the end of fiscal year.

FUNDING HISTORY

Funding History	PRC	CHEF	Total
FY 2014	$827,075,000	$51,500,000	$878,575,000
FY 2015	$863,139,000	$51,500,000	$914,139,000
FY 2016	$863,139,000	$51,500,000	$914,139,000
FY 2017 Annualized CR	$860,901,000	$51,500,000	$912,401,000
FY 2018 President's Budget	$863,139,000	$51,500,000	$914,139,000

TRIBAL SHARES

Purchased and Referred Care funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities.

BUDGET REQUEST

The FY 2018 budget submission for Purchased/Referred Care of $914,139,000 is $1,738,000 above the FY 2017 Annualized Continuing Resolution level.

The FY 2018 budget submission will provide for the following approximate services:

- 30,100 inpatient admissions
- 693,900 outpatient visits
- 38,700 patient travel trips

The FY 2018 increase of $1,738,000 would provide the following additional estimated services:

- 60 Inpatient admissions
- 1,400 Outpatient visits
- 80 Patient travel trips

Performance Impact

Since 2011, the GAO has published four reports on the PRC program.[9] The IHS PRC Workgroup has reviewed the recommendations and the Agency is implementing a majority of the GAO recommendations, including the MLR regulatory proposal described above and many programmatic and policy improvements. In addition, the program has identified several risk categories and is working to ensure proper policies and procedures are in place to maintain programmatic consistency across all Areas. These ongoing activities continue to be monitored by PRC staff at the IHS Area office and Headquarters level.

[9] GAO-11-767, "IHS Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need;" GAO-12-466, "Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Services Program;" GAO-13-272, "Capping Payment Rates for Nonhospital Services Could Save Millions For Contract Health Services;" GAO-14-57, "Opportunities May Exist To Improve The Contract Health Services Program."

In its 2013 report, the GAO recommended the PRC program modify the IHS GPRA measure on the timeframe for payment of referrals to track results for IHS authorized referrals and patient self-referrals separately. In the FY 2018 Budget, IHS is adopting the GAO recommendation in recognition of the differences in payment processes for these two types of referrals. The two new measures track IHS authorized referrals[10] and establish a timeframe for payment and track patient self-referrals[11] and establish a separate target timeframe for authorization and payment of referrals. FY 2017 results from the two new measures will be reported to better assess the timeliness of provider payments, ensure continued access to care and program quality in monitoring timely payment to external providers and reinforce partnerships.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
PRC-2 Track IHS PRC referrals (Outcome)	FY 2017: Result Expected Dec 31, 2017 Target: Set Baseline (Pending)	Baseline	TBD	N/A
PRC-3 Track PRC self-referrals (Outcome)	FY 2017: Result Expected Dec 31, 2017 Target: Set Baseline (Pending)	Baseline	TBD	N/A

GRANT AWARDS. This program does not fund grant awards.

AREA ALLOCATION

Purchased/Referred Care
(dollars in thousands)

DISCRETIONARY SERVICES	FY 2016 Final			FY 2017 Estimated			FY 2018 Estimated			FY'18 +/- FY'17
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$88,824	$88,824	$0	$89,308	$89,308	$0	$89,479	$89,479	$170
Albuquerque	28,802	15,503	44,306	28,503	15,588	44,091	28,557	15,618	44,175	84
Bemidji	13,570	48,834	62,404	13,429	49,101	62,529	13,454	49,194	62,649	119
Billings	58,779	5,106	63,885	58,168	5,134	63,302	58,279	5,144	63,422	121
California	0	49,807	49,807	0	50,078	50,078	0	50,174	50,174	95
Great Plains	73,021	17,253	90,273	72,261	17,347	89,608	72,399	17,380	89,779	171
Nashville	5,879	31,291	37,170	5,818	31,462	37,279	5,829	31,522	37,350	71
Navajo	58,979	41,081	100,060	58,366	41,305	99,671	58,477	41,383	99,861	190
Oklahoma	46,338	67,656	113,994	45,856	68,025	113,881	45,943	68,155	114,098	217
Phoenix	45,407	29,446	74,852	44,934	29,606	74,541	45,020	29,663	74,683	142
Portland	12,350	84,463	96,813	12,221	84,924	97,145	12,244	85,086	97,330	185
Tucson	8,395	10,761	19,155	8,307	10,819	19,127	8,323	10,840	19,163	36
Headquarters	72,596	0	72,596	71,841	0	71,841	71,978	0	71,978	137
Total, PRC	**$424,115**	**$490,024**	**$914,139**	**$419,704**	**$492,697**	**$912,401**	**$420,504**	**$493,635**	**$914,139**	**+$1,738**

Note: FY 2016 are actual amounts. FY 2017 and FY 2018 are estimates.

[10] As defined by the GAO, IHS referrals are "cases in which an IHS-funded provider refers a patient for care to an external provider."
[11] As defined by the GAO, self-referrals are "typically emergency situations where the patient receives services from external providers without first obtaining a referral from an IHS-funded provider."

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

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$155,734	$155,438	$156,667	+$1,230
FTE*	231	231	231	0

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

SUMMARY OF THE BUDGET REQUEST

The FY 2018 budget submission for Preventive Health programs of $156.667 million is $1.23 million above the FY 2017 Annualized Continuing Resolution (CR) level. Included in the budget is $933,000 for Staffing for New Facilities. 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 critical health care needs.

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. The budget proposes an increase of $1.021 million for Public Health Nursing.

- **Health Education** to support the provision of community health, school health, worksite health promotion, and patient education. The Health Education Program standardizes, coordinates, and integrates education initiatives within IHS, including health literacy for American Indian/Alaska Native (AI/AN) individuals and communities, provision of professional education and training, and developing educational materials for staff, patients, families, and communities. The budget proposes an increase of $93,000 for Health Education.

- **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. CHRs use local community knowledge to help integrate and disseminate basic information about health promotion/disease prevention and self-management support to patients. With more pilot sites participating in the Agency's Improving Patient Care and Partnership for Patients efforts, several are reporting how valuable the input and services provided by CHRs are to improving patient care. The Budget proposes an increase of $112,000 for Community Health Representatives.

- **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. The Budget proposes an increase of $4,000 for the Hepatitis B and Haemophilus Immunization Programs (Alaska).

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 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$76,623	$76,477	$77,498	+$1,021
FTE*	208	208	208	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 2018 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.

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. PHNs play a critical role in the surveillance and early efforts to halt the spread of communicable diseases. 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 and immunizations to homebound American Indian/Alaska Natives (AI/AN).

PHNs conduct home visiting services for:

- 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. This activity targets fragmentation in services and improves care continuums, including patient safety, and patient services. Interventions are monitored with data collection and evaluated for outcome with an emphasis on producing a good return on investments in terms of clinical and financial results.

PROGRAM ACCOMPLISHMENTS

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 populations focused nurse visiting program which serves the patient and family in the home and in the community. The PHN Program assesses the care provided in meeting the agency's priority Government Performance and Results Act (GPRA) measures and integrates the Department's Strategic Goal to strengthen health care to ensure AI/ANs have access to preventive services. GPRA reporting begins on July 1 and ends on June 30. PHN Data Mart reports for GPRA year 2016 reflect a total number of individual PHN patient related encounters was 370,556; and, some of the PHNs accomplishments in GPRA screening activities include the following encounter numbers:

- Tobacco Screening (6,504)
- Domestic Violence Screening (12,033)
- Depression Screening (15,220)
- Alcohol Screening (13,124)
- Adult Influenza Vaccines (30,338)
- Adult Pneumococcal Vaccines (1,633)

In 2016, the PHN Program sustained efforts to support the IHS' goal to decrease childhood obesity and prevent diabetes by supporting Baby Friendly 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. To assess how the PHN program delivers services, PHN data mart provides a mechanism to evaluate this evidence-based prevention service of promoting breastfeeding during the nurse home visit. For GPRA year 2016, there were a total of 14,704 PHN patients encounters related to this initiative with documented 39,819 patient education on breastfeeding provided during prenatal, postpartum and newborn encounters by the PHN. The PHN documented education provided as follows:

- prenatal (43,690)
- postpartum (13,422)
- newborn (24,774)
- immunizations (253,740)

In FY 2015, the IHS established a Memorandum of Understanding with the Department of Veterans Affairs (VA) and the University of Tennessee to begin the implementation of the Resource to Enhance All Caregivers Health (REACH) program, an evidenced-based program that provides a structured intervention to support caregivers of individuals suffering from dementia.

Caregivers supported by the REACH-VA program show improvement in depression, the effect of depression on daily life, and caregiver burden and frustration. In 2015-2016, PHN training, certification and support from the VA and University of Tennessee was provided in the Navajo, Phoenix, Albuquerque and Oklahoma Areas. For GRPA year 2016, there have been 5,443 PHN encounters to patients with dementia. Services provided at these PHN encounters include the following:

- Immunizations (1,105)
- Medications (849)
- Life adaptation (545)
- Safety and fall prevention (402)
- Tobacco use/prevention (171)

The overall goal is to implement this service in 50 tribal communities by 2018 and to adapt this intervention to deliver in AI/AN communities.

Addressing behavioral health issues, in 2016, the Pine Ridge PHN Mental Health Case Management Program was established to focus on suicide prevention in the local community. This intervention will improve health outcomes of high risk patients through a community case management model that utilizes the PHN as a case manager. In FY 2016, the program began investigating billing for this service as a means of leveraging revenue to expand the services in the community, supplemented data collection reports on the PHN Data Mart to report outcome, and initiated plans for a program at the Standing Rock Service Unit. In FY 2017, this service is being shared as a best practice for other communities and serve as a resource for the PHN grant program for tribal and urban grant recipients as part of awards that will be made in 2017.

PHNs support services for improving quality care and safety of patients during transitions across care settings by follow up on hospital discharges in an effort to decrease hospital readmissions; in 2016 GPRA year, PHNs had: 64,615 patient encounters with patients who were discharged from the hospital and provided a total of 115,131 follow-up visits; some of these patients had multiple post discharge follow-up visits. In support of the Million Hearts campaign to prevent heart attacks and strokes, PHNs provided 41,802 patient encounters that encompassed patient education on tobacco cessation at 5,889, hypertension at 30,151 and sodium reduction at 5,525. Additional education provided during these PHN encounters include tobacco use, immunizations, diabetes, and medications.

In FY 2016, the PHN program began a review of the delivery service for safe and quality service standards of various accrediting bodies to develop recommendations for the public health nursing program. This activity included coordinating with the Joint Commission agency to define the PHN services as an integrated IHS service for review and hosting the first webinar for PHN to share practices on safe and quality care with a focus on the Accreditation Association for Ambulatory Health Care survey. This activity will continue into FY 2017, helping to ensure that quality PHN services are provided in a safe manner.

In FY 2016, the PHN grant program encouraged Tribal and Urban grant recipients to engage local resources to sustain the PHN Grant program activities as the project period will be ending in 2017. The purpose of this grant funding is to improve health outcomes of an identified high risk group of patients through a case management model with the PHN as a case manager. In addition, the PHN program engages local resources to achieve annual strategic plans. For example, PHNs collaborate with local community program such as the Women's Infant and Children's (WIC) and Tribal Community Health Representatives (CHR) program to support breastfeeding efforts. Many WIC programs make available breast pumps for breastfeeding moms and CHR staff also are engaged in community outreach to encourage breastfeeding.

The FY 2016 target for the PHN Program measure was 390,556 encounters. The final result of 370,556 encounters did not meet the target by 20,000 encounters, a 5.0 percentage decrease. Recent data exporting processes has 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. The end result has been a decrease in the number of PHN activities being reported. In FY 2016, several PHN data briefs were created and posted on the PHN data mart to reflect the PHN activity in meeting several Agency initiatives (i.e. million hearts campaign, baby friendly hospital initiative, etc) and to supplement the PHN program's accomplishments report. These reports provide an avenue to monitor the PHN program's support of the health care delivery services in the community. In FY 2017 the PHN Documentation Manual will be updated to include most recent documentation additions to the electronic health record and include information on the PHN data mart reports to improve reporting of outcome.

FUNDING HISTORY

Fiscal Year	Amount
2014	$70,909,000
2015	$75,640,000
2016	$76,623,000
2017 Annualized CR	$76,477,000
2018 President's Budget	$77,498,000

TRIBAL SHARES

Public Health Nursing funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities. A portion of the overall Public Health Nursing 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 2018 budget submission for Public Health Nursing of $77,498,000 is $1,021,000 above the FY 2017 Annualized Continuing Resolution (CR) level.

FY 2017 Base Funding of $76,477,000 – 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 2018 Funding Increase of $1,021,000 includes:

- Staffing for New Facilities FY (2018) +$875,000 - 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 critical health care needs. The following table displays this request.

New Facilities FY 2018	**Amount**	**FTE/Tribal Positions**
Choctaw Nation Regional Medical Center (JV), Durant, OK	$601,000	4

Flandreau Health Center (JV), Flandreau, SD	$274,000	2
Grand Total:	**$875,000**	**6**

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
23 Public Health Nursing: Total number of public health activities captured by the PHN data system; emphasis on primary, secondary and tertiary prevention activities to individuals, families and community groups. (Outcome)	FY 2016: 370,556 Target: 390,556 (Target Not Met)	381,314	381,314	Maintain

GRANTS AWARDS

(whole dollars)	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Number of Awards	15	15	15
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

Note: Allocation amounts are estimates.

AREA ALLOCATION

Public Health Nursing

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2016 Final			FY 2017 Estimated			FY 2018 Estimated			FY'18 +/- FY'17
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$9,953	$9,953	$0	$9,892	$9,892	$0	$9,911	$9,911	$19
Albuquerque	1,881	1,434	3,315	1,890	1,425	3,316	1,894	1,428	3,322	6
Bemidji	4	2,113	2,117	4	2,100	2,104	4	2,104	2,108	4
Billings	1,849	2,241	4,091	1,858	2,228	4,086	1,862	2,232	4,094	8
California	0	1,009	1,009	0	1,002	1,002	0	1,004	1,004	2
Great Plains	4,733	4,315	9,048	4,756	4,288	9,044	4,765	4,570	9,335	291
Nashville	396	1,534	1,931	398	1,525	1,923	399	1,528	1,927	4
Navajo	8,546	6,821	15,366	8,587	6,779	15,366	8,603	6,792	15,395	29
Oklahoma	3,412	10,651	14,063	3,428	10,586	14,014	3,435	11,207	14,641	628
Phoenix	3,998	4,598	8,596	4,017	4,570	8,587	4,025	4,579	8,604	16
Portland	596	2,270	2,867	599	2,256	2,856	600	2,261	2,861	5
Tucson	992	0	992	0	992	992	0	994	994	2
Headquarters	3,276	0	3,276	3,296	0	3,296	3,303	0	3,303	6
Total, PHN	**$29,683**	**$46,940**	**$76,623**	**$28,834**	**$47,643**	**$76,477**	**$28,889**	**$48,609**	**$77,498**	**+$1,021**

Note: FY 2016 are actual amounts. FY 2017 and FY 2018 are estimates.

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

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$18,255	$18,220	$18,313	+$93
FTE*	20	20	20	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 2018 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 and communities about their health. The program focuses on the importance of educating patients in a manner that empowers them to make better 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.

The Health Education Program is essential to the mission of the IHS to promote and measure evidenced-based practices of education and education outcomes. At a national level, the Health Education Program assists in developing policy, planning health education programs, setting priorities that impact meeting and monitoring "Healthy People 2020," and complying with the National Health Education Standards.

The Health Education Program supports the IHS' performance goals to report the number of visits with Health/Patient Education, and the proportion of tobacco-using patients that receive tobacco cessation intervention. The Health Education Program performance measures as shown in the outputs and outcomes table document 4,056,285 patient visits with patient education provided in FY 2015. In FY 2016, there was a decline of 0.7 percent or 285,987 patient visits. Staffing shortages significantly impacted provision of patient services, which was demonstrated in the decrease in patient visits for FY 2016.

Educational services provided by IHS demonstrate a steady increase in the number of AI/AN patients that have a documented educational encounter. The number of visits in which education was provided in FY 2015 was 4,056,285; in FY 2016 the number of visits with any patient education was 3,770,298. There was decline of 285,987 visits in FY 2016.

PROGRAM ACCOMPLISHMENTS

In FY 2016, the National Patient Education Committee (NPEC) identified commonly used ICD-10 codes for health education. The NPEC will ultimately phase out the current system and focus on protocols/guides for a well-defined and specific subset within the Resource Patient Management System. NPEC will also formalize an education data mart to provide reports for commonly used health education codes. 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, site location where patient education was provided, information provided, amount of time spent on providing patient health education, patient understanding, and behavior goals.

The Health Education program addressed the following IHS priorities in FY 2016:

- Assessing care through collaborate efforts with clinical staff at health fairs and in the clinic-conducted patient needs assessments and patient satisfaction surveys, reviewed data stored in the National Patient Information Reporting System (NPIRS)/National Data Warehouse (NDW) to target top diagnosis areas.
- Improving how we deliver services by analyzing patient satisfaction surveys/needs assessments and collaborating with Improving Patient Care teams to target areas of patient concern. Developing literature to educate patients about the "medical home model".
- Addressing behavioral health issues by assisting Tribes, health boards, and States in Behavioral Risk Factor Surveillance Surveys (BRFSS), providing health education in schools by addressing "bullying" and using the "Courage 2 Care" curriculum, implementing the Basic Tobacco Intervention Skills for Native Communities curriculum to increase smoking cessation efforts.
- Strengthening management by providing training to staff to increase patient education and documentation of education provided through the Basic Tobacco Intervention Skills for Native Communities to increase commercial tobacco cessation documentation.
- Bringing health care quality expertise to IHS by educating patients on the "medical home model," and training staff on tobacco cessation, sexually transmitted diseases/infections, and methamphetamine/prescription drug abuse. Providing NPIRS/NDW data when requested.
- Engaging local resources by collaborating with Tribes, health boards, universities, county, state and national organizations to increase patient education in the community. Partnerships include the American Lung Association, American Cancer Society, University of Arizona's HealthCare Partnership, and Bureau of Indian Education. Efforts include increasing immunizations, providing tobacco cessation, providing and improving Human Papilloma Virus education and immunization.

In partnership with other IHS programs, disciplines and staff, the Health Education Program staff continue to:

- Provide for comprehensive clinical and community health education services to AI/AN patients that is health literate, culturally appropriate, and written in plain language;
- Provide patient education in the clinic, schools and group encounters in the community; and
- Promote health literacy through the standardization, coordination and integration within IHS of health education for patients, professional education and training, and educational materials for staff, patients, families and communities.

FUNDING HISTORY

Fiscal Year	Amount
2014	$17,001,000
2015	$18,026,000
2016	$18,255,000
2017 Annualized CR	$18,220,000
2018 President's Budget	$18,313,000

TRIBAL SHARES

Health Education funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for carrying 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 2018 budget submission for Health Education of $18,313,000 is $93,000 above the FY 2017 Annualized Continuing Resolution (CR) level.

FY 2018 Funding Increase of $93,000 includes:

- Staffing for New Facilities FY (2018) +$58,000 - 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 critical health care needs. The following table displays this request.

New Facilities FY 2018	**Amount**	**FTE/Tribal Positions**
Choctaw Nation Regional Medical Center (JV), Durant, OK	$58,000	1
Grand Total:	**$58,000**	**1**

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2017 Target**	**FY 2018 Target**	**FY 2018 Target +/-FY 2017 Target**
HE-1 Number of visits with Health/Patient Education (Output)	FY 2016: 3,028,074 visits Target: 3,894,658 visits (Target Not Met)	3,987,514 visits	TBD	N/A

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

AREA ALLOCATION

Health Education

(dollars in thousands)

DISCRETIONARY	FY 2016 Final			FY 2017 Estimated			FY 2018 Estimated			FY '18 +/- FY '17
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$2,481	$2,481	$0	$2,462	$2,462	$0	$2,467	$2,467	$5
Albuquerque	329	839	1,167	333	832	1,165	334	834	1,167	2
Bemidji	62	543	605	63	539	602	63	540	603	1
Billings	540	636	1,177	548	632	1,179	549	633	1,182	2
California	32	291	323	32	289	321	32	289	321	1
Great Plains	372	1,509	1,881	377	1,497	1,874	377	1,500	1,878	4
Nashville	186	586	772	189	581	770	189	582	771	1
Navajo	0	2,725	2,725	0	2,705	2,705	0	2,710	2,710	5
Oklahoma	861	2,000	2,861	873	1,985	2,858	875	2,047	2,922	63
Phoenix	1,034	993	2,027	1,048	985	2,033	1,050	987	2,037	4
Portland	109	799	908	111	793	904	111	795	906	2
Tucson	213	0	213	0	213	213	0	213	213	
Headquarters	1,116	0	1,116	1,134	0	1,134	1,136	0	1,136	2
Total, Hlth Ed	**$4,852**	**$13,403**	**$18,255**	**$4,706**	**$13,514**	**$18,220**	**$4,716**	**$13,598**	**$18,313**	**+$93**

Note: FY 2016 are actual amounts. FY 2017 and FY 2018 are estimates.

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

COMMUNITY HEALTH REPRESENTATIVES

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$58,906	$58,794	$58,906	+$112
FTE*	3	3	3	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 2018 Authorization.....Permanent

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

PROGRAM DESCRIPTION

Community Health Representatives (CHRs) are a critical part of the Indian Health Service (IHS) public health system as they link available health programs to American Indian and Alaska Native (AI/AN) patients and communities. The National CHR program was founded on the concept that Tribal health workers are especially well adapted to serve Tribal communities, as they are familiar with Native languages, customs, and traditions. The National CHR program addresses the identified need for a cultural liaison between Tribal members and communities to provide: (1) a greater involvement of AI/AN people in their own health and in the identification and treatment of their health problems; (2) a greater understanding between AI/AN people and IHS staff; (3) improving cross-cultural communication between the AI/AN community and health service providers; and, (4) increasing basic health care and instruction in AI/AN homes and communities.

The need for CHR services is essential due to the remote and rural location of the Indian health system. CHRs serve to link the patient to the Indian healthcare system and help to prevent avoidable hospital readmissions and emergency department visits. This is accomplished by providing medically-guided home visits, case finding and case management of patients with chronic health conditions such as asthma, diabetes and hypertension. The aim of the CHR Program is to help AI/AN patients and communities to achieve an optimal state of well-being by providing health promotion and disease prevention, wellness and injury prevention education, translation and interpretation, transportation to medical appointments and delivery of medical supplies and equipment within their tribal community.

PROGRAM ACCOMPLISHMENTS

As CHR programs have transitioned from IHS direct care services to local community control via Tribal contracting and compacting, IHS' role has transitioned to providing support to enable communities to plan, develop, and implement culturally-informed programs. Tribal CHR programs using the Resource Patient Management System (RPMS) are encouraged to use the

CHR Patient Care Component (PCC) to document patient care services to export their data to the Indian Health Performance Evaluation System (IHPES). The aim of IHPES is to capture the scope of CHR services provided and to link the CHR program contributions to community-based prevention, education and services which contribute to Government Performance and Results Act measures.

Exported CHR program data in FY 2016 demonstrated that CHRs conducted 340,270 home visits and provided 1,102,164 patient contacts/services on a variety of health related conditions. Reflected in the data below, 70 percent of services provided by CHRs are related to chronic disease management. Those services are:

- 18.9 percent of services involved collection of patient data (e.g., taking vital signs, delivering medication, delivering medical equipment and providing emotional support).
- 17.9 percent of services were related to case finding as a result of patient screening (e.g., identifying a patient with elevated blood pressure and referring the patient for medical follow up).
- 14.1 percent of services were performing case management activities.
- 12.8 percent of services were providing health education to individuals and communities.
- 7.1 percent of services were providing transportation for coordination of care.

In FY 2016, the training target for CHRs was not met. An evaluation of CHR training was conducted and demonstrated the training content was useful to first time participants. The training data also revealed many CHRs had not attempted to take an online training module, suggesting a broader promotion of the online trainings, as well as in-person training options for CHRs with more years of experience. As a result, IHS is in development of a communication strategy to ensure CHRs are aware of the training offerings and hosting in-person training on topics related to maternal child health, early intervention, and mental health first aide.

FUNDING HISTORY

Fiscal Year	Amount
2014	$57,895,000
2015	$58,469,000
2016	$58,906,000
2017 Annualized CR	$58,794,000
2018 President's Budget	$58,906,000

TRIBAL SHARES

Community Health Representatives funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities. A portion of the overall Community Health Nursing 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 2018 budget submission for Community Health Representatives of $58,906,000 is $112,000 above the FY 2017 Annualized Continuing Resolution (CR) level.

The FY 2018 funding will maintain the program's progress in addressing community health activities.

Funding to be used as follows:

- For contracting, compacting and Tribal CHR programs to provide direct health care, health promotion and disease prevention services in homes and other community-based settings.
- For training, information technology costs, and special projects. Approximately 68 percent of this amount represents shares for Tribally-administered funds.
- The remaining 32 percent of federally-retained funds will support the following plans for FY 2017, but are not limited to:
  - Sustaining the CHR Basic and Advanced on-line training to support CHR skills and competencies.
  - Provide training, web management, listserv, and other program administrative, technical and logistical assistance to Tribes and Areas.
  - Continue health information technology development, refinement, and data support to enhance the CHR data application in RPMS and integration into the Electronic Health Record.
  - Train CHRs nationally on the CHR PCC data system.
  - Continue efforts to integrate CHR's into the patient's health care team and medical home.
  - Share information on the use and benefits of the CHR Data Mart, an online tracking system which allows authorized local CHR Program staff to monitor exported CHR PCC patient data and workload management.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2017 Target**	**FY 2018 Target**	**FY 2018 Target +/-FY 2017 Target**
CHR-1 Number of patient contacts (Output)	FY 2016: 1,102,164 patient contacts Target: 992,464 patient contacts (Target Exceeded)	1,212,084 patient contacts	1,265,000 patient contacts	+52,916 patient contacts
CHR-2 CHR patient contacts for Chronic Disease Services (Output)	FY 2016: 453,252 patient contacts Target: 429,814 patient contacts (Target Exceeded)	498,200 patient contacts	505,900 patient contacts	+7,700 patient contacts
CHR-3 Number of CHRs Trained (Output)	FY 2016: 474 CHRs Target: 551 CHRs (Target Not Met)	600 CHRs	600 CHRs	Maintain

GRANTS AWARDS – No grant awards are anticipated for FY 2018.

AREA ALLOCATION

Community Health Representatives

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2016 Final			FY 2017 Estimated			FY 2018 Estimated			FY'18 +/- FY'17
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$4,276	$4,276	$0	$4,273	$4,273	$0	$4,281	$4,281	$8
Albuquerque	0	3,362	3,362	0	3,360	3,360	0	3,366	3,366	6
Bemidji	0	4,621	4,621	0	4,618	4,618	0	4,627	4,627	9
Billings	0	4,277	4,277	0	4,274	4,274	0	4,282	4,282	8
California	0	1,923	1,923	0	1,922	1,922	0	1,926	1,926	4
Great Plains	296	6,665	6,961	289	6,660	6,949	290	6,673	6,962	13
Nashville	392	3,053	3,444	382	3,051	3,433	383	3,056	3,439	7
Navajo	0	6,615	6,615	0	6,610	6,610	0	6,622	6,622	13
Oklahoma	0	8,716	8,716	0	8,709	8,709	0	8,726	8,726	17
Phoenix	0	6,002	6,002	0	5,997	5,997	0	6,009	6,009	11
Portland	0	4,496	4,496	0	4,493	4,493	0	4,501	4,501	9
Tucson	0	1,889	1,889	0	1,889	1,889	0	1,892	1,892	4
Headquarters	2,323	0	2,323	2,267	0	2,267	2,272	0	2,272	4
Total, CHR	**$3,011**	**$55,895**	**$58,906**	**$2,939**	**$55,856**	**$58,794**	**$2,944**	**$55,962**	**$58,906**	**+$112**

Note: FY 2016 are actual amounts. FY 2017 and FY 2018 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 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$1,950	$1,946	$1,950	+$4
FTE*	0	0	0	0

* This program is managed by Tribal staff. FTE numbers reflect no Federal 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 2018 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 maintains high vaccine coverage by providing resources, training, and coordination to Tribal facilities throughout Alaska. Regular meetings are held with regional Immunization Coordinators, Clinical Directors, Community Health Aide Program, IHS Immunization Coordinators, and the State of Alaska Immunization Program. The Program works with Tribal public relations to address parental immunization hesitancy and highlight the importance of vaccines.

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 immunization coverage, and high clinical management coverage of hepatitis B and C in Alaska Natives. The programs' activities support the IHS priorities on quality and partnerships.

PROGRAM ACCOMPLISHMENTS

The Immunization Alaska program has several performance measures to monitor progress in achieving the goal of high vaccine coverage for Alaska Natives 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 liver disease that disproportionately affect the Alaska Native population.

In FY 2016:

- Hepatitis A vaccination coverage was close to meeting Target, and hepatitis B vaccination coverage exceeded the target. Hepatitis A vaccination coverage was 89 percent (90 percent Target) and hepatitis B vaccination coverage was 94 percent (90 percent Target).
- At least 65 percent of AI/ANs with chronic hepatitis B (61 percent) or C (67 percent) infection were screened for liver cancer and for liver aminotransferase levels.
- The program maintains its practice of encouraging hepatitis patients to have regular, bi-annual screening.

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 Natives. Vaccine coverage data is collected for each Tribal region and measured in collaboration with local Tribal immunization coordinators. Consultation for the varying electronic health record systems within each Tribal health organization is provided to improve vaccine coverage for all Tribes. Statewide Alaska Native immunization coverage rates are reported to IHS Headquarters for infants 3-27 months, 19-35 months, adolescents, and older adults and flu vaccine immunization rates are reported for all ages.

During FY 2016:

- Immunization Coverage for Alaska Native 19-35 month olds was 72 percent, which is approaching the Healthy People 2020 goal of 80 percent for child vaccine coverage with 4:3:1:3*:3:1:4 series (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Var, 4 PCV).
- Achieved 89 percent coverage with full series Haemophilus influenza type b (Hib) vaccine in 19-35 month olds, which is much higher than the US all-races 2014 rate of 83 percent.
- Increased Tdap vaccine coverage in 19-64 year olds from 71 percent in 2013 to 82 percent in 2014, 83 percent in 2015, and 86 percent in 2016.
- Assisted Tribal facilities using the RPMS immunization package in maintaining their interface to share vaccine records with the Alaska State Immunization Information System (SIIS).
    - Provided consultation with numerous facilities who were implementing new Electronic Health Records (EHR) on immunization documentation and helped facilitate SIIS interface implementation.
    - Completed the development and implementation of alternative reminder-recall systems.

A summary of immunization results is included below:

Immunization Measure	Age Group	Alaska Native coverage as of 12/31/2016
4:3:1:3*:3:1:4	19-35 months	72%
4:3:1:3:3:1	19-35 months	78%
3 Hib vaccines doses		89%
3 PCV (pneumococcal conjugate vaccine)	19-35 months	92%
1+ HPV	13-17 years female	81%
Pneumococcal vaccine	65+ years	93%
Tdap	19-64 years	86%

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

The program continues to maintain collaborations with Centers for Disease Control and Prevention in networking with IHS and tribal agencies to provide technical assistance regarding EHRs. Challenges include the diversity of EHRs employed by Tribal agencies that may result in a temporary loss or delay of Area-wide reporting of immunization coverage. Regular reporting of immunizations is critical in assuring follow-up with facilities experiencing vaccination administration issues. This will continue to be addressed through coordinated efforts by the Hib program, IHS and Tribes. Vaccine and immunization coverage are measured as well as consults provided to Tribal partners.

FUNDING HISTORY

Fiscal Year	Amount
2014	$1,826,000
2015	$1,826,000
2016	$1,950,000
2017 Annualized CR	$1,946,000
2018 President's Budget	$1,950,000

TRIBAL SHARES

Alaska Immunization funds are paid out as tribal shares in their entirety.

BUDGET REQUEST

The FY 2018 budget submission for Alaska Immunization of $1,950,000 is $4,000 above the FY 2017 Annualized Continuing Resolution level (CR).

The FY 2018 funding 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 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 three days of outpatient clinics 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 (Adobe Connect) 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. 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 support on site and many location, including rural and isolated location to provide program support for regional Tribal programs and limited printing of media materials. 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. Statewide Alaska Native immunization coverage rates are reported to IHS Headquarters for infants 3-27 months, 19-35 months, adolescents, and older adults and flu vaccine immunization rates are reported for all ages. In addition, the number of consultations and trainings offered to tribal facilities is also reported.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/- FY 2017 Target
AK-1 Chronic Hepatitis B Patients Screened/Targeted (Output)[1]	FY 2016: 630 Screened Target: 628 Screened (Target Met)	600 Screened	600 Screened	Maintain
AK-2 Chronic Hepatitis C Patients Screened/Targeted (Output)[2]	FY 2016: 1181 Screened Target: 976 Screened (Target Exceeded)	990 Screened	990 Screened	Maintain
AK-3 Other Liver Disease Patients Screened (Output)[3]	FY 2016: 213 Screened Target: 199 Screened (Target Exceeded)	200 Screened	200 Screened	Maintain
AK-4 Hepatitis A vaccination (Output)[4]	FY 2016: 89 % Target: 90 % (Target Not Met)	90 %	90 %	Maintain
AK-5 Hepatitis B vaccinations (Output)[5]	FY 2016: 94 % Target: 90 % (Target Exceeded)	90 %	90 %	Maintain

All data reported is from the Alaska Native Tribal Health Consortium.

[1] Hepatitis Program (Known Cases Screened) Sum of known heapatitis B cases FY 2016: 1,026. 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 2016: 1,771. With new treatment regimens available screening rates have increased; number of new hepatitis C cases identified did not decline in this report period.
[3] Hepatitis Program (Known Cases Screened) Sum of known other liver disease cases FY 2016: 230. Other liver disease includes autoimmune hepatitis and primary biliary cirrhosis.
[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. The rates reported herein represent an average for the reporting period. The established target immunization rate for each vaccine is 90%.
[5] 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. The rates reported herein represent an average for the reporting period. The established target immunization rate for each vaccine is 90%.

GRANTS AWARDS -- The program does not award grants.

AREA ALLOCATION

Immunization Alaska

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2016 Enacted			FY 2017 Estimated			FY 2018 Estimated			FY'18 +/- FY'17
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$1,950	$1,950	$0	$1,946	$1,946	$0	$1,950	$1,950	$4
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	0	0	0	0	0	0	0	0	0	0
Total, Imm AK	**$0**	**$1,950**	**$1,950**	**$0**	**$1,946**	**$1,946**	**$0**	**$1,950**	**$1,950**	**+$4**

Note: FY 2016 are actual amounts. FY 2017 and FY 2018 are estimates.

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

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$44,741	$44,656	$44,741	+$85
FTE*	6	6	6	0

*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 2018 Authorization.....Permanent

Allocation Method .....Formula Contracts and Competitive Formula Grants awarded to Urban Indian Organizations

PROGRAM DESCRIPTION

The Office of Urban Indian Health Program (OUIHP) was established in 1976 to make health services more accessible to urban American Indians and Alaska Natives (AI/AN). The Indian Health Service (IHS) enters into limited, competing contracts and grants with 34 urban Indian 501(c)(3) non-profit organizations to provide health care and referral services for urban Indians residing in 59 sites throughout the United States. Urban Indian Organizations (UIO) define their scope of work and services based upon the service population, health status, and documented unmet needs of the urban Indian community they serve. Each UIO is governed by a Board of Directors that must be made up of at least 51 percent urban AI/AN. UIO provide unique access to culturally appropriate and quality health care for urban AI/AN.

UIO provide primary medical care and public health case management outreach and referral services for approximately 54,000 urban AI/AN 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. UIO health program sizes and services vary, as follows:

- Twenty-one are full ambulatory programs providing direct medical care to the population served for 40 or more hours per week.
- Six are limited ambulatory programs providing direct medical care to the population served for less than 40 hours per week.
- Six are 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.
- Seven are residential treatment facilities.
- Two are Urban IHS Service Units (Oklahoma City and Tulsa, OK).
- Another (not included in the 42) provides national education and research services for UIO and the Office of Urban Indian Health Programs (OUIHP) through a cooperative agreement.
- In addition, funding is also provided for dental services through the Albuquerque Area IHS Dental Program.

UIO are evaluated in accordance with the Indian Health Care Improvement Act (IHCIA) requirements. The program is administered by OUIHP at IHS Headquarters. OUIHP integrates Enterprise Risk Management by annually reviewing UIO progress with set goals and objectives. The IHS Urban Indian Health Program Review Manual is used by the IHS Area Urban Coordinators to conduct annual onsite reviews of the IHS funded UIO to monitor compliance with Federal Acquisition Regulation contractual requirements that are established through legislation. The results are submitted to OUIHP for review and follow-up to ensure that corrective action plans are successfully completed prior to continuation of funding.

PROGRAM ACCOMPLISHMENTS

UIO fulfill IHS data reporting requirements including the IHS Government Performance and Results Act (GPRA) report and the Diabetes Non-Clinical Audit report. UIO 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 July 1, 2015 to June 30, 2016 the UIO 2015 GPRA cycle accomplishments included:
- 100 percent of the UIO reported on 20 of the 20 performance measures,
- 24 UIO reported through the Clinical Reporting System (CRS),
- 10 UIO reported using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records), and
- In FY 2016, UIO improved performance on 9 of the GPRA measures with comparable FY 2015 data.

OUIHP has 33 Title V Urban Indian Health Programs, 2 Urban IHS Service Units and has added 7 Alcohol and Substance Abuse (former NIAAA) programs for a total of 42. IHS will proceed with plans to have all 42 urban programs export data to the IHS data center and assist with the National Patient Reporting System (NPIRS) staff to compare data for the budget formulation for Urban programs.

The IHS, through the OUIHP and with the assistance of the Office of Information Technology, will continue to provide training and technical assistance to urban programs on accurate and uniform data collection, so as to achieve standardization throughout the system.

The IHS is completing development of the Integrated Data Collection System (IDCS). During FY 2017, IHS will evaluate and validate the new performance data mart which contains urban program data submitted to the National Data Warehouse. As the urban program data mart matures, the expectation is to produce all reports from the NPIRS environment to automate and alleviate, where possible, manual data collection efforts. The goal is to have a consolidated, centralized, integrated data store that enables ‘on-demand’ reporting to support the management and monitoring of key performance measures. The plan is to report performance data from the data mart in FY 2018. With the addition of UIO data, the IHS will report aggregated results in FY 2018 from federal, tribal and urban sites. Currently, aggregated performance results include only federal and tribal sites.

FUNDING HISTORY

Fiscal Year	Amount
2014 Final	$40,729,000
2015 Final	$43,604,000
2016 Enacted	$44,741,000
2017 Annualized CR	$44,656,000
2018 President's Budget	$44,741,000

BUDGET REQUEST

The FY 2018 budget submission for the Urban Indian Health program of $44,741,000 is $85,000 above the FY 2017 Annualized Continuing Resolution (CR) level.

Base Funding of $44,656,000 – The base funding provides for the following:

- Improving urban AI/AN access to health care to improve health outcomes in urban centers.
- Strengthening programs that serve urban AI/AN in 59 sites throughout the United States.
- Enhancing 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 programs and patient centered medical homes for urban AI/AN. Seven UIO are currently accredited. Seven have achieved Patient Centered Medical Home (PCMH) status and four are working towards achieving PCMH recognition. All UIO participate in the IHS' IPC Initiative.
- Emphasizing preventive health including evaluation, dissemination, and promotion of effective clinical preventive services.
- Applying innovative solutions to public health challenges to increase understanding of what works in public health.
- Implementing and utilizing advanced health information technology.
- Expanding access to quality, culturally competent care for urban AI/AN through collaboration with other federal agencies.
- Investing in the number of workload demands.
- Implementing the new IHCIA authorities' specific to Urban Indian Organizations.

Program Increase of $85,000 – Strengthen UIO operations and improve urban AI/AN access to health care to achieve improved health outcomes.

OUTPUTS / OUTCOMES

The Outcomes and Outputs Table(s) list the proposed measure changes for this budget narrative.

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2017 Target**	**FY 2018 Target**	**FY 2018 Target +/-FY 2017 Target**
UIHP-2 Percent of AI/AN patients with diagnosed diabetes served by urban health programs that achieve good blood sugar control. (Outcome)	FY 2016: 46.7 % Target: 49.5 % (Target Not Met but Improved)	48.4 %	Retire after 2017	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
UIHP-3 Proportion of children ages 2-5 years, with a BMI at or above the 95th percentile. (Outcome)	FY 2016: 22.1 % Target: 22.8 % (TargetExceeded)	N/A	Retire after 2017	N/A
UIHP-6 Increase the number of diabetic AI/ANs that achieve ideal blood pressure control (<140/90). (Outcome)	FY 2016: 75.9 % Target: 68.9 % (Target Exceeded)	69.4 %	Retire after 2017	N/A
UIHP-7 Number of AI/ANs served at Urban Indian clinics. (Outcome)	FY 2015: 53,408 Target: 51,167 (Target Exceeded)	53,408	53,408	Maintain
UIHP-8 Percentage of AI/AN patients with diagnosed diabetes served by urban health programs that achieve good blood sugar control (Outcome)	FY 2018: Result Target: Set Baseline (Pending)	N/A	Baseline	N/A
UIHP-9 Proportion of children, ages 2-5 years, with a BMI at or above the 95th percentile (Outcome)	FY 2018: Result Target: Set Baseline (Pending)	N/A	Baseline	N/A
UIHP-10 Increase the number of diabetic AI/ANs that achieve blood pressure control (Outcome)	FY 2018: Result Target: Set Baseline (Pending)	N/A	Baseline	N/A

GRANTS AWARDS - Funding for UIO for FY 2016 included both grants and contracts awarded to the programs.

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Number of Awards	34	34	34
Average Award	$246,856	$246,856	$246,856
Range of Awards	$122,832 - $626,765	$122,832 - $626,765	$122,832 - $626,765

AREA ALLOCATION

Urban Health

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2016 Final			FY 2017 Estimated			FY 2018 Estimated			FY'18 +/- FY'17
	Federal	Urban	Total	Federal	Urban	Total	Federal	Urban	Total	Total
Alaska	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Albuquerque		2,418	2,418		2,420	2,420		2,425	2,425	5
Bemidji		4,135	4,135		4,140	4,140		4,148	4,148	8
Billings		2,276	2,276		2,279	2,279		2,283	2,283	4
California		6,325	6,325		6,332	6,332		6,344	6,344	12
Great Plains		1,524	1,524		1,525	1,525		1,528	1,528	3
Nashville		939	939		941	941		942	942	2
Navajo		720	720		720	720		722	722	1
Oklahoma		2,062	2,062		2,065	2,065		2,069	2,069	4
Phoenix		2,475	2,475		2,478	2,478		2,482	2,482	5
Portland		5,517	5,517		5,523	5,523		5,534	5,534	11
Tucson		514	514		515	515		516	516	1
Headquarters	8,164	7,671	15,835	8,038	7,680	15,718	8,053	7,694,496	15,748	30
Total, Urban	**$8,164**	**$36,577**	**$44,741**	**$8,038**	**$36,618**	**$44,656**	**$8,053**	**$36,688**	**$44,741**	**+$85**

Note: FY 2016 are actual amounts. FY 2017 and FY 2018 are estimates.

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

INDIAN HEALTH PROFESSIONS

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$48,342	$48,250	$43,342	-$4,908
FTE*	22	22	22	0

*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 2018 Authorization.....Permanent

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

PROGRAM DESCRIPTION

The Indian Health Care Improvement Act (IHCIA) P.L. 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 to recruit and retain health professionals to provide high-quality primary care and clinical preventive services to American Indians and Alaska Natives (AI/AN). The IHP programs also work with IHS, Tribal facilities and 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:

- Enabling AI/ANs to enter the 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.

While the IHP programs have seen successes, we continue to strive to improve our 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 online manuals, e-Newsletters, emails, and referral of graduates to recruiters have all been used to facilitate the 90 day scholar placement. In FY 2016, 45.4 percent of scholars had a hire letter within 90 days (target was 78 percent). Failure to meet this goal was primarily due to nursing scholars not completing their licensing boards and finding positions within the 90 day period. The Scholarship program continues to look for new ways to assist our scholars in meeting 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 health care professionals 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 2016, a total of 1,253 health professionals were receiving IHS loan repayment. This included 437 new two-year contracts, 379 one-year extension contracts and 437 health professionals starting the second year of their FY 2015 two-year contract.

Applicants who apply for funding and do not receive it, 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 2016, there were 446 "matched unfunded" applicants (including 126 nurses, 14 behavioral health providers, 11 dentists, 56 mid-level providers and 128 pharmacists) and 493 "unmatched unfunded" health professionals (including 18 physicians, 73 behavioral health providers, 34 dentists, 74 mid-level providers and 160 nurses). The inability to fund these 939 health professional applicants is a significant challenge for the recruitment efforts of the agency. It is estimated that an additional $48.3 million would be needed to fund the 939 unfunded health professional applicants from FY 2016. A more detailed breakout of loan repayment awards in FY 2016 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 2016, there were 1,250 new online scholarship applications submitted to the IHS Scholarship program. After evaluating the application for completeness and eligibility, a total of 456 of these new scholarship applications were considered eligible for funding. The IHS Scholarship program was able to fund 124 new awards. An additional $3.3 million in scholarship funding would have been needed to fund all qualified scholarship applicants. The IHS Scholarship program also reviewed applications from previously awarded scholars that were continuing their education. A total of 172 continuation awards were funded in FY 2016.

A detailed breakout of scholarships awarded by discipline in FY 2016 is included in a table at the end of the narrative.

In 2013, the IHS Scholarship program provided retention metrics for inclusion in a system design guide for the revision of the Scholarship Management System. System upgrades to date have allowed for easier tracking of scholars throughout the application and award process, while in school and during post graduate training, and while fulfilling their service commitment. Additional enhancements, when completed, will provide annual reports on retention of scholarship recipients employed by IHS beyond the obligated service period.

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 FY 2016, the Extern Program funded a total of 92 student externs. A breakout of extern awards in FY 2016 by Area Offices is included in a table at the end of the narrative.

FUNDING HISTORY

Fiscal Year	Amount
2014	$28,466,000
2015	$48,342,000
2016	$48,342,000
2017 Annualized CR	$48,250,000
2018 President's Budget	$43,342,000

BUDGET REQUEST

The FY 2018 budget submission for the Indian Health Professions program of $43,342,000 is $4,908,000 below the FY 2017 Annualized Continuing Resolution level. This funding level will maintain the current loan repayments and scholarship commitments, and will not support additional awards.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2017 Target**	**FY 2018 Target***	**FY 2018 Target +/-FY 2017 Target**
42 Scholarships: Proportion of Health Scholarship recipients placed in Indian health settings within 90 days of graduation. (Outcome)	FY 2016: 45.4 % Target: 78 % (Target Not Met)	78 %	78 %	Maintain
IHP-1 Number of scholarship awards under section 103 (Output)	FY 2016: 69 Awards Target: 89 Awards (Target Not Met)	89 Awards	34 Awards	-55 Awards

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target*	FY 2018 Target +/-FY 2017 Target
IHP-2 Number of scholarship awards under section 104 (Output)	FY 2016: 227 Awards Target: 223 Awards (Target Exceeded)	223 Awards	223 Awards	Maintain
IHP-3 Number of externs under section 105 (Output)	FY 2016: 92 Externs Target: 135 Externs (Target Not Met)	135 Externs	135 Externs	Maintain
IHP-4 Number of new 2 year contract awarded loan repayments under section 108 (Output)**	FY 2016: 437 contracts[1] Target: 465 contracts (Target Not Met)	465 contracts	367 contracts	-98 contracts
IHP-5 Number of continuing 1 year loan repayment contract extensions under section 108 (Output)	FY 2016: 379 Awards Target: 360 Awards (Target Exceeded)	360 Awards	360 Awards	Maintain
IHP-6 Total number of new awards funded in previous fiscal year under section 108 (Outcome)	FY 2016: 437 awards Target: 360 awards (Target Exceeded)	360 awards	360 awards	Maintain

***** FY 2018 "Targets" include estimates based on complete FY 2015 funding cycle data and additional Loan Repayment Program funding received in the FY 2016 budget.
** The "Number of Loan Repayments – Total" includes New Awards, Contract Extensions and Continuation Awards.

GRANTS AWARDS

The IHP administers three grant programs which fund colleges and universities to train students for health professions: (1) Quentin N. Burdick 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 critical support to students during their health career professional pathway and encourage students to practice in the Indian health system.

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
***Quentin N. Burdick American Indians Into Nursing Program (Section 112) – CFDA No. 93.970**			
Number of Awards	4	4	4
Average Award	$414,924	$414,924	$414,924
Range of Awards	$414,924	$414,924	$414,924
Indians Into Medicine Program (Section 114) – CFDA No. 93.970			

[1] Target not met; however, several awardees declined their awards after the fiscal year ended and it was too late to make more awards.

Number of Awards	3	3	3
Average Award	$356,083	$356,083	$356,083
Range of Awards	$170,000 - $728,250	$170,000 - $691,837	$170,000 - $691,837
American Indians Into Psychology Program (Section 217) – CFDA No. 93.970			
Number of Awards	3	3	3
Average Award	$238,359	$238,359	$238,359
Range of Awards	$200,000-$253,000	$238,259	$238,359

* A new grant cycle in FY 2014 changed all 4 awards to the same level of funding, $414,924 per award.

Scholarship Program Awards – In FY 2016, students in the following disciplines received IHS Scholarship Program funding:

Section 103 Pre-professional - 28 students				
Pre-Clinical Psychology	6		Pre-Pharmacy	8
Pre-Nursing	13		Pre-Social Work	1
Section 103 Pre-graduate – 41 students				
Pre-Dentistry	9		Pre-Optometry	3
Pre-Medicine	29			
Section 104 Health Professions - 227 students				
Chemical Dependency Counseling	3		Pharmacy	30
Clinical Psychology	10		Physical Therapy	9
Dentistry	31		Physician Assistant	18
Health Records	3		Physician, Allopathic	26
Medical Technology	4		Physician, Osteopathic	9
Nurse Midwife	3		Podiatry	2
Nurse Practitioner	13		Respiratory Therapy	1
Nurse, Associate Degree	10		Sanitarian	0
Nurse, Baccalaureate Degree	24		Social Work	12
Nurse, Master's Degree	1		Ultrasonography	1
Optometry	11		X-Ray Technology	2
Counseling Psychology	1		Nurse Anesthetist	1
Environmental Engineering	1		Public Health Nutritionist	1

Loan Repayment Program Awards – In FY 2016, the IHS LRP made awards to the following disciplines:

Awards by Profession	**Total Awards**	**New Awards**	**Contract Extensions**	**Matched Not Awarded**
Behavioral Health	77	66	11	14
Dental*	107	53	54	11
Nurse	164	134	30	126
Optometrists	47	17	30	7
Pharmacists	160	18	142	128
Physician Assistants/ Advanced Practice Nurses	73	45	28	56
Physicians	87	50	37	0
Podiatrists	13	4	37	0
Rehabilitative Services	40	21	19	24
Other Professions	48	29	19	80
TOTAL	**816**	**437**	**379**	**446**

***** Includes Dentists, Dental Hygienists, and Dental Assistants.

Other Professions	Total Awards	Matched Not Awarded	By Pay System	Awards
Acupuncturist	1	0	Tribal Employees	472
Certified Professional Coder	0	3	Civil Service	229
Chiropractors	6	3	Commissioned Corps	101
Dietetics/Nutrition	8	10	Urban Health Employees	14
Engineering	4	17		
Health Records	1	0		
Medical Laboratory Scientist	6	11		
Medical Technology	7	7		
Naturopathic Medicine	0	1		
Radiology Technicians	11	19		
Respiratory Therapist	2	0		
Sanitarian	2	9		
TOTAL	**48**	**80**	**Total**	**816**

Extern Program Awards – In FY 2016, the IHS Extern Program funded summer or winter externships for the following Area Offices for a total of 92:

AREA OFFICES	NUMBER OF EXTERNS
ALASKA	1
BEMIDJI	8
BILLINGS	8
CALIFORNIA	5
GREAT PLAINS	15
NASHVILLE	1
NAVAJO	19
OKLAHOMA	14
PHOENIX	13
PORTLAND	7
TUCSON	1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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TRIBAL MANAGEMENT GRANT PROGRAM

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$2,442	$2,437	$0	-$2,437
FTE*	0	0	0	0

*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 2018 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. 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.

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; and, 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 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.

PROGRAM ACCOMPLISHMENTS

- For almost 40 years, the TMG program has assisted a majority of federally-recognized T/TO to evolve organizationally with good health management infrastructure. The feasibility funds are critical in helping T/TOs conduct planning to assess if it is feasible to assume an IHS PFSA.

- 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.

FUNDING HISTORY

Fiscal Year	Amount
2014	$1,442,000
2015	$2,442,000
2016	$2,442,000
2017 Annualized CR	$2,437,000
2018 President's Budget	$0

BUDGET REQUEST

For FY 2018, the Tribal Management Grant program budget request does not fund this program to prioritize funding for direct care services.

OUTPUTS / OUTCOMES

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2017 Target**	**FY 2018 Target**	**FY 2018 Target +/-FY 2017 Target**
TMG-1 Planning Grants (Output)	FY 2016: 0 planning grants Target: 2 planning grants (Target Not Met)	2 planning grants	0 planning grants	-2 planning grants
TMG-2 Health Management Structure (HMS) grants (Output)	FY 2016: 11 HMS grants Target:	26 HMS grants	0 grants	-26 grants

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
	26 HMS grants (Target Not Met)			

GRANTS AWARDS

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Number of Awards[1]	$2,442,000 13 Noncompeting Continuations and 3 New	$2,442,000 13 Noncompeting Continuations and 3 New	$0
Average Award	$90,125	$90,125	$0
Range of Awards	$50,000 - $150,000	$50,000 - $150,000	$0

[1] Includes partial awards

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DIRECT OPERATIONS

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$72,338	$72,200	$72,338	+$138
FTE*	259	259	259	0

*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 2018 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) in providing 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.

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.

Continuing agency efforts to improve the quality of and access to health care, the IHS developed a quality framework in consultation with Tribes. As part of this framework, the IHS began a system-wide mock survey initiative for assessing compliance with the Centers for Medicare & Medicaid Services Conditions of Participation and readiness for re-accreditation. Initial efforts focused on hospitals in the Great Plains Area; however, the initiative will continue extending to all 26 hospitals. By assessing IHS hospitals and the quality of healthcare services provided by those hospitals, the IHS will continue efforts for ensuring consistent accreditation or certification practices that maintain high quality standards and instill trust in the patients receiving care. The accreditation or certification performance measure is critical to IHS operations. In total, IHS has six representative performance measures for which progress is tracked in meeting defined targets and reported and monitored. The Direct Operations budget helps fund the staff leading and supporting these activities, as well as the oversight needed to measure, track, and report performance outcomes.

On an ongoing and as needed basis, the IHS hosts webinars and disseminates educational materials related to impacts of public health concerns and threats, such as Ebola, Zika, and Influenza viruses. In FY 2016, the IHS administered several activities related to Zika virus preparation and planning including conducting communications and outreach to the IHS clinical community, improving surveillance for the Zika virus and engaging with partners and stakeholders. The IHS continues to address ongoing public health concerns and ensure staff and facilities are equipped to help educate patients, screen for the viruses such as Zika, and are implementing current clinical guidance as needed. Funding from the Direct Operations budget covers technical leadership, educational and informational material development and dissemination, webinar services, and other related activities necessary to maintain timely, accurate, and coordinated communications and oversight.

In FY 2016, the IHS also launched a new effort to increase Medicaid and Medicare enrollment of IHS patients at six health facilities in four states: Arizona, South Dakota, Montana, and North Dakota. The pilot targeted AI/AN IHS patients eligible for Medicaid and Medicare who were not yet able to access the health care options and support available through those programs because they were not enrolled. The goal of the pilot was to increase enrollment at the selected sites, help the IHS identify best practices for increasing enrollment in all communities, and leverage resources to provide access to quality health care. Over time, these important efforts are expected to increase the amount of reimbursements IHS is able to collect from Medicaid and Medicare for services provided to beneficiaries at IHS facilities. In accordance with the Indian Health Care Improvement Act, these collections are retained at the local facility and used to meet conditions of participation in the Medicaid and Medicare programs and increase resources for hiring more providers, purchasing new equipment, and providing additional healthcare services. The Direct Operations budget supports the staff leading this pilot effort as well as the work to enhance agency policy, procedures, oversight, and exchange of best practices.

To bring quality healthcare expertise and strengthen management, the IHS has focused considerable efforts on HR management. The IHS historically has difficulties recruiting and retaining healthcare providers. In FY 2016, the agency obtained streamlined Title 38 pay approval authority to offer more competitive salaries for Emergency Department physicians and advanced practice nursing specialties. The IHS obtained a blanket HHS policy exception to pay relocation expenses for mid-level providers and established search committees for filling Senior Executive Service vacancies in partnership with Tribes. The IHS also continued the collaborative work with the Health Resources and Services Administration, which resulted in approval of 684 I/T/U health care delivery sites for placement of National Health Service Corps health care providers and the number of placements increased to 443 providers as of August 2016.

The progress was made possible by collaboratively developing a process for a pre-approved method for site eligibility. In addition, the IHS began implementing the use of Global Recruitments to streamline the recruitment process, reduce redundancy, and utilize resources efficiently for commonly recruited health professional positions. The ultimate goal is attracting a greater pool of qualified candidates. To ensure consistency and accountability in workforce management, the IHS established an enhanced supervisory training focusing on employee and labor relations and an agency-wide tracking of all employee relations actions. A Leadership Training program was also implemented to build executive leadership capacity within the existing workforce and strengthen succession planning. The Direct Operations budget funds HR leadership and supporting staff, interagency agreements for collaborating with other government agencies to obtain additional expert support, and efforts to streamline and strengthen the overall HR program for maintaining a quality workforce.

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 and recruiting and retaining a high performing workforce.

FUNDING HISTORY

Fiscal Year	Amount
2014	$65,894,000
2015	$68,065,000
2016	$72,338,000
2017 Annualized CR	$72,200,000
2018 President’s Budget	$72,338,000

TRIBAL SHARES

Direct Operations funds are subject to Tribal shares and are transferred to Tribes when they assume the responsibility for carrying out 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 2018 budget submission for Direct Operations of $72,338,000 is $138,000 above the FY 2017 Annualized Continuing Resolution (CR) level.

Direct Operations funds continue support for system-wide administrative, management and oversight priorities that include:

- Continuing vital investments to enhance the IHS' 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 General Accountability Office (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 Purchased/Referred Care (PRC) program.
- 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 claims and maintaining policies and procedures to accurately determine CSC needs in the future.

Direct Operations Headquarters and Area Offices – Estimated Distribution: The distribution of funds includes Headquarters operations (excluding Urban, Self-Governance, and Office of Environmental Health and Engineering programs), 12 Area Offices operations, and Tribal shares as indicated by the table below:

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 Pres. Budget
Headquarters (58.7%)	$42,462,406	$42,381,400	$42,462,406
Title I Contracts (non-add)	*1,746,438*	*1,746,438*	*1,746,438*
Title V Compacts (non-add)	*6,463,865*	*6,463,865*	*6,463,865*
Area Offices (12) (41.3%)	29,875,594	29,818,600	29,875,594
Title I Contracts (non-add)	*540,703*	*540,703*	*540,703*
Title V Compacts (non-add)	*8,573,396*	*8,573,396*	*8,573,396*
BA	**$72,338,000**	**$72,200,000**	**$72,338,000**

AREA ALLOCATION

Direct Operations

(dollars in thousands)

DISCRETIONARY SERVICES	FY 2016 Final			FY 2017 Estimated			FY 2018 Estimated			FY'18 +/- FY'17
	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$4,703	$4,703	$0	$4,723	$4,723	$0	$4,732	$4,732	$9
Albuquerque	1,025	276	1,301	1,022	277	1,299	1,024	278	1,302	2
Bemidji	1,394	0	1,394	1,390	0	1,390	1,393	0	1,393	3
Billings	1,813	416	2,229	1,808	418	2,226	1,812	418	2,230	4
California	1,473	0	1,473	1,469	0	1,469	1,472	0	1,472	3
Great Plains	2,435	0	2,435	2,428	0	2,428	2,432	0	2,432	5
Nashville	1,016	787	1,802	1,013	790	1,803	1,015	792	1,806	3
Navajo	3,055	0	3,055	3,046	0	3,046	3,052	0	3,052	6
Oklahoma	1,790	1,779	3,568	1,785	1,786	3,571	1,788	1,789	3,577	7
Phoenix	2,641	406	3,048	2,634	408	3,042	2,639	409	3,048	6
Portland	1,592	980	2,572	1,587	985	2,572	1,591	986	2,577	5
Tucson	678	0	678	678	0	678	679	0	679	1
Headquarters	44,080	0	44,080	43,954	0	43,954	44,038	0	44,038	84
Total, Direct Ops	**$62,991**	**$9,347**	**$72,338**	**$62,814**	**$9,386**	**$72,200**	**$62,934**	**$9,404**	**$72,338**	**+$138**

Note: FY 2016 are actual amounts. FY 2017 and FY 2018 are estimates.

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SELF-GOVERNANCE

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$5,735	$5,724	$4,735	-$989
FTE*	14	14	14	0

*FTE numbers reflect only Federal staff and do not include increases for 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 2018 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' relationship with American Indian and Alaska Native (AI/AN) nations, Tribal organizations, and other AI/AN groups. Since 1993, the Indian Health Service (IHS), in cooperation with Tribal representatives, developed formula methodologies for identification of Tribal shares for all Indian Tribes. Tribal shares are those program and administrative funds that Tribes are eligible to assume through self-determination contracts and self-governance compacts.[1] Today, Indian Tribes and Tribal organizations currently administer over one-half of IHS resources through ISDEAA self-determination contracts and self-governance compacts.

PROGRAM ACCOMPLISHMENTS

The IHS Tribal Self-Governance Program has grown dramatically since the initial 14 compacts and funding agreements were signed in 1994. In FY 2016, approximately $1.9 billion of the total IHS budget appropriation was transferred to Tribes and Tribal organizations to support 89 ISDEAA self-governance compacts and 115 funding agreements.[2].

[1] The ISDEAA provides two mechanisms for Tribes and Tribal organizations to assume responsibility for health care formerly provided by the Federal government. The IHS Tribal Self-Governance Program is authorized under Title V of the Act. Tribes may also contract with the IHS through self-determination contracts and annual funding agreements authorized under Title I of the Act.

[2] For FY 2017, 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. 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.

The Self-Governance budget supports activities, including but not limited to: government-to-government negotiations of self-governance compacts and funding agreements; oversight of the IHS Director's Agency Lead Negotiators (ALNs); technical assistance on Tribal Consultation activities; analysis of Indian Health Care Improvement Act (IHCIA) authorities; and supporting the activities of the IHS Director's Tribal Self-Governance Advisory Committee.

The Self-Governance budget engages local Tribal resources through several activities:

- Develops and oversees the implementation of Tribal self-governance legislation and authorities in the IHS.
- Reviews eligibility requirements for Tribes to participate in the Tribal Self-Governance Program and to receive Self-Governance Planning and Negotiation Cooperative Agreements.
- Provides resources and technical assistance to Tribes and Tribal organizations for the implementation of Tribal self-governance.
- Provides Tribal Self-Governance Program training to Tribes, Tribal organizations, and Tribal groups.
- Coordinates national Tribal self-governance meetings, including an annual 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 activities and program direction.
- Develops, publishes, and presents information related to the IHS Tribal Self-Governance Program activities to Tribes, Tribal organizations, state and local governmental agencies, and other interested parties.
- Coordinates self-governance Tribal Delegation Meetings for the IHS Headquarters, and Area Senior officials.

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 to enhance information technology infrastructure and prepare for meaningful use and other federal reporting standards;
- Providing support for negotiation for Title V construction project agreements to assist Tribes to expand and to modernize health care facilities; and
- Collaborating on crosscutting issues and processes including, but not limited to: budget formulation; program management issues; self-determination issues; Tribal shares methodologies; and emergency preparedness, response and security.

These services are deployed in accordance with strategic planning, are data driven, and support program integrity through adherence to reporting requirements. The OTSGFM support the delivery of services by improved access to data to evaluate performance and identify areas of process improvement.

FUNDING HISTORY

Fiscal Year	Amount
2014 Final	$4,227,000
2015 Final	$5,727,000
2016 Final	$5,735,000
2017 Annualized CR	$5,724,000
2018 President's Budget	$4,735,000

BUDGET REQUEST

The FY 2018 budget submission for the Tribal Self-Governance Program of $4,735,000 is $989,000 below the FY 2017 Annualized Continuing Resolution level. This funding level will support direct services.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
TOHP-1 Percentage of TOHP clinical user population included in GPRA data. (Outcome)	FY 2016: 47.5 % Target: 57.7 % (Target Not Met)	58.6 %	Retire after 2017	N/A
TOHP-SP Implement recommendations from Tribes annually to improve the Tribal consultation process. (Output)	FY 2016: 7 recommendations Target: 3 recommendations (Target Exceeded)	3 recommendations	3 recommendations	Maintain

GRANT AWARDS

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Planning Cooperative Agreements			
Number of Awards	5	5	5
Award Amount	$120,000	$120,000	$120,000
Negotiation Cooperative Agreements			
Number of Awards	5	5	5
Award Amount	$48,000	$48,000	$48,000

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

PUBLIC AND PRIVATE COLLECTIONS

(Dollars in Thousands)

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
Medicare:				
Federal	$184,408	$184,408	$184,408	$0
Tribal[1]	6,986	6,986	6,986	0
Tribal[2]	57,244	57,244	57,244	0
Subtotal:	$248,638	$248,638	$248,638	$0
Medicaid:				
Federal	$659,185	$659,185	$659,185	$0
Tribal[1]	22,517	22,517	22,517	0
Tribal[2]	125,903	125,903	125,903	0
Subtotal:	$807,605	$807,605	$807,605	$0
M/M Total:	**$1,056,243**	**$1,056,243**	**$1,056,243**	**$0**
Private Insurance	$109,272	$109,272	$109,272	$0
VA Reimbursements[3]	$28,062	$28,062	$28,062	$0
TOTAL:	**$1,193,577**	**$1,193,577**	**$1,193,577**	**$0**
FTE[4]	6,244	6,244	6,244	0

[1] Estimated amount based on CMS tribal collection estimates as last provided.
[2] Estimated amount based on tribal collections due to direct billing between FY 2002 – FY 2016.
[3] The FY 2016, FY 2017 and FY 2018 amounts include the payments that the Veteran's Administration expects to make for both Federal and Tribal facilities. The VA and IHS will continue to work together to re-evaluate future growth estimates based on FY 2016 and FY 2017 actual collections.
[4] FTE numbers reflect only federal staff and do not include increases in tribal staff.

Authorizing Legislation……..…Indian Health Care Improvement Act, Pub. L. 94-437, as amended by Pub. L. 111-148, title X, §10221(a), Mar. 23, 2010, 124 Stat. 935); the Social Security Act sec. 1880 & 1911, 42 U.S.C 1395qq &1396j and the Economy Act (31 U.S.C 1535).

PROGRAM DESCRIPTION

In 1976, the Indian Health Care Improvement Act (IHCIA) authorized the Indian Health Service (IHS) to collect Medicare and Medicaid (M&M) reimbursements for services provided in IHS facilities to patients with M&M eligibility. The IHCIA was later amended to allow IHS to collect Private Insurance (PI) reimbursements for services provided in IHS facilities for patients with PI.

In fiscal year (FY) 2016, $1.194 billion was collected from third party insurers, of which $843.593 million was Federal M&M collections and $109.272 million was private insurers. The FY 2018 estimates above are based on the FY 2016 actual collections.

Public and private collections represent a significant portion of the IHS and Tribal health care delivery budgets.

Accreditation - In accordance with IHCIA authorization for collections, the IHS places the highest priority on meeting accreditation and certification standards for its healthcare facilities. Third party revenue is essential to maintaining facility accreditation, certification and standards of

health care through organizations such as the Joint Commission or the Accreditation Association for Ambulatory Health Care. Collection funds are ultimately used to improve the delivery and access to healthcare for American Indian and Alaska Native (AI/AN) people.

Monitoring – The IHS has developed and implemented a data system to identify deficiencies and monitor the third party collections process for IHS operated facilities. The Third Party Internal Control Self-Assessment online data tool provides necessary information for local managers and Headquarters staff to monitor compliance with applicable policies and procedures during the collections process so they can take necessary corrective actions and improve overall program activity. Over the past year, the Agency has had 100 percent of all IHS federal facilities participate in completing the online tool and 100 percent of all facilities with identified red flags have established a corrective action plan and are working towards compliance.

During FY 2017, IHS is continuing the development of a third party interface with the Unified Financial Management System and enhancement of systems, reports, and processes to meet legislative requirements for IHS operated facilities. The IHS will also continue improvements to the Electronic Health Record (EHR) and incrementally enhance handling of ICD-10 codes. The IHS will continue to strengthen its business office policies and management practices, including internal controls, patient benefits coordination, provider documentation training, certified procedural coding training, electronic claims processing and debt management. Priority activities include continued enhancement of third party billing and accounts receivable software to improve effectiveness and to ensure system integration with its business processes, compliance with M&M regulations, and industry standards and changes in operational processes. Improvements for IHS operated facilities are coordinated with concurrent enhancements in Purchased and Referred Care business practices related to alternate resources.

In addition, IHS is working to incorporate statutory rules and regulations that impact third party collections directly and indirectly. Some rules pertaining to the Medicare and Medicaid programs have a direct impact on revenue generation over the next few years. IHS has formed workgroups to maximize impact for all IHS, Tribal, and Urban Indian health program facilities, such as the National Business Office Committee, which serves as a subcommittee to the National Council of Executive Officers. These efforts support IHS's priority on resources to secure and effectively manage the assets needed to promote the IHS mission.

Partnerships – IHS is working to develop and enhance partnerships with federal and state agencies. IHS continues to work with CMS and the state Medicaid agencies to identify patients who are eligible to enroll in M&M and the state Children's Health Insurance Programs and in the implementation of provisions in the IHCIA, and the Children's Health Insurance Program Reauthorization Act. Enrollment and collections depend, in large part, on IHS' successful partnerships/relationships, state participation in Medicaid expansion, and awareness and willingness of IHS users to enroll in Medicaid and other programs.

Areas have developed and shared their Area Business Plan Templates with Tribes in the Areas and continue to monitor implementation progress. IHS anticipates that in-network contracting with health plans may work for many facilities and is working with CMS to identify ways to encourage and monitor implementation. In FY 2017, IHS is continuing to implement, train, and participate in the Medicare Payment Reform efforts by CMS. This included increasing awareness, implementation, training, and monitoring of Physician Quality Reporting Systems (PQRS) and Value Based Modifier (VBM) Payment Incentives and Adjustments. IHS is now working on implementation of the Merit-Based Incentive Payment System and Advanced Alternative Payment Models with the end goal of improving access to care.

IHS collaborates with CMS and the Tribes on a number of issues, including implementation of recent legislative changes, third party coverage, claims processing, denials, training and placement of state Medicaid eligibility workers at IHS and Tribal sites to increase the enrollment of Medicaid eligible AI/AN patients. IHS is coordinating outreach, education, and training efforts in order to avoid duplication of efforts. IHS has partnered with CMS to provide a number of training sessions for Tribal and IHS employees, focusing on outreach and improving access to M&M programs.

In December 2012, IHS and the Department of Veterans Affairs (VA) signed the VA/IHS National Reimbursement Agreement that facilitates reimbursement by the VA to the IHS and Tribal facilities for direct health care services provided to eligible AI/AN veterans. In January 2017 the IHS and VA signed an amendment to the agreement that extends the period of the reimbursement agreement through June 30, 2019. This was a significant step in continuing to ensure implementation of Section 405 of the IHCIA[1]. The agreement represents a positive partnership to support improved coordination of care between IHS federal facilities and the VA and it paved the way for agreements negotiated between VA and tribal health programs. IHS will continue to work directly with the VA to implement billing practices to ensure IHS receives proper payment for care provided at IHS and Tribal facilities to AI/AN veterans. Monitoring, auditing, and compliance with the agreement will continue to be a focus for FY 2017 through FY 2019.

Annually, IHS trains health care facility staff in areas related to coding, third party billing and other aspects of the revenue cycle. Area I/T/U staff are highly encouraged to participate in annual CMS trainings. IHS hosts a Partnerships conference to provide the most current information related to finance, information technology, Purchased/Referred Care, and business office functions; special emphasis is also provided for the specific management needs of Tribes and urban programs.

Claims Processing Improvements - During FY 2017, IHS continues to work to enhance each IHS operated facility's capability to identify patients who have private insurance coverage and improve claims processing. The local service units utilize private insurance funds to improve services, purchase medical supplies and equipment, and to improve local service unit business management practices in support of maintaining accreditation. The IHS continues to make use of private contractors to pursue collections on outstanding claims from private payers.

PROGRAM ACCOMPLISHMENTS

- Over the past year, the Agency has had 100 percent of all IHS federal facilities participate in completing the Third Party Internal Control Self-Assessment online tool and 100 percent of all facilities with identified red flags have established a corrective action plan and are working towards compliance.
- With the agreement between the VA and IHS in place, IHS developed and executed an implementation plan to collect at all IHS federal sites serving eligible Veterans. Currently, 100 percent of federal sites are billing the VA for services. Tribal health programs currently have 89 agreements with the VA. This partnership with the VA and implementation of VA reimbursement at IHS sites serve to support the IHS priority to build, strengthen, and sustain

[1] 25 U.S.C. § 1645(c), "Reimbursement. The Service, Indian tribe, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

collaborative relationships that advance the IHS mission and enable IHS to provide further services to local communities funded with these collections.

- In 2015, IHS completed an update of its Third Party Revenue Accounts Management and Internal Controls Policy and is currently preparing a training plan and a schedule of trainings for staff across the country.

FY 2017 - 2018 Collections Estimates

Medicare and Medicaid (M&M) **--** The FY 2018 President's Budget includes $1.056 billion. The request continues the FY 2017 collections level for FY 2018.

Medicaid – The FY 2018 President's Budget includes $807.605 million, the same level as FY 2017. IHS continues to educate its users on the benefits of increased Medicaid enrollment. IHS is continuing to monitor its user population and insurance coverage and is making all possible efforts to maximize Medicaid enrollment in all States and maintain current level of collections.

Medicare – The FY 2018 President's Budget includes $248.638 million. IHS hospitals and clinics are expanding steps to improve quality of care and maintain current levels of collections.

Private Insurance – The FY 2018 President's Budget includes $109.272 million, the same level as FY 2017. IHS will continue to monitor its user population and insurance coverage to maintain and maximize private insurance collections.

VA/IHS National Reimbursement Agreement – The FY 2018 President's Budget includes $28.062 million, the same level as FY 2017.

The estimates include collections for Federal and Tribal payments made by the VA. The FY 2017 and FY 2018 requests were developed in collaboration between the IHS and the VA. IHS and VA have agreed to continue to monitor actual reimbursements and will update estimates as more date becomes available. IHS continues to work with the VA in identifying the actual number of AI/ANs with VA benefits eligibility and, of those, how many receive direct care from IHS. IHS and the VA continue to work in partnership to identify and resolve billing and reimbursement issues and provide sites with on-going support and training. All IHS sites have signed implementation plans and have the ability to bill the VA for Veterans Services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2018 Performance Budget Submission to Congress

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Contract Support Costs: 75-0344-0-1-551

CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final[1]	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$717,970	$716,605	$717,970	+$1,365
FTE*	0	0	0	0

[1]The FY 2016 level includes revised estimate of $718 million for Contract Support Costs and the FY 2017 level reflects an estimated actual cost of Contract Support Costs.
*Contract Support Costs are not used to support FTEs.

Authorizing Legislation ..... 25 U.S.C. §§ 450 et seq., Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended

FY 2017 Authorization.....Permanent

Allocation Method ..... P.L. 93-638 Self-Determination Contracts and Compacts

PROGRAM DESCRIPTION

The Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 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.

CSC are defined as 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 in October 2016[1], an update to reflect necessary changes. These changes have included the method by which Congress has funded CSC, moving from a system of limited awards to uncapped awards and the provision of CSC as an indefinite appropriation.

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.

[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.

PROGRAM ACCOMPLISHMENTS

- As of April 2017, the IHS has paid 366 tribal contractors $662,676,228 for CSC for FY 2016. Consistent with the IHS CSC policy, IHS is working with tribes to determine each tribe's full CSC amount based on the most current data for 2016. During the March 2016, CSC reconciliation process, an additional need of $19 million was identified. IHS will continue to work with tribes and on a quarterly basis; IHS Headquarters allocates funds to each Area office to pay tribes.

- IHS uses the CSC automated data base 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 of funds. The IHS also uses the system to project CSC need based on the most current data.

- IHS paid $7.7 million for one time direct CSC for pre-award and startup funds for 8 tribes that assumed new programs, functions, services and activities (PFSA) or renegotiated their direct or indirect type CSC amount.

- IHS updated its CSC Policy in October 2016, after working with the IHS CSC Workgroup, consisting of IHS and Tribal leaders/officials, and engaging in tribal consultation; the first update in a decade. The updated policy provides detailed guidance and clarifies the data used to determine each T/TO's estimated CSC need and/or final amount. The policy further describes IHS's business process and includes a calculation tool which is used to determine each T/TO CSC amount and subsequent payment is consistent with the ISDEAA.

- IHS provided several training session to IHS federal negotiators, including one all agency ISDEAA team meeting. The IHS is committed to ensure that consistent CSC business practices are used throughout the IHS. In April 2017, the IHS will roll out CSC video clips that will be available for external customers, with primary focus of changes in the updated CSC policy.

- In March 2017, the IHS developed an internal electronic database to track each Title I ISDEAA negotiation, including CSC negotiations. The database monitors each phase of a negotiation to ensure that IHS uses a consistent agency business approach, ensure that deadlines are met, and that funding amounts are correctly calculated. This supports an agency-wide approach to monitoring and improving the overall negotiation process. In addition, this information will track new and expanded activity assumptions and will be used to determine the status of funds, workload, planning of resources, and subsequent years' funding needs.

- IHS continues to make progress in resolving Contract Disputes Act claims from T/TO for additional CSC funding for prior years. As of April 6, 2017, the IHS has extended settlement offers on 1,475 of the 1,535 claims, with settlement payments of approximately $831.3 million that has been tentative or confirmed for payment from the Judgment Fund.

FUNDING HISTORY

Fiscal Year	Amount
2014	$612,484,000
2015	$662,970,000
2016	$717,970,000
2017 Annualized CR	$716,605,000
2018 President's Budget	$717,970,000

BUDGET REQUEST

The FY 2018 budget submission for Contract Support Costs continues the indefinite discretionary appropriation established in FY 2016, with an estimated funding level of $717,970,000.

AREA ALLOCATION

CONTRACT SUPPPORT COSTS

(dollars in thousands)

DISCRETIONARY	FY 2016 Final			FY 2017 Estimated			FY 2018 Estimated			FY'18 +/- FY'17
SERVICES	Federal	Tribal	Total	Federal	Tribal	Total	Federal	Tribal	Total	Total
Alaska	$0	$194,852	$194,852	$0	$194,482	$194,482	$0	$194,852	$194,852	$370
Albuquerque	0	18,419	18,419	0	18,384	18,384	0	18,419	18,419	35
Bemidji	0	34,796	34,796	0	34,729	34,729	0	34,796	34,796	66
Billings	0	11,232	11,232	0	11,210	11,210	0	11,232	11,232	21
California	0	55,435	55,435	0	55,329	55,329	0	55,435	55,435	105
Great Plains	0	19,797	19,797	0	19,760	19,760	0	19,797	19,797	38
Nashville	0	18,441	18,441	0	18,406	18,406	0	18,441	18,441	35
Navajo	0	56,134	56,134	0	56,028	56,028	0	56,134	56,134	107
Oklahoma	0	101,569	101,569	0	101,376	101,376	0	101,569	101,569	193
Phoenix	0	30,664	30,664	0	30,605	30,605	0	30,664	30,664	58
Portland	0	53,774	53,774	0	53,672	53,672	0	53,774	53,774	102
Tucson	0	2,582	2,582	0	2,577	2,577	0	2,582	2,582	5
Headquarters	0	120,275	120,275	0	120,047	120,047	0	120,275	120,275	229
Total, CSC	**$0**	**$717,970**	**$717,970**	**$0**	**$716,605**	**$716,605**	**$0**	**$717,970**	**$717,970**	**+$1,365**

Note: FY 2016 are actual amounts. FY 2017 and FY 2018 are estimates.

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

(Dollars in Thousands)

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget	FY 2018 +/- FY 2017
BA	$523,232	$522,237	$446,956	-$75,281
FTE*	1,211	1,214	1,214	0

*FTE numbers reflect only federal staff and do not include 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 critical 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.

BUDGET AUTHORITY

The FY 2018 budget submission for Facilities of $446.956 million is $75.281 million below the FY 2017 Annualized Continuing Resolution (CR).

Maintenance & Improvement –The budget submission for M&I of $60.00 million is a decrease of $13.474 million from the FY 2017 Annualized CR. These funds provide for 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 over $515 million for all IHS and reporting Tribal facilities;
- Ensuring that health care facilities meet building codes and standards; and
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., sustainability, energy conservation, seismic, environmental, handicapped accessibility, and security.

The budget proposes a decrease of $13.474 million for a total $60 million for M&I.

Sanitation Facilities Construction –The budget submission for Sanitation Facilities Construction of $75.423 million is a decrease of $23.811 million from the FY 2017 Annualized CR. These funds provide for essential 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 budget submission for Health Care Facilities Construction of $100.0 million is a decrease of $4.848 million below the FY 2017 Annualized CR. This funding level for the construction of new and replacement healthcare facilities will allow IHS to continue the following projects:
- Rapid City Health Center, SD
- Dilkon Alternative Rural Health Center, AZ
- Alamo Health Center, NM

Facilities and Environmental Health Support (FEHS) – The budget submission for FEHS of $192.022 million is a decrease of $30.165 million from the FY 2017 Annualized CR. 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 budget submission for Equipment of $19.511 million is a decrease of $2.983 million from the FY 2017 Annualized CR. 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.

COLLECTIONS

Personnel Quarters funds are not discretionary budget authority but are rents collected by IHS and returned to the service unit for Quarters maintenance and operation costs. Quarters are displayed under Program Level Authority:

Quarters – The budget submission for Personnel Quarters of $8.500 million is the same as the FY 2017 Annualized CR projection based on FY 2016 collections data. Collected funds are to be used for:
- Operation, management, and general maintenance of quarters, including temporary maintenance personnel services, security guard services, etc.; and
- Repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (e.g., stoves, water heaters, furnaces, etc.).

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

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$73,614	$73,474	$60,000	-$13,474
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 2018 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 37 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 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

[1] The 'average age of hospital plant' measures the average age of the facility including capital improvements, replacement of built-in equipment and modernization.

(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 BEMAR for all IHS and reporting Tribal health care facilities as of October 1, 2016 is $515.4 million. Approximately 4 percent of the current replacement value $179.0 million annually - is necessary to fully 'sustain' the facilities and fund a project pool for restoration/modernization/improvement projects to support program requirements. Also, an aggressive new construction program is essential to reduce the backlog. 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 BEMAR and make improvements necessary to support health care delivery. Funding allocation is formula based. Under the Budget Request, no funds will be formula allocated as 'project funds'.

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.

FUNDING HISTORY

Fiscal Year	Amount
2014	$53,614,000
2015	$53,614,000
2016	$73,614,000
2017 Annualized CR	$73,474,000
2018 President's Budget	$60,000,000

[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.

BUDGET REQUEST

The FY 2018 President's Budget submission for Maintenance and Improvement program of $60,000,000 is $13,474,000 below the FY 2017 Annualized Continuing Resolution (CR) base level.

This level of funding provides for the following allocation categories:

- Approximately $57.1 million for routine maintenance 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 $2.5 million would be available for environmental compliance projects, which is a reduction of $500,000 from the amount reserved in FY 2017. 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 $10.9 million in environmental compliance tasks and included them in the BEMAR database.

Approximately $400,000 for demolition projects, which is a reduction of $100,000 from the amount reserved in FY 2017. The IHS has approximately 130 Federally-owned buildings that are vacant, excess, or obsolete which are no longer needed. Many of these buildings are safety and security hazards. Demolition of some of these buildings, in concert with transferring others, reduces hazards and liability. Demolition Funds may be augmented with environmental compliance funds as available for demolition of the Federal buildings to the extent that the proposed action reduces hazards, environmental concerns, or liability to the Indian Health Service.

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.

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 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$99,423	$99,234	$75,423	-$23,811
FTE*	137	137	137	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; 42 U.S .C 2004a, Indian Sanitation Facilities Act; 25 U.S.C. 1632, Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2018 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 provide new and existing homes with first time services such as water wells, onsite waste water systems or connecting homes to community water, and waste water facilities. The universe of need includes upgrading existing water supply and waste disposal facilities.

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 all federally recognized AI/AN communities; the sanitation deficiencies include needed water, sewer, and solid waste facilities for existing AI/AN homes. 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.

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 serve existing housing are annually prioritized with tribal input, then funded in priority order.

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 who will be served, and construction is performed by either the IHS or the Tribes. 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.

PROGRAM ACCOMPLISHMENTS

SFC is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated for SFC to provide potable water and waste disposal facilities for AI/AN people and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have been reduced by about 80 percent since 1973. Research supported by the Centers for Disease Control and Prevention state populations in regions with lower proportion of homes and absent of 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 SFC Program works collaboratively with tribes to assure all communities and homes are provided with safe and adequate water supply systems and sanitary sewage disposal systems as soon as possible.

In FY 2016, IHS provided service to 22,898 AI/AN homes with an average project duration of 3.4 years. However, at the end of FY 2016 about 26,772, or 5.7 percent of all AI/AN homes were without access to adequate sanitation facilities; and, about 171,674 or approximately 43 percent of AI/AN homes 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.

The total sanitation facility need in FY 2017, as reported through the SDS, continues to be adjusted and is expected to decrease, but will still be approximately $3.0 billion. The reason for this decrease is attributed to the SFC program's focus on improving quality of the data reported through the SDS process for the past few years. This effort focused on ensuring the sanitation facilities needs included in SDS were:

- Adequately documented
- Reflected an update of current needs
- Included only sanitation facilities fundable by the SFC program and within the intent of the IHCIA

[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] 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 from 2005 to 2016 has increased over 80 percent from $1.86 billion to $3.38 billion. As a result of the SFC program's data quality initiative, the sanitation facility need is not expected to continue trending up. However, the underlying challenges of construction inflation, population growth, an increasing number of regulations, and failing infrastructure, still significantly influence sanitation facility needs across Indian country. Failing infrastructure is presumably the largest factor, a result of inadequate operations 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.

Additionally, to ensure appropriate funds are expediently and efficiently utilized to construct sanitation facilities serving Indian-occupied homes, the SFC program will continue to obligate funds to construction projects that are '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.

In FY 2018, the program will continue to examine and improve data quality of the reported home and community sanitation facility needs and will continue its focus on maintaining average project duration to less than 4 years.

FUNDING HISTORY

Fiscal Year	Amount
2014	$79,423,000
2015	$79,423,000
2016	$99,423,000
2017 Annualized CR	$99,234,000
2018 President's Budget	$75,423,000

BUDGET REQUEST

The FY 2018 President's budget submission for Sanitation Facilities Construction of $75,423,000 is $23,811,000 below the FY 2017 Annualized Continuing Resolution (CR) base level.

This level of funding provides for the following allocation categories:

- Approximately $37.9 million may be distributed to the Areas for prioritized projects to serve existing homes, based on a formula that considers, among other factors, the cost of facilities to serve existing homes that: (a) have not received sanitation facilities for the first time, or (b) are served by substandard sanitation facilities (water and/or sewer). Another 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.

  From this distribution, up to $5.0 million may be used for projects to clean up open dump sites on Indian lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994[3], pending coordination with the EPA on oversight and evaluation of tribal solid waste management programs.

[3] Indian Lands Open Dump Cleanup Act of 1994 Pub. L.103-399, Oct. 22, 1994, 108 Stat. 4164 (25 U.S.C. 3091et seq.)

- Approximately $37 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.[4] 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 the first bullet of this section.

- Up to $523,000 may be reserved at IHS Headquarters and be distributed to Areas to address water supply and waste disposal emergencies caused by unanticipated situations that require immediate attention to minimize potential threats to public health. Emergency funds remaining at the end of the fiscal year may be distributed to Areas to address the SDS priority list of needs.

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.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
35 Number of new or like-new and existing AIAN homes provided with sanitations facilities. (Outcome)	FY 2016: 22,898 Target: 18,710 (Target Exceeded)	20,000	17,500	-2,500
SFC-3 Percentage of AI/AN homes with sanitation facilities. (Outcome)	FY 2016: 93.3 % Target: 92 % (Target Exceeded)	Retire after 2016	Retire after 2016	N/A
SFC-E Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. (Outcome)	FY 2016: 3.41 yrs Target: 3.5 yrs (Target Exceeded)	3.5 yrs	3.5 yrs	Maintain

GRANT AWARDS – This Program has no grant awards.

[4] 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.

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

HEALTH CARE FACILITIES CONSTRUCTION

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$105,048	$104,848	$100,000	-$4,848
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 2018 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 staff quarters where no suitable housing alternatives are available. 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 small ambulatory care facilities projects, and provide funding to construct new and replacement dental units.

The construction and modernization of IHS infrastructure through the health care facilities construction program is essential to ensure the IHS commitment to the Department of Health and Human Services Strategic Objectives 1.2: Increase health care service availability and accessibility; and 1.3: Improve health care quality, safety, cost and value. 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, in consultation with the Tribes, the IHS revised 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 $2.3 billion as of April 2016. The reauthorization of the Indian Health Care Improvement Act (IHCIA) includes a provision stating "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 $14.5 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 their own funds, through financing, grants, contributions, or a combination thereof, for the construction of their 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. In the next three years the HCFC Program is working with Tribes/Health Corporations to complete 7 JVCP projects

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. With the increase in facility size comes more healthcare providers and exam rooms, dentists and dental chairs, improved imaging systems, and expanded or new health 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 compliments IHS programs. Tribes typically provide land, at no cost to the Federal Government, for the new or replacement health care facility.

The JVCP has saved the Federal Government over $1.15 billion dollars in capital expenses since its inception. The outcome of the JVCP provides the same accomplishments as described above.

The FY 2016 appropriation completed funding for the Gila River Community Health Center near Chandler, AZ; and contributed to the Phoenix Indian Medical Center NE Health Center, Phoenix, AZ; the Rapid City Health Center, Rapid City, SD; and the Dilkon Alternative Rural Health Center, Dilkon, AZ.

In FY 2016 the following health organizations entered into a Joint Venture with IHS:

1. Cherokee Nation for the W.W. Hastings Regional Health Center in Tahlequah, Oklahoma
2. Yukon Kuskokwim Health Corporation for the Yukon-Kuskokwim Primary Care Center in Bethel, Alaska

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
2014	$85,048,000
2015	$85,048,000
2016	$105,048,000
2017 Annualized CR	$104,848,000
2018 President's Budget	$100,000,000

BUDGET REQUEST

The FY 2018 President's Budget submission for Health Care Facilities Construction of $100,000,000 is $4,848,000 below the FY 2017 Annualized CR base level.

FY 2018 Funding of $100,000,000 provides funding for the following Health Care Facilities Construction projects:
- Rapid City Health Center, Rapid City, SD, to complete construction.
- Dilkon Alternative Rural Health Center, Dilkon, AZ, to continue construction.
- Alamo Health Center, Alamo, NM, for design/build activities.

Rapid City Health Center, Rapid City, SD $45,000,000

These funds will be used to complete construction of the health care facility to replace the Sioux San Hospital with a new 200,000 GSF health center at today's medical standard. This project includes funding for refurbishing historic buildings and mitigation of historic buildings that will be demolished. The proposed new ambulatory health care center will serve a projected user population of 21,544 generating 52,195 primary care provider visits and 104,233 outpatient visits annually. It will be a modern, technologically advanced facility with enough space and staff to provide an expanded level of health care services specifically designed to meet the health care needs of the Rapid City Service Unit. 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 FY 2018 requested amount for Rapid City Health Center will complete the facility construction and is in addition to the funding from the Nonrecurring Expenses Fund allocated for this facility in prior years.

Dilkon Alternative Rural Health Center, Dilkon, AZ $50,000,000

These funds will be used to continue construction of the alternative rural health center with 8 short stay beds and 109 staff quarters located in Dilkon, Arizona. The proposed new facility will consist of 150,000 GSF outpatient health center and serve a projected user population of 17,195 generating 61,633 primary care provider visits and 123,080 outpatient visits annually. The new facility will provide an expanded outpatient department, community health department, and a full array of ancillary and support services. This FY 2018 request for Dilkon Alternative Rural Health Center is in addition to the funding from the Nonrecurring Expenses Fund allocated for this facility in prior years.

Alamo Health Center, Alamo, NM $5,000,000

These funds will be used for design-build activities of the health center and 33 staff quarters located in Alamo, New Mexico. The proposed new facility will consist of a 55,000 GSF outpatient health center and serve a projected user population of 2,500 generating 9,400 primary care provider visits and 18,080 outpatient visits annually. The facility will

provide an expanded outpatient and community health department, and a full array of ancillary and support services.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
36 Health Care Facility Construction: Number of health care facilities construction projects completed. (Outcome)	FY 2016: 1 projects Target: 1 projects[1] (Target Met)	0 projects	2 projects[2]	+2 projects
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 2016: 0 Target: 0 (Target Met)	0	2	+2

GRANT AWARDS – Program has no grant awards.

[1]The health care facility completed in FY 2016 was the Southern California Youth Regional Treatment Center in Hemet, CA.

[2]The health care facilities scheduled to be completed in FY 2018 are the Gila River Health Care Center in Sacaton, AZ, and the Fort Yuma Health Center in Winterhaven, CA.

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$222,610	$222,187	$192,022	-$30,165
FTE*	1,074	1,077	1,077	0

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

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
Detail Breakout of FEHS Activity	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$222,610	$222,187	$192,022	-$30,165
Facilities Support	*$133,129*	*$132,706*	*$102,541*	*-$30,165*
Environmental Health Support	*$73,202*	*$73,202*	*$73,202*	*$0*
Office of Environmental Health and Engineering Support	*$16,279*	*$16,279*	*$16,279*	*$0*
FTE	1,074	1,077	1,077	0
Facilities Support	*600*	*603*	*603*	*0*
Environmental Health Support	*405*	*405*	*405*	*0*
Office of Environmental Health and Engineering Support	*69*	*69*	*69*	*0*

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 2018 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 costs, funding under this activity is used for utilities, certain non-medical supplies and personal property, and biomedical equipment repair.

FUNDING HISTORY

Fiscal Year	Amount
2014	$211,051,000
2015	$219,612,000
2016	$222,610,000
2017 Annualized CR	$222,187,000
2018 President's Budget	$192,022,000

BUDGET REQUEST

The FY 2018 budget submission for the Facilities & Environmental Health Support Account of $192,022,000 is $30,165,000 below the FY 2017 Annualized Continuing Resolution (CR) base level.

Within the funding level provided, $2,022,000 will support Staffing for New Facilities.

Staffing for New Facilities FY (2018) +$2,022,000 - 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 critical health care needs. The following table displays this request.

Staffing and Operating Costs for New/Replacement Facility	Amount	Tribal Pos
Choctaw National Regional Medical Center (JV), Durant, OK	$1,556,000	7
Flandreau Health Center (JV), Flandreau, SD	$466,000	3
FY 2018 Total	**$2,022,000**	**10**

This level of funding provides for the following allocation categories:

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 Agency's priorities including: (1) people; (2) partnerships; (3) quality; and (4) resources.

The IHS owns approximately 9,920,000 square feet of facilities (totaling 2,110 buildings) and 1,770 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 160 years, with an average age greater than 37 years. A professional and fully-functional workforce is essential to ensure effective and efficient operations. 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 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.

PROGRAM ACCOMPLISHMENTS

In FY 2016, total utility costs were $22.3 million and total utility costs per Gross Square Feet (GSF) was $3.99/GSF. In FY 2018, the total utility cost is expected to be $23.0 million reflecting a 3.25 percent annual increase. The cost per GSF is expected to rise to approximately $4.12/GSF. IHS has made conscious efforts to help stem the growth in utility costs to ensure appropriations are sufficient to fund these needs. For example, IHS reduced the energy related utility consumption for IHS managed facilities from 199,649 British Thermal Units per Square Foot (BTU/SF) in 2003 to 143,482 BTU/SF in 2016, a 28.1 percent reduction.

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.

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, environmental health technicians, 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. 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 by about 80 percent since 1973. Research supported by the Centers for Disease Control and Prevention

state populations in regions with lower proportion of homes and absent of 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 staff work collaboratively with tribes to assure all communities and homes are provided with safe water supply and waste disposal systems as soon as possible. Under this program in FY 2016, staff managed and/or provided professional engineering services to construct 458 sanitation projects with a total cost of over $198.0 million 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," $1.0 million of these support funds are used for technical assistance, training, and guidance to Indian families and communities regarding the operation and maintenance of essential 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.

- Environmental Health Services Program (EHS) –The EHS program identifies environmental hazards and risk factors in Tribal communities and proposes control measures to prevent adverse health effects. These measures include monitoring and investigating disease and injury; inspections to identify environmental hazards in homes, healthcare facilities, food service establishments, Head Start centers, and many other types of Tribal establishments; and providing training, technical assistance, and project funding (including competitive

[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.

cooperative agreements) to develop the capacity of Tribal communities to address environmental health issues. National priority areas include: food safety, children's environments, healthy homes, vector borne and communicable disease, and safe drinking water.

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 community disease outbreaks from multiple patient exposures to contaminated food or water.

EHS created and supports the IHS Incident Reporting System – WebCident which is used to record, document case investigation, and analyze worker injuries, patient safety events (falls, medication errors, and medication near miss events), hazardous conditions, property damage, and security events. This information is crucial for assessing and improving patient care and providing a safe environment for patients, healthcare workers, and visitors. Through its Institutional Environmental Health Program (IEH), the EHS Program identifies environmental 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 healthcare accreditation which improves the quality of care. Maintaining accreditation ensures that IHS continues to have access to third-party funding.

PROGRAM ACCOMPLISHMENTS

Through OEHE staff accomplishments the need for direct healthcare services is diminished when environmentally related diseases and injuries are reduced. For example, the IHS Injury Prevention Program has been instrumental in reducing the injury mortality rate of AI/ANs by 58 percent since it moved from an "education only" focus to a public health approach based upon effective strategies and initiatives to reduce the devastating burden of injuries experienced by AI/ANs. Preventing severe, debilitating injuries reduce 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.

Staff collaborate with IHS and Tribal behavioral health programs in supporting suicide and violence prevention initiatives. Examples include initiatives for training students and teachers on suicide prevention and bullying prevention measures and more recent involvement in efforts supporting prevention of prescription drug overdose.

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, environmental compliance, fire safety, chemical safety, and radiation safety are accessed and recommendations for corrective action are provided.

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 food-borne (i.e., salmonellosis), vector-borne (i.e., Rocky Mountain spotted fever, hantavirus), and water-borne (i.e. legionellosis) disease outbreaks. Other examples of collaboration include arbovirus surveillance activities related to Zika virus and West Nile virus and public health emergency preparedness.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
EHS-3 Injury Intervention: Occupant protection restraint use (Outcome)	FY 2016: 64[4] Target: 64 (Baseline)	Develop and implement interventions	Develop and implement interventions	Maintain
EHS-4 Environmental Surveillance (Outcome)	FY 2016: 5.7[5] Target: 5.7 (Baseline)	Develop and implement interventions	Develop and implement interventions	Maintain

Performance Discussion

Injury Intervention: During the 2016-2020 performance cycle, in FY 2016, Area EHS Programs identified targeted communities from which a national baseline measure of seatbelt use was developed. For the FY 2017 target, Area programs will implement comprehensive interventions using at least three effective strategies to increase seatbelt usage rate in targeted Tribal communities.

Environmental Surveillance: During the 2016-2020 performance cycle, in FY 2016, Area EHS Programs identified targeted Tribal Head Start and non-residential day care establishments from which a national baseline of foodborne illness risk factors was calculated. For the FY 2017 target, Areas will implement and report comprehensive interventions using at least three effective strategies to decrease food risk factor deficiencies at targeted Tribal Head Start and non-residential day care establishments

The FY 2016 – 2020 EHS performance measures focus on reducing the risk of foodborne illness in children's environments and reducing the risk of motor vehicle-related injuries and deaths through increased use of seatbelts. Barriers that may impact the program's ability to meet these targets include competing local, regional and national priorities, staff turn-over, lapsed vacant positions, and a decentralized approach to program management that can result in non-standardized processes across the country. To help mitigate these barriers, EHS provides ongoing competency development through specialized training programs; strategic planning efforts that support uniform program management; and data management tools to support local staff.

[4] 64 percent of drivers use seat belts.

[5] 5.7 percent out of compliance.

GRANT AWARDS

In 2015, all previous injury prevention cooperative agreements came to an end and a new cycle was awarded. The Injury Prevention Program awarded $1,008,224 in cooperative agreements to fund 23 Tribal programs. In 2016, 23 Tribal programs were awarded $880,000 in cooperative agreements.

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 critical 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)
- and 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. Also, announcements and review of joint venture and small ambulatory projects which represent quality health care infrastructure which addresses assessing health care and improving health care delivery including behavioral health services which are included during the planning process. 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. 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 both 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 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$22,537	$22,494	$19,511	-$2,983
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 2018 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 $500 million. With today's medical devices/systems having an average life expectancy of approximately six 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-year life would require approximately $84.0 million per year.

Equipment Funds Allocation Method

The IHS Equipment funds are allocated in three categories: Tribally-constructed health care facilities, TRANSAM program, 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. The Budget Request supports approximately $4.45 million for competitive awards to Tribes and Tribal organizations that construct new or expand health care facilities space using non-IHS funding sources. This amount is a reduction of $550,000 from prior year. Tribes and Tribal Organizations will use these funds to serve approximately 500,000 patients with newly purchased medical equipment.

2. TRANSAM and Ambulance Programs – 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] The Budget includes $450,000 for the TRANSAM Program from the Equipment budget. Under the TRANSAM Program, excess equipment and supplies, at an annual estimated value of $5.0 million, are acquired for distribution to federal and Tribal sites. No funding for the Ambulance program is allocated in the Budget as IHS transitions to full-cost GSA leased ambulances.

3. New and Replacement Equipment –Approximately $14.6 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
2014	$22,537,000
2015	$22,537,000
2016	$22,537,000
2017 Annualized CR	$22,494,000
2018 President's Budget	$19,511,000

BUDGET REQUEST

The FY 2018 President's Budget submission for Equipment of $19,511,000 is $2,983,000 below the FY 2017 Annualized Continuing Resolution (CR) base level.

This level of funding provides for the following allocation categories:

- Approximately $14.611 million for new and routine replacement medical equipment to over 1,500 federally and tribally-operated healthcare facilities;
- $4.450 million for new medical equipment in tribally-constructed health care facilities;
- $450,000 for the TRANSAM program; and
- $0 for the ambulance program.

These funds will be used for maintenance, upgrades, replacement, and the purchase of new medical equipment systems at IHS and Tribal healthcare facilities.

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 to deliver services.

GRANT AWARDS – This program has no grant awards.

[1] The IHS Facilities appropriation limits total expenditures up to $500,000 for equipment purchased through the TRANSAM Program and up to $2.7 million from Services and Facilities appropriations for purchasing ambulances.

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

PERSONNEL QUARTERS / QUARTERS RETURN FUNDS

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$8,500	$8,500	$8,500	$0
FTE*	37	37	37	0

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

*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; Public Law 98-473, Sec. 320, as amended

FY 2018 Authorization.....Permanent

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

PROGRAM DESCRIPTION

When available housing is limited in the area of Indian Health Service (IHS) health care facilities, staff quarters are provided to assist with recruitment and retention of health care providers. The operation, maintenance, and improvement costs of the staff quarters are funded with this funding designated as Quarters Return (QR) funds, i.e., the rent collected from tenants residing in the quarters. The use of the funds includes maintenance personnel services, security guard services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (e.g., stoves, water heaters, furnaces, etc.). In certain situations, Maintenance and Improvement Program funds may be used, in conjunction with QR funds, to ensure adequate quarters' maintenance. For example, this may be necessary in locations with few quarters where QR funds are insufficient to pay for all required maintenance costs.

FUNDING HISTORY

Fiscal Year	Amount
2014	$8,000,000
2015	$8,000,000
2016	$8,500,000
2017 Annualized CR	$8,500,000
2018 President's Budget	$8,500,000

BUDGET REQUEST

The FY 2018 Quarters Return budget submission for Rent Collections of $8,500,000 is the same as the FY 2017 Annualized Continuing Resolution (CR) base level for anticipated rental collections. Rental rates are established in accordance with OMB Circular A-45 and adjusted annually based on the national Consumer Price Index (CPI).

This level of funding for Anticipated Rent Collections provides for the following:

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

OUTPUTS / OUTCOMES - This program measures outcomes through the inventory of staff quarters.

GRANT AWARDS – This program has no grant awards.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2018 Performance Budget Submission to Congress

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

SPECIAL DIABETES PROGRAM FOR INDIANS

(Dollars in Thousands)

	FY 2016	FY 2017	FY 2018	
	Final	Annualized CR	President's Budget	FY 2018 +/- FY 2017
BA	$150,000	$147,000	$150,000	+$3,000
FTE*	32	32	32	0

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

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. H.R. 2 – The Medicare Access and CHIP Reauthorization Act of 2015 authorized SDPI for FY 2016 and FY 2017. The program authorization is set to expire after FY 2017.

FY 2018 Authorization..... Expires FY 2017

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 2017 is the 20th year of the SDPI. SDPI operates with a budget of $150 million per year that is currently authorized through FY 2017. 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. 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 (15.9 percent) among all racial and ethnic groups in the United States, more than twice the rate of

the non-Hispanic white population (7.6 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 in AI/ANs. 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.

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.

This collaborative approach supports the strategic planning process necessary to identify the goals and objectives needed to achieve the intended SDPI outcomes. This process aligns with the IHS priorities to renew and strengthen partnerships with Tribes and also to improve access to quality health care.

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.

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[1] Centers for Disease Control and Prevention (CDC). *National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2014.* Atlanta, GA: U.S. Department of Health and Human Services; 2014. *Available at*:http://www.cdc.gov/diabetes/data/statistics/2014statisticsreport.html

[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.

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 proven 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. The SDPI has incorporated these Indian Health Diabetes Best Practices into the SDPI grant application process used throughout AI/AN communities. 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:

Diabetes treatment and prevention services available to AI/AN individuals	Access in 1997	Access in 2015	Absolute Percentage increase
Diabetes clinics	31%	64%	+33%
Diabetes clinical teams	30%	97%	+67%
Diabetes patient registries	34%	89%	+55%
Nutrition services for adults	39%	83%	+44%
Access to registered dieticians	37%	68%	+31%
Culturally tailored diabetes education programs	36%	95%	+59%
Access to physical activity specialists	8%	73%	+65%
Adult weight management programs	19%	73%	+54%

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 8.1 percent in 2016, nearing the A1C goal for most patients of less than 8 percent.
- *Improving Blood Lipid Levels*

[3] *Available at* https://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=toolsBP_New

Average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 92 mg/dL in 2016, 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. SDPI supports the development and implementation of the IHS Electronic Health Record, and the IHS Diabetes Management System in all 12 IHS Areas.

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 2016 Diabetes Audit included a review of 122,051 patient charts at 332 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 levels. 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 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 five 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; and
- 2014 SDPI Report to Congress: Changing the Course of Diabetes: Turning Hope into Reality.

[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.

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)
Original Community-Directed Grants – now called SDPI Grant Programs (272 Tribal and IHS grants, sub-grants, and technical assistance in FY 2017). • Number and amounts of grants awarded increased in FY 2016 due to the competitive application process and the merger of the SDPI Diabetes Prevention and Healthy Heart (DP/HH) Initiative program into the SDPI C-D grant program.	**86.8%**	**$130.2**
Administration of SDPI grants (includes program support funds to IHS Areas, Tribal Leaders Diabetes Committee, DDTP, Grants Management, evaluation support contracts, etc.)	**4%**	**6.1**
Urban Indian Health Program SDPI Grant Programs ($8.5M allocated to 29 grants and technical assistance in FY 2017) • Increase of $1 million compared to FY 2015	**5.7%**	**8.5**
Funds to strengthen the Data Infrastructure of IHS	**3.5%**	**5.2**
TOTAL:	**100%**	**$150.0**

BUDGET REQUEST

The SDPI is currently authorized through September 30, 2017, under P.L. 114-10, the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) of 2015. The FY 2018 request for the SDPI is $150 million. The distribution of funding is shown in the grant tables that follow.

OUTPUTS / OUTCOMES

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
2 American Indian and Alaska Native patients with diagnosed diabetes achieve Good Glycemic Control (A1c Less than 8.0%). (Outcome)	FY 2016: 46.9 % Target: 49.5 % (Target Not Met)	48.4 %	Retire after 2017	N/A
2 Tribally Operated Health Programs (Outcome)	FY 2016: 49.2 % Target: 52.5 % (Target Not Met)	51.4 %	Retire after 2017	N/A
3 Diabetes: Blood Pressure Control: Proportion of patients with diagnosed diabetes that have achieved	FY 2016: 68.3 % Target: 65 % (Target Exceeded)	63.8 %	Retire after 2017	N/A

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2017 Target	FY 2018 Target	FY 2018 Target +/-FY 2017 Target
blood pressure control (<140/90). (Outcome)				
3 Tribally Operated Health Programs (Outcome)	FY 2016: 67 % Target: 64.3 % (Target Exceeded)	62.5 %	Retire after 2017	N/A
50 DM Statin Therapy (Intermediate Outcome)	FY 2016: 61.9 % Target: 61.9 % (Baseline)	61.9 %	Retire after 2017	N/A
50 TOHP DM Statin Therapy (Intermediate Outcome)	FY 2016: 61.7 % Target: 61.7 % (Baseline)	61.7 %	Retire after 2017	N/A
52 Good Glycemic Control (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 36.2 %(Pending)	N/A	36.2 %	N/A
53 Controlled BP <140/90 (Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 52.3 % (Pending)	N/A	52.3 %	N/A
54 Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes (Intermediate Outcome)	FY 2018: Result Expected Jan 31, 2019 Target: 37.5 % (Pending)	N/A	37.5 %	N/A

GRANTS AWARDS

The SDPI provides grants for diabetes treatment and prevention services to IHS, Tribal and Urban Indian health programs in 35 states. The SDPI grant programs provide local diabetes treatment and prevention services based on community needs.

(whole dollars)	FY 2016 Final	FY 2017 Annualized CR	FY 2018 President's Budget
Number of Awards	301 (includes sub-grants)	301 (includes sub-grants)	301 (includes sub-grants)
Average Award	$452,076	$452,076	$452,076
Range of Awards	$19,394 - $7,553,570	$19,394 - $7,553,570	$19,394 - $7,553,570

*Number and amounts of grants awarded in FY 2016 and FY 2017 will be different from FY 2015 due to the FY 2016 competitive application process and the conclusion of the SDPI DP/HH grant programs at the end of FY 2015.

FY 2016 Mandatory State/Formula Grants

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2017 Annual Financial Assistance Awards								
State	State Name	FY 98 – FY 15 Total # Grant Programs	FY 16 Total # Grant Programs	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget*	Difference # +/- FY 2016 – FY 2015	Difference $ +/- FY 2016 – FY 2015
AK	Alaska	25	19	$8,927,252	$10,191,326	$10,191,326	-6	+$1,264,074
AL	Alabama	1	1	207,422	276,249	276,249	0	+68,827
AZ	Arizona	33	27	26,284,093	28,338,793	28,338,793	-6	+2,054,700
CA	California	42	39	8,714,164	9,740,219	9,740,219	-3	+1,026,055
CO	Colorado	3	3	728,212	903,625	903,625	0	+175,413
CT	Connecticut	2	2	195,466	232,550	232,550	0	+37,084
FL	Florida	2	2	526,853	479,662	479,662	0	-47,191
IA	Iowa	1	1	254,197	304,592	304,592	0	+50,395
ID	Idaho	4	4	760,150	935,841	935,841	0	+175,691
IL	Illinois	1	1	226,282	281,832	281,832	0	+55,550
KS	Kansas	6	5	366,961	937,919	937,919	-1	+570,958
LA	Louisiana	4	4	307,833	367,019	367,019	0	+59,186
MA	Massachusetts	2	2	67,506	168,477	168,477	0	+100,971
ME	Maine	5	5	460,160	543,068	543,068	0	+82,908
MI	Michigan	13	12	2,128,707	2,363,824	2,363,824	-1	+235,117
MN	Minnesota	13	8	3,287,642	3,274,552	3,274,552	-5	-13,090
MS	Mississippi	1	1	1,029,119	1,227,316	1,227,316	0	+198,197
MT	Montana	17	10	5,512,348	5,564,865	5,564,865	-7	+52,517
NE	Nebraska	5	5	1,590,573	1,931,172	1,931,172	0	+340,599
NV	Nevada	14	14	2,941,217	5,203,730	5,203,730	0	+2,262,513
NM	New Mexico	31	29	6,938,491	13,190,620	13,190,620	-2	+6,252,129
NY	New York	4	3	1,176,338	1,310,560	1,310,560	-1	+134,222
NC	North Carolina	1	1	1,184,081	1,340,392	1,340,392	0	+156,311
ND	North Dakota	8	5	2,643,997	3,168,173	3,168,173	-3	+524,176
OK	Oklahoma	34	27	17,649,873	23,460,585	23,460,585	-7	+5,810,712
OR	Oregon	14	9	1,799,861	1,832,727	1,832,727	-5	+32,866
RI	Rhode Island	1	1	94,684	112,563	112,563	0	+17,879
SC	South Carolina	1	1	136,424	161,201	161,201	0	+24,777
SD	South Dakota	14	9	5,399,117	6,014,473	6,014,473	-5	+615,626
TN	Tennessee	2	1	79,915	130,002	130,002	-1	+50,087
TX	Texas	4	4	575,946	789,528	789,528	0	+213,582
UT	Utah	7	5	1,449,293	2,051,292	2,051,292	-2	+601,999
WA	Washington	34	27	3,892,836	4,792,337	4,792,337	-7	+899,501
WI	Wisconsin	13	12	3,062,885	3,421,213	3,421,213	-1	+358,328

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2017 Annual Financial Assistance Awards								
State	State Name	FY 98 – FY 15 Total # Grant Programs	FY 16 Total # Grant Programs	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget*	Difference # +/- FY 2016 – FY 2015	Difference $ +/- FY 2016 – FY 2015
WY	Wyoming	3	2	747,878	1,032,196	1,032,196	-1	+284,318
	Total States	**365**	**301**	**$111,347,776**	**$136,074,763**	**$136,074,763**	**-64**	**+$24,726,987**
	Indian Tribes**	**286**	**252**	**$92,603,859**	**$111,111,398**	**$111,111,398**	**-**	**-**

* Number and amounts of grants awarded in FY 2016 and FY 2017 will be different from FY 2015 due to the FY 2016 competitive application process and the conclusion of the SDPI DP/HH grant programs at the end of FY 2015.

**This is the number tribes that are primary grantees or sub-grantees.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2018 Performance Budget Submission to Congress

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Drug Budget

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Drug Control Budget
FY 2018

	Budget Authority (in Millions)		
	FY 2016 Final	**FY 2017 Annualized CR**	**FY 2018 President's Budget**
Drug Resources by Function			
Prevention	23.418	23.395	23.418
Treatment	81.291	81.541	81.684
Total Drug Resources by Function	**$104.709**	**$104.936**	**$105.102**
Drug Resources by Decision Unit			
Alcohol and Substance Abuse	101.498	101.332	101.498
Urban Indian Health Program	3.211	3.604	3.604
Total Drug Resources by Decision Unit	**$104.709**	**$104.936**	**$105.102**
Drug Resources Personnel Summary			
Total FTEs (direct only)	171	171	171
Drug Resources as a Percent of Budget			
Agency Budget	$ 6,159.666	$ 6,150.527	$5,991.368
Drug Resources Percentage	1.70%	1.71%	1.75%

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 Indians and Alaska Natives (AI/AN). 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 Program (UIHP) funds from the National Institute on Alcohol Abuse and Alcoholism programs transferred to the IHS under the UIHP budget.

BUDGET SUMMARY

In FY 2018, IHS requests $105.102 million for its drug control activities, an increase of $166,000 over the FY 2017 Annualized Continuing Resolution.

Alcohol and Substance Abuse
FY 2018 Request: $101.498 million

The FY 2018 budget request is necessary to maintain the program's progress in addressing the 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.

Urban Indian Health Program – Alcohol and Substance Abuse Title V Grants
FY 2018 Request: $3.6 million
(Flat with FY 2017)

The FY 2018 request includes funding for the Urban Indian Health Program which will be used to continue serving urban AI/ANs impacted by alcohol and substance abuse through the Title V grant program, Alcohol and Substance Abuse Prevention and Treatment. Substance abuse prevention, treatment, and education programs address alcohol/drugs, suicide, self-esteem, injury control, domestic violence, and sexual abuse. All Urban Indian Health Programs have active partnerships with their local Veterans Health Administration programs and several have identified joint alcohol and substance abuse initiatives.

ONDCP FUNDING PRIORITIES

In FY 2018, the IHS budget request for its drug control activities supports the Office of National Drug Control Policy's (ONDCP) funding priorities.

IHS established a multi-disciplinary workgroup to focus on Prescription Drug Abuse in Indian Country in 2012. In March 2017, IHS elevated its workgroup to a National Committee on Heroin, Opioids, and Pain Efforts (HOPE Committee) comprised of multidisciplinary team members with pharmacy, medical, nursing, and behavioral health professional backgrounds. The HOPE Committee will work from a framework based on six tenets: 1) Establishing IHS policies; 2) Training Health Care Providers; 3) Ensuring Effective Pain Management; 4) Increasing Access to Naloxone; 5) Expanding Medication Assisted Treatment (MAT); and 6) Reducing the Inappropriate Use of Methadone.

IHS policy work includes establishing the Indian Health Manual (IHM) Chapter 30 "Chronic Non-Cancer Pain" and Chapter 32 "State Prescription Drug Monitoring Programs." The purpose of Chapter 30 is to assist IHS providers to provide prompt and effective assessment, diagnosis, and treatment of chronic non-cancer pain. In 2016, IHS Implemented IHM Chapter 32, a groundbreaking new policy regarding opioid prescribing which requires all healthcare providers working in IHS federal-government-operated facilities, including doctors, pharmacists, nurse practitioners and other providers who prescribe opioids, to check state Prescription Drug Monitoring Program databases prior to prescribing opioids for pain treatment longer than seven days and periodically throughout chronic pain treatment, one of the first such actions by any federal agency involved in direct medical care.

IHS implemented a mandatory training course, entitled "IHS Essential Training," for all Federal prescribers, contractors, residents and trainees who prescribe controlled substances and spend at least 50 percent of their time in a clinical setting. The purpose of this training is to assure that providers have the knowledge needed to appropriately and effectively prescribe controlled substance medications. As of December 2016, IHS had trained 96 percent of its providers who are required to attend the training. Many Tribal and Urban Indian providers have also taken

advantage of the no cost training. IHS will continue to offer the training on a regular basis to capture new employees who require training, as well as offer refresher courses every three years.

To assist providers as they provide effective and optimal pain management, IHS developed two websites "Opioid Use Disorder Management" available at https://www.ihs.gov/odm and "Pain Management," available at https://www.ihs.gov/painmanagement which provide resources, current clinical guidelines, and best practices for providers in the Indian health system. IHS, in partnership with the University New Mexico Pain Center, provides IHS, Tribal, and Urban Indian providers with weekly, real-time consultation with experts in the field of pain management and additional web-based educational services.

To increase access to naloxone, IHS signed a memorandum of agreement with Bureau of Indian Affairs (BIA). The agreement allows IHS to provide BIA officers with training and naloxone rescue kits for responding to incidents of opioid overdose. This partnership has put naloxone in the hands of law enforcement officers, who are often the first responders to incidents of opioid overdose in Tribal communities. As of December 2016, IHS trained and provided emergency naloxone kits to 284 BIA law enforcement officers.

IHS is working to increase access to MAT, the use of medications with counseling and behavioral therapies, to treat opioid use disorders. IHS is currently working to increase the number of primary care providers who have been trained to prescribe MAT. IHS provided waiver training in the Bemidji area in 2016 and plans to host additional onsite waiver trainings in FY 2017.

IHS is actively working to reduce the use of methadone for pain management. Recent guidelines released by the Centers for Disease Control and Prevention pointed to several studies showing that the use of methadone in the treatment of chronic pain was associated with a much higher number of overdose deaths compared to other opioid pain relievers and therefore recommended against using it as a first line medication for the treatment of pain. IHS is currently updating policies to align with this recommendation and providing training to Indian health system providers.

In FY 2018, IHS will continue to serve AI/ANs impacted by substance abuse and dependence through its Youth Regional Treatment Centers (YRTCs) and other IHS, Tribal, and Urban Indian operated substance abuse treatment and prevention programs. In addition to those direct services, the IHS Substance Abuse and Suicide Prevention Program (SASP) (formerly known as the Methamphetamine and Suicide Prevention Initiative, or MSPI) is a nationally-coordinated grant program, focusing on providing targeted substance abuse and suicide prevention and intervention resources to communities in AI/AN communities with the greatest need for these programs. There is mutual development and implementation of the SASP with Tribes, Tribal programs, urban Indian organizations, and other Federal agencies which now provides support nationally. The strategic goal is to support Tribal programs in their continued substance use prevention, treatment, and recovery services. 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.

IHS continues to support the integration of substance abuse treatment into primary care and emergency services through its activities to implement Screening, Brief Intervention, and Referral to Treatment (SBIRT). IHS has incorporated SBIRT as a national measure to be tracked and reported.

The IHS provides several training opportunities annually on alcohol and substance abuse issues for its providers. In FY 2016, the TBHCE, in partnership with the University of New Mexico, provided more than 15,000 hours of training on current and pressing behavioral health issues through a series of webinars, including a concentrated focus on substance use disorders with topics including: Introduction to Addiction; Opioid Dependence; Chronic Pain and Depression; Anxiety and Chronic Pain; Fibromyalgia; Chronic Pain and Neurology; Epidemiology of Chronic Pain; Non-Opioid Pain Medication; Screening for Misuse, Diversion, and Addiction; Buprenorphine; Medication Management; Screening for Opiate Addictions; Methadone - An Introduction; FASD; Naloxone and MAT for Opioid Dependence. To provide clinical support for providers, IHS launched weekly Pain and Addiction consultations, in partnership with the University of New Mexico. Healthcare providers may receive a no-cost consultation from an expert panel on the most challenging pain and addiction cases.

The TBHCE evaluates models of care delivery, access to care, and sustainability. A toolkit is available for sites to prepare the infrastructure for tele-behavioral health services. Intra-Agency agreements continue between the TBHCE and IHS Billings, Great Plains, Nashville, Navajo, Phoenix, and Tucson Areas. In FY 2016, over 10,000 patient encounters were provided nationally via tele-behavioral health. As IHS promotes the use of MAT programming, future development work includes options to expand tele-health for MAT maintenance.

In FY 2018, IHS will begin to track the number of naloxone prescriptions as part of our efforts to increase access to naloxone.

FY 2018 Changes (no change): IHS will continue to serve AI/ANs impacted by substance abuse and dependence through its YRTCs and other IHS, Tribal, and Urban Indian operated substance abuse treatment and prevention programs.

Indian Health Service		
Selected Measures of Performance	**FY 2016 Target**	**FY 2016 Achieved**
» Alcohol-use screening among appropriate female patients	Baseline	67.2%
» Accreditation rate for Youth Regional Treatment Centers in operation 18 months or more	100%	100%
» Report on number of emergency department patients who receive SUD intervention	44,554	39,737
Report on number of SUD services in primary care clinics	115,247	120,273

Information regarding the performance of the drug control efforts of IHS is based on agency GPRA/GPRAMA documents and other information that measures the agency's contribution to the *Strategy*. The table above and accompanying text below represent highlights of IHS's achievements during FY 2016, the latest year for which data are available. The selected performance measures reported in the table provide targets and results from both Tribally-Operated Health Programs and Federally-Administered Health Programs.

To provide more comprehensive routine screening, IHS expanded its Alcohol Screening measure to include all patients 12 through 75 years of age in FY 2017 and retired the Alcohol Screening measure for female patients. Additionally, IHS will report a new SBIRT measure with baseline results in 2017.

The accreditation measure for YRTCs reflects an evaluation of the quality of care associated with accreditation status by either the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), state certification, or regional Tribal health authority certification. For youth with substance use disorders, the YRTCs provide invaluable treatment services. The accreditation measure for YRTCs reflects an evaluation of the quality of care by either the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or State licensure.

The IHS monitors two program measures on the number of substance use disorder (SUD) encounters provided in emergency departments and primary care clinics. In FY 2018, IHS will include overall SUD encounters provided in all clinical settings across the health system to aid in promoting integrated SUD services. Tracking overall clinical SUD encounters will allow IHS to report on the effectiveness of IHS programs that focus on drug abuse. In FY 2016, the result for SUD encounters across all IHS clinics was 688,427 encounters.

Office of Urban Indian Health Programs

Urban Indian Organizations (UIO) are resources to both tribal and urban communities. UIO that offer inpatient and outpatient substance abuse treatment have become reliable referral sites for tribes. In FY 2018 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 UIO see their efforts in health education, health promotion, and disease prevention as essential to impacting the behavioral contributors to poor health[1]:

- 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.
- Tuberculosis death rates are 2 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. Alcohol-induced mortality rates for urban AI/AN are markedly higher than for urban all races. All regions,[2] with the exception of eastern seaboard cities in the Nashville Area, show dramatically higher rates for urban AI/AN 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 Aberdeen Area has a 13.4 times greater alcohol-induced rate of mortality[3].

Urban AI/AN populations are more likely to engage in health risk behaviors. Urban AI/AN are more likely to report heavy or binge drinking than all-race populations and urban AI/AN are 1.7 times more likely to smoke cigarettes. Urban AI/AN 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.

[1] Indian Health Service, Office of Urban Indian Health Programs, *Urban Needs Assessment Report*, 2015.
[2] Ibid.
[3]Indian Health Service, Office of Urban Indian Health Programs, *Urban Needs Assessment Report*, 2015

UIO emphasis on integrating behavioral health, health education, health promotion and disease prevention into primary care offered within a culturally appropriate framework, leads to positive outcomes for urban AI/AN. Urban AI/AN in need of substance abuse treatment commonly exhibit co-occurring disorders. UIO programs have recognized the need for more mental health and substance abuse counselors to adequately address the needs presented by AI/AN with co-occurring disorders. AI/AN need gender- and age-appropriate substance abuse treatment. Stakeholders reported the need for more age- and gender-appropriate resources for substance abuse treatment. While male AI/AN can encounter wait times for treatment admission up to 6 months, treatment options for youths, women, and women with children can be greater than 6 months. Some of the best AI/AN treatment programs for youth, women, and women with children are administered by UIO. Affecting lifestyle changes among urban AI/AN families requires a culturally sensitive approach. The existing UIO have operated culturally appropriate initiatives to reduce health risk factors. UIO continued efforts to target behavioral or lifestyle changes offer the best hope for impacting the major health challenges of the urban AI/AN population.

Fetal alcohol spectrum disorders (FASD) is used to describe a range of effects that can occur in someone whose mother consumed alcohol during pregnancy. FASD includes disorders such as fetal alcohol syndrome (FAS), alcohol-related neuro developmental disorder (ARND), and alcohol-related birth defects (ARBD). Interventions are needed in urban centers to address prevention efforts for urban AI/AN with a FASD. The IHS Policy on Conferring with Urban Indian Organizations identifies FASD as a provision that requires the IHS to confer with UIO “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 FAS. FAS is the leading and most preventable cause of intellectual disability. The rates of FAS are higher among AI/ANs than the general population. Screening with intervention has been shown to be effective in reducing alcohol misuse in pregnancy and to reduce the incidence of FAS.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2018 Performance Budget Submission to Congress

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Supplemental Tables

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FY 2017 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2016 Final	FY 2017 Annualized CR	FY 2018 Pres. Budget	FY 18 +/- FY 2017
DIRECT OBLIGATIONS				
Personnel Compensation:				
Full-Time Permanent(11.0).....	445,053	450,640	460,792	10,152
Other than Full-Time Permanent(11.3).....	19,818	20,069	20,542	473
Other Personnel Comp.(11.5).....	60,679	61,449	62,812	1,363
Military Personnel Comp (11.7).....	87,424	88,673	90,823	2,150
Special Personal Services Payments (11.8).....	243	243	259	16
Subtotal, Personnel Compensation.....	613,217	621,074	635,228	14,154
Civilian Personnel Benefits(12.1).....	174,217	176,400	180,345	3,945
Military Personnel Benefits (12.2)	37,199	37,732	38,643	911
Benefits to Former Personnel(13.0).....	1,432	1,432	1,444	12
Subtotal, Pay Costs.....	**826,065**	**836,638**	**855,660**	**19,022**
Travel(21.0).....	46,758	46,329	46,036	(293)
Transportation of Things(22.0).....	9,713	9,474	9,315	(159)
Rental Payments to GSA(23.1).....	16,269	15,844	15,594	(250)
Rental Payments to Others(23.2).....	992	967	949	(18)
Communications, Utilities and				
Miscellaneous Charges(23.3.....	28,180	27,649	27,385	(264)
Printing and Reproduction(24.0).....	103	99	94	(5)
Other Contractual Services:				
Advisory and Assistance Services(25.1).....	7,992	7,781	7,617	(164)
Other Services(25.2).....	176,838	176,361	176,388	27
Purchases from Govt. Accts.(25.3).....	69,915	68,509	67,766	(743)
Operation and Maintenance of Facilities(25.4)....	8,458	8,356	8,308	(48)
Research and Development Contracts(25.5).....	23	24	25	1
Medical Care(25.6).....	371,522	370,702	370,649	(53)
Operation and Maintenance of Equipment(25.7).	13,065	12,814	12,697	(117)
Subsistence and Support of Persons(25.8).....	17,027	16,879	16,804	(75)
Subtotal, Other Contractual Current.....	**664,840**	**661,426**	**660,254**	**(1,172)**
Supplies and Materials(26.0).....	99,691	99,440	99,634	194
Equipment (31.0).....	25,769	25,399	25,101	(298)
Land & Structures (32.0).....	107,411	107,194	102,335	(4,859)
Investments & Loans (33.0).....	0	0	0	0
Grants, Subsidies, & Contributions (41.0).....	2,263,533	2,251,095	2,178,675	(72,420)
Insurance Claims & Indemnities (42.0).....	251	247	246	(1)
Interest & Dividends (43.0).....	44	43	43	0
Subtotal Non-Pay Costs.....	**3,263,554**	**3,245,206**	**3,165,661**	**(79,545)**
Total, Direct Obligations.....	**4,089,619**	**4,081,844**	**4,021,321**	**(60,523)**

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

Object Class	FY 2017 Annualized CR	FY 2018 Pres. Budget	Increase or Decrease
Personnel Compensation:			
Full-Time Permanent (11.0)	450,460	460,792	10,332
Other than Full-Time Permanent (11.3)	20,069	20,542	473
Other Personnel Comp. (11.5)	61,449	62,812	1,363
Military Personnel Comp. (11.7)	88,673	90,823	2,150
Special Personnel Services Payments (11.8)	243	259	16
Subtotal, Personnel Compensation	620,894	635,228	14,334
Civilian Personnel Benefits (12.1)	176,400	180,345	3,945
Military Personnel Benefits (12.2)	37,732	38,643	911
Benefits to Former Personnel (13.0)	1,432	1,444	12
Total, Pay Costs	**836,458**	**855,660**	**19,202**
Travel (21.0)	13,094	12,801	(293)
Transportation of Things (22.0)	9,474	9,315	(159)
Rental Payments to Others (23.2)	967	949	(18)
Communications, Utilities & Misc. Charges (23.3)	27,649	27,385	(264)
Printing and Reproduction (24.0)	99	94	(5)
Other Contractual Services:			
Advisory and Assistance Services (25.1)	7,781	7,617	(164)
Other Services (25.2)	176,361	176,388	27
Purchases from Govt. Accts. (25.3)	68,509	67,766	(743)
Operation and Maintenance of Facilities (25.4)	8,356	8,308	(48)
Operation and Maintenance of Equipment (25.7)	12,814	12,697	(117)
Subsistence and Support of Persons (25.8)	16,879	16,804	(75)
Subtotal, Other Contractual	290,700	289,580	(1,120)
Supplies and Materials (26.0)	99,440	99,364	(76)
Total, Non-Pay Costs	**441,423**	**439,488**	**(1,935)**
Total Salaries & Expenses	1,277,881	1,295,148	17,267
Direct FTE	8,797	8,797	0

INDIAN HEALTH SERVICE
Detail of Full-Time Equivalents (FTE)

	FY 2016 Final	FY 2017 Annualized CR	FY 2018 PB
Headquarters			
Sub-Total, Headquarters	435	435	435
Area Offices			
Alaska Area Office	274	275	275
Albuquerque Area Office	1,058	1,061	1,061
Bemidji Area Office	546	547	547
Billings Area Office	968	970	970
California Area Office	95	95	95
Great Plains Area Office	2,197	2,203	2,203
Nashville Area Office	199	200	200
Navajo Area Office	4,059	4,069	4,069
Oklahoma City Area Office	1,653	1,657	1,657
Phoenix Area Office	2,589	2,596	2,596
Portland Area Office	511	512	512
Tucson Area Office	475	476	476
Sub-Total, Area Offices	14,624	14,661	14,661
Trust Funds (Gift)	23	23	23
TOTAL FTES	15,082	15,119	15,119

INDIAN HEALTH SERVICE
DETAIL OF PERMANENT POSITIONS

(Dollars in Thousands)

	FY 2016 Final	/FTE Addition	FY 2017 Annualized CR	/FTE Addition	FY 2018 Pres. Budget
Total - ES's	17		17		17
Total - ES Salaries	$3,139		$3,139		$3,139
GS/GM-15	423	1	424	0	424
GS/GM-14	42	0	42	0	42
GS/GM-13	457	1	459	0	459
GS-12	1,125	4	1,128	0	1,128
GS-11	1,379	4	1,383	0	1,383
GS-10	615	2	616	0	616
GS-9	1,308	4	1,312	0	1,312
GS-8	387	1	389	0	389
GS-7	1,216	4	1,219	0	1,219
GS-6	1,548	5	1,553	0	1,553
GS-5	2,063	6	2,070	0	2,070
GS-4	1,072	3	1,075	0	1,075
GS-3	175	1	176	0	176
GS-2	31	0	31	0	31
Subtotal	11,841	37	11,878	0	11,878
Total - GS Salaries	$649,422		$657,597		$672,441
Director Grade CO-06	412	0	412	0	412
Senior Grade CO-05	560	0	560	0	560
Full Grade CO-04	626	0	626	0	626
Senior Assistant Grade CO-03	288	0	288	0	288
Assistant Grade CO-02	28	0	28	0	28
Junior Grade CO-01	14	0	14	0	14
Subtotal	1,928	0	1,928	0	1,928
Total - CO Salaries	$124,623	10,922	$126,405	11,412	$129,466
Ungraded	1,290		1,290		1,290
Total - Ungraded Salaries	$48,524		$49,166		$50,082
Trust Funds (Gift)	23		23		23
Average ES level	ES-02		ES-02		ES-02
Average ES salary	$174		$174		$174
Average GS grade	5.1		5.1		5.1
Average GS salary	$55		$55		$57

Physicians' Comparability Allowance (PCA)

Indian Health Service

Table 1

		PY 2016 (Actual)	CY 2017 (Estimates)	BY 2018 (Estimates)
1) Number of Physicians Receiving PCAs		1	0	0
2) Number of Physicians with One-Year PCA Agreements		0	0	0
3) Number of Physicians with Multi-Year PCA Agreements		1	0	0
4) Average Annual PCA Physician Pay (without PCA payment)		$129,599	$0	$0
5) Average Annual PCA Payment		$28,000	$0	$0
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	1	0	0
	Category II Research Position	0	0	0
	Category III Occupational Health	0	0	0
	Category IV-A Disability Evaluation	0	0	0
	Category IV-B Health and Medical Admin.	0	0	0

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

Not applicable.

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

Maximum annual PCA for Category I (Clinical Position) - $30,000. Factors used were board certification, multi-year agreements, shortage specialty, location (remote), and duties.

Maximum annual PCA for Category IV-B (Health and Medical Administration) - $18,000. Factors used were board certification, multi-year agreement, categorical allowance.

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

Overall, Physician vacancy rates continue in the 20% range due to a shortage of physicians, particularly in primary care specialties. IHS has moved to using Title 38 Physician and Dentist Pay instead of PCA as the only option to compete successfully with private sector salaries. Many of our previous PCA recipients have been converted to Title 38.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

IHS is using Title 38 Physician and Dentist Pay authority more than PCA authority at this point in time. In general, PCA does not provide the pay flexibility needed to recruit and retain Physicians.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

Over the next few years IHS PCA levels should decrease. This is based on knowledge of the physicians' contract dates and management intent. If the recipients predicted to change to T38 PDP are converted then only 3 doctors will be left receiving PCA.

INDIAN HEALTH SERVICE
Summary of Reimbursements, Assessments, and Purchases
FY 2018 Estimates

		FY 2016 Estimate	FY 2017 Estimate	FY 2018 Estimate
Type of Funding	**Reimbursement for Services Purchased within HHS**			
SSF	Service & Supply Fund (SSF)	22,629,460	23,319,099	24,029,755
SSF	HHS Consolidated Acquisition System (HCAS) Operations & Maintenance	2,711,000	2,711,000	2,711,000
SSF	Unified Financial Management System (UFMS) Operations & Maintenance	5,778,000	5,778,000	5,778,000
SSF	UFMS (Governance)	1,129,000	1,129,000	1,129,000
SSF	UFMS (CFRS, FBIS/OBIEE)	1,769,000	2,024,000	2,137,000
	Subtotal SSF	34,016,460	34,961,099	35,784,755
OS TAP	Audit Resolution	437,000	530,000	603,000
OS TAP	Web Communications	3,542,000	3,726,000	3,726,000
OS TAP	DATA Act	416,662	416,662	416,662
OS TAP	Strategic Sourcing/Planning System	22,500	29,000	26,250
OS TAP	Web Crawler	152,000	152,000	152,000
OS TAP	(ITIO) Telecommunications Management/WITS	323,000	299,000	291,000
OS TAP	(ITIO) Unified Communication & Collaboration (UCC) Voice (formerly Telecommunications Services)	91,000	261,000	261,000
OS TAP	(ITIO) OS IT Security Operations Enterprise	579,000	396,000	396,000
OS TAP	(OIS) Computer Security Incident Response Center (CSIRC)	2,281,000	2,224,000	3,196,000
OS TAP	(OIS) Trusted Internet Connection (TIC)	728,000	789,000	789,000
OS TAP	OHR Enterprise Services (formerly Human Resource Centers)	2,876,000	2,717,000	2,932,000
OS TAP	Small Business Center (formerly Small Business Consolidation)	765,000	770,000	770,000
OS TAP	Tracking Accountability Government Grants System (TAGGS)	307,000	307,000	307,000
OS TAP	Departmental Contract Information System (DCIS)	482,000	482,000	482,000
OS TAP	Acquisition Integration Modernization (AIM)	239,000	239,000	239,000
OS TAP	Commissioned Corps Force Management (CCFM)	8,056,000	7,802,000	7,802,000
OS TAP	Office of General Counsel (OGC) Claims	182,000	182,000	182,000
OS TAP	Credit Monitoring (OPM)	101,359	132,251	172,558
OS TAP	Security Clearances (OPM)	469,763	472,265	472,265
OS TAP	Grants.gov System	36,000	30,000	30,000
OS TAP	Grants Solutions Center of Excellence-Support & System Services	410,000	415,000	415,000
OS TAP	Category Management	231,000	231,000	231,000
	Subtotal Non-PSC	22,727,284	22,602,178	23,891,735
JFA	OGC Departmental Ethics Program	340,000	424,416	424,416
JFA	Legislatively Mandated Initiatives & Emerging Technologies (LMIE) - Transferred under the Service & Supply Fund			
JFA	Regional Health Administrators	308,010	308,010	308,010
JFA	Office of Global Health Affairs	20,000	20,000	20,000
JFA	CFO Financial Statement Audit	624,510	652,613	681,981
JFA	Media Monitoring and Analysis	77,769	82,000	82,000
JFA	President's Council on Study of Bioethics	22,800	11,400	22,800
JFA	HHS Broadcast Studio	11,865	15,000	15,000
JFA	Interdepartmental Council on Native American Affairs	80,000	80,000	80,000
	Subtotal JFA Assessments	1,484,954	1,593,439	1,634,207
	Government-wide Administrative Functions			
IAA	Office of General Counsel (OGC) - Legal Services	1,488,386	1,519,059	1,550,364
IAA	National Institute of Health - Health Services Research Library	567,740	619,171	675,261
IAA	Federal Employment Services (USAJOBS)	86,532	92,799	92,799
IAA	Radio Frequency Spectrum	168,557	98,597	98,597
	Subtotal, GAF	2,311,214	2,329,626	2,417,022
	Grand Total	60,539,912	61,486,343	63,727,719

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Significant Items in Committee Reports

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INDIAN HEALTH SERVICE
FY 2018 CONGRESSIONAL JUSTIFICATION
House Report 114-632
Significant Items

Dental Health – The Committee understands that the geographic isolation of Indian tribes makes it difficult to attract and retain dentists and may limit access to care as tooth decay continues to be a problem. One way to help address access would be to allow volunteer dentists to treat patients who can provide important services that will improve access to oral health care. The Committee directs the Service to conduct a pilot project to explore establishing a centralized credentialing system to address workforce needs as well as volunteer providers similar to the Departments of Defense and Veterans Affairs who have centralized credentialing systems. The Committee directs the Service to consult with these agencies and private organizations to include the credentialing of dentists in a pilot program (p. 88).

Action taken or to be taken

The Indian Health Service (IHS) understands the Committee's concerns about the length of time required for credentialing of volunteer healthcare practitioners, including dental care practitioners, prior to work commencing at tribal or IHS facilities. The IHS is currently undergoing efforts to establish a national credentialing system which could encompass volunteer practitioners. (The background research for which included consultation with the Department of Veteran's Affairs, Department of Defense, and other organizations.) IHS has awarded a contract for centrally procured credentialing software for use at the IHS Area and Service Unit level that will provide enhanced capabilities and improve standardization of the credentialing process across IHS, as called for by the IHS Quality Framework. IHS will use the software to manage the credentialing of health professional staff agency-wide. The credentialing functions are best performed at the local or regional level since the local Service Unit is responsible (Governance responsibilities defined by the CMS Conditions of Participation and external accreditation standards) for the granting of privileges to provide services commensurate with the verified credentials and qualifications. Use of the credentialing software system is anticipated to accelerate the credentialing process and to facilitate transfer of credentials between facilities for staff who change duty location (including volunteers).

Purchased/Referred Care – The recommendation includes $960,831,000 for Purchased/Referred Care (PRC), $46,692,000 above the fiscal year 2016 enacted level. The Committee remains concerned about the inequitable distribution of funds as reported by the Government Accountability Office (GAO–12–446). The Service is therefore directed to allocate the increase above the fiscal year 2016 enacted level according to the PRC allocation formula normally reserved for program increases only (p. 88).

Action taken or to be taken

Tribal consultation would be necessary prior to making any adjustment to the allocation method already agreed to by the IHS and Tribes. The existing IHS Director's Workgroup on Improving PRC—which includes Tribal leaders and federal staff has reviewed the GAO report and conducted consultation with Tribes focused on an evaluation of equitable distribution of funds. The outcome of these prior consultations with Tribes stressed the importance of distributing funds in the following priority order: inflation, population growth, and then the PRC allocation formula for increases above the medical inflation rate. The purpose of the existing prioritization is to

cover the current cost of doing business before distributing increases. Further discussion and consultation with Tribes would be required and initiated.

Indian Health Care Improvement Act - It has been over five 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 directs the Service to provide, no later than 90 days after enactment of this Act, a detailed plan with specific dollar amounts identified to fully fund and implement the IHCIA (p. 89).

Action taken or to be taken

A comprehensive plan, including dollar amounts would require significantly more time than the 90 days allotted in the report, as well as dedicated resources (e.g., necessary funding for a health economist and a team of researchers may be several million dollars).

Health Care Facilities Construction - The recommendation includes $120,934,000 for health care facilities construction, $15,886,000 above the fiscal year 2016 enacted level. Recognizing that inadequate and non-existent staff quarters are a significant impediment to recruitment, the recommendation includes $12,000,000 as requested for staff quarters. In order to determine whether IHS patients across the system have comparable access to healthcare, the IHS is directed to conduct and publish a gap analysis of the locations and capacities of patient health facilities relative to the IHS user population. The analysis may include: facilities within the IHS system, including facilities on the Health Facilities Construction Priority System list and the Joint Venture Construction Program list; and where possible facilities within private or other Federal health systems for which arrangements with IHS exist, or should exist, to see IHS patients (p. 90).

Action taken or to be taken

In the short term, minimal analysis using currently available data could be accomplished within existing resources.

Significant Items

Dental Care Alternatives – The Committee is concerned that tooth decay in Indian Country has reached epidemic proportions and notes that preschool children of American Indian and Alaska Natives have the highest level of tooth decay of any population group in the United States. The Committee understands that the geographic isolation of tribal health facilities makes it difficult to attract dentists to serve as providers and believes that one alternative to improve access to dental care is to allow volunteer dentists to treat patients. However, the Committee has heard reports that delays in getting approved healthcare providers credentialed to work at tribal or Indian Health Service facilities have resulted in candidates abandoning their efforts to volunteer because they could not be processed in a timely fashion. To address this problem, the Committee urges the Service to explore establishing a centralized credentialing system to encompass volunteer providers. The Departments of Defense and Veterans Affairs have centralized credentialing systems and the Committee believes that the Service should consult with those Departments, as well as private sector credential verification organizations and state dental associations, and work to establish a pilot project to test the feasibility of a centralized credentialing system (p. 90).

Action taken or to be taken

The Indian Health Service (IHS) understands the Committee's concerns about the length of time required for credentialing of volunteer healthcare practitioners, including dental care practitioners, prior to work commencing at tribal or IHS facilities. The IHS is currently undergoing efforts to establish a national credentialing system which could encompass volunteer practitioners. (The background research for which included consultation with the Department of Veteran's Affairs, Department of Defense, and other organizations.) IHS has awarded a contract for centrally procured credentialing software for use at the IHS Area and Service Unit level that will provide enhanced capabilities and improve standardization of the credentialing process across IHS, as called for by the IHS Quality Framework. IHS will use the software to manage the credentialing of health professional staff agency-wide. The credentialing functions are best performed at the local or regional level since the local Service Unit is responsible (Governance responsibilities defined by the CMS Conditions of Participation and external accreditation standards) for the granting of privileges to provide services commensurate with the verified credentials and qualifications. Use of the credentialing software system is anticipated to accelerate the credentialing process and to facilitate transfer of credentials between facilities for staff who change duty location (including volunteers).

Indian Health Facilities – The Committee recommends $543,607,000 for health facilities operations of the Indian Health Service. This amount is $20,375,000 above the enacted level. Increases above the enacted level include $3,395,000 for the staffing of new facilities; $3,367,000 for facilities maintenance and improvement, equal to the request; $3,613,000 for sanitation facilities construction, equal to the request; and $10,000,000 for healthcare facilities construction for the small ambulatory clinic program. The Committee notes that this is the first funding for the small ambulatory program since 2008. This program is another critical tool for addressing facilities maintenance and construction backlogs throughout the Nation. The Committee encourages the Service to give strong consideration to utilizing these new resources to assist with infrastructure improvements at remote sites such as Gambell and Savoonga on St. Lawrence Island, Alaska. The Committee directs the Service to work with the Southeast Alaska Regional

Health Consortium to formulate options for facilities upgrades and ultimately a replacement facility at Mt. Edgecombe in Sitka. The plan shall be submitted to the Committee within 180 days of enactment of this act. The stipulations included in the ''Indian Health Services'' account regarding the allocation of funds for the staffing of new facilities pertain to the funds in this account as well. Within 60 days of enactment of this act, the Service shall submit a spending plan to the Committee that details the project-level distribution of funds provided for healthcare facilities construction. The Committee continues to be concerned about the quality of healthcare services provided at many of the Service's facilities and expects the Service, in consultation with the Committee, to update its performance metrics to better address patient health outcomes. (p. 91).

Action taken or to be taken

Regarding the Small Ambulatory Program, the IHS will initiate a competitive solicitation process to assist Tribes with their infrastructure needs utilizing these funds.

Regarding the Southeast Alaska Regional facility, the IHS will work with the Southeast Alaska Regional Health Consortium (SEARHC) to further evaluate the existing Sitka facility and formulate options for facilities upgrades. A plan may be submitted within 180 days of enactment of this act. The IHS will work with the SEARHC to evaluate the existing healthcare facility in Sitka within overall facility needs within the United States and within the constraints of the Indian Health Facilities budget.

A spending plan to detail the project-level distribution of funds for healthcare facilities construction will be provided within 60 days of enactment.

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Department of Health & Human Services
Indian Health Service
Number of Service Units and Facilities
Operated by IHS and Tribes, October 1, 2016

Type of Facility	TOTAL	IHS Total	TRIBAL Total	Title I [a]	Title V [b]	Other [c]
Service Units	170	54	116			
Hospitals	48	26	22	2	19	1
Ambulatory	614	87	527	118	402	7
Health Centers	342	53	289	88	201	0
School Health Centers	19	4	15	0	15	0
Health Stations	103	30	73	24	48	1
Alaska Village Clinics	150	0	150	6	138	6

[a] Operated under P.L. 93-638, Self Determination Contracts

[b] Operated under P.L. 106-260, Tribal Self-Governance Amendment of 2000

[c] Operated by a local government, not a tribe, for some Alaska Native villages through a standard procurement contract or also to denote certain Navajo Area contractors

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2015 Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**17,254**	**22,051**	**39,305**
Alaska	*	11,128	11,128
Albuquerque	687	*	687
Bemidji	222	*	222
Billings	833	*	833
California	*	*	0
Great Plains	3,303	*	3,303
Nashville	*	790	790
Navajo	7,070	4,230	11,300
Oklahoma	1,138	5,786	6,924
Phoenix	3,573	115	3,688
Portland	*	*	0
Tucson	428	*	428

* No direct inpatient facilities in FY 2015

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	**4,006,041**	**5,100,430**	**8,497,591**
Alaska	*	1,756,880	1,756,880
Albuquerque	491,652	125,187	125,187
Bemidji	268,053	734,215	734,215
Billings	478,741	126,617	126,617
California	*	654,262	654,262
Great Plains	955,319	132,376	132,376
Nashville	21,685	554,592	554,592
Navajo	1,117,272	735,986	735,986
Oklahoma	628,514	2,467,425	2,467,425
Phoenix	814,683	519,349	519,349
Portland	284,718	599,975	599,975
Tucson	183,850	90,727	90,727

** No IHS facilities in FY 2015

INDIAN HEALTH SERVICE
Immunization Expenditures[1]

	FY 2013 Estimate	FY 2014 Estimate	FY 2015 Estimate	FY 2016 Estimate	FY 2017 Estimate	Increase or Decrease
Infants, <2 yrs	$13,329,165	$21,922,093	$18,793,408	$18,816,007	$18,234,078	- $581,929
Adolescents, 13-17 yrs		$12,412,350	$11,704,995	$11,824,249	$14,184,614	+$2,360,365
HPV vaccine, Female 19-26 yrs	$9,388,432	$6,001,292	$7,389,130	$2,654,568	$7,116,136	+$4,461,568
HPV Vaccine, Males 19-21 yrs		$5,889,641	$6,799,171	$3,136,902	$5,339,282	+$2,202,380
Tdap, 19+ yrs		$6,508,229	$6,977,397	$1,399,293	$4,369,742	+$2,970,449
Hepatitis B for diabetics, 19-59 yrs		$5,752,971	$4,595,452	$4,870,146	$5,400,839	+$530,693
Influenza, 19yrs+	$3,210,800	$25,969,076	$29,225,712	$29,542,047	$25,539,057	-$4,002,990
Zoster vaccine, 60yrs		$494,463	$36,189	$558,050	$598,728	+$40,678
Pneumococcal (PPSV23), 65yrs+		$392,934	$432,156	$179,359	$270,111	+$90,752
Pneumococcal (PCV13), 65yrs+				$4,410,552	$4,790,620	+$380,068
Monitoring	$110,442	$114,528	$118,078	$122,565	$127,100	+$4,535
TOTAL	$26,038,839	$85,457,577	$86,071,688	$77,513,738	$85,970,307	$8,456,569

The Indian Health Service (IHS) patient care data system does not calculate itemized costs for the treatment of various conditions. Because the cost of vaccines for infants and adolescents < 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. Vaccine administration fees were based on an average of the CMS Maximum Regional Charges for vaccine administration, multiplied by the number of doses of vaccine routinely recommended for each age group (25 doses for children < 2 yrs; 6 doses of vaccine for adolescents).

In order to incorporate the vaccine provisions included under the Affordable Care Act and Healthcare Reform, all routinely recommended adult vaccines were added to the IHS Core Formulary in September of 2011. Costs for the purchase and administration of these vaccines are included in the 2017 estimated costs. In prior years, costs were only included for adults 65+ yrs and for influenza vaccine. In August 2014, the Advisory Committee on Immunization Practices (ACIP) for the first time recommended routine use of 13-valent pneumococcal conjugate vaccine (PCV13) among adults aged ≥65 years; the projected costs for incorporating this additional vaccine are included starting with the FY 2016 expenditures. The assumptions for all calculations are included in the table below.

Costs for monitoring of immunization coverage were also included, and represent a 3.7 percent increase over the FY 2016 estimate.

- FY 2013 Estimated Costs = FY 2012 cost plus 3.1 percent
- FY 2014 Estimated Costs = FY 2013 cost plus 3.7 percent
- FY 2015 Estimated Costs = FY 2014 cost plus 3.1 percent
- FY 2016 Estimated Costs = FY 2015 cost plus 3.8 percent
- FY 2017 Estimated Costs = FY 2016 cost plus 3.7 percent

For 2017, $85,843,207 is estimated for vaccine costs, and $127,100 for immunization monitoring costs, for a total of $85,970,307 estimated for all immunization expenditures. This represents a $8,456,569 increase over FY 2016 due to redistribution in population age categories and realignment of coverage goals to Healthy People 2020 goals. Calculations for the costs included as part of the 2017 estimated immunization costs were based on the assumptions outlined in the table below:

	Estimated User Pop (FY 2015)	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	41,956	80%	NA	33,565	$0.00	$21.73	25	$543.25	$18,234,078
Adolescents, 13-17 years	135,993	80%	NA	108,794	$0.00	$21.73	6	$130.38	$14,184,614
HPV Females, 19-26	118,178	60%	46%	16,545	$121.64	$21.73	3	$430.11	$7,116,136
HPV Males, 19-21 yrs	38,793	60%	28%	12,414	$121.64	$21.73	3	$430.11	$5,339,282
Tdap, 19+ yrs	1,074,650	90%	81%	96,719	$23.45	$21.73	1	$45.18	$4,369,742
Hepatitis B for diabetics, 19-59 yrs	93,330	60%	21%	36,399	$27.73	$21.73	3	$148.38	$5,400,839
Influenza, 19+ yrs	1,074,650	70%	NA	752,255	$12.22	$21.73	1	$33.95	$25,539,057
Zoster, 60 yrs	14,325	30%	NA	4,298	$117.59	$21.73	1	$139.32	$598,728
Pneumococcal (PPSV23) 65yrs+	135,489	90%	86%	5,420	$28.11	$21.73	1	$49.84	$270,111
Pneumococcal (PCV13) 65yrs+	135,489	30%	NA	40,647	$96.13	$21.73	1	$117.86	$4,790,620
Vaccine Costs									$85,843,207
Monitoring									$127,100
Total Costs									$85,970,307

† Based on Healthy People 2020, where applicable

*Coverage estimates based on most current coverage levels reported by IHS.
HPV estimate is 3 dose coverage. http://www.ihs.gov/epi/index.cfm?module=epi_vaccine_reports

** Based on an average of the 2012 state CMS Maximum Regional Charges for Vaccine administration.
http://www.cdc.gov/vaccines/programs/vfc/index.html

Overall, the estimated costs for these immunizations are affected by:

1. Individuals outside these target 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 a methodology to estimate the size of these groups.
2. The CMS vaccine administration fee was used to estimate these indirect costs, which is necessary because there is not a methodology to estimate indirect costs or administrative overhead associated with the administration of immunizations, or operation of the immunization program.

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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 $2.7 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 223 Tribes and Tribal Organizations operating 249 contracts and annual funding agreements which comprise approximately $791.7 million. Under Title V, IHS is party to 92 compacts and 118 funding agreements; through which $1.9 billion of the IHS budget is transferred to Tribes and Tribal organizations. Sixty-three percent of federally-recognized Tribes participate in Title V.

IHS and Tribally-Operated Service Unit and Medical Facilities – In recent years, the amount of funding administered under ISDEAA contracts and compacts has nearly doubled, with a corresponding increase in services provided and managed by Tribal programs. Tribes have traditionally assumed operation of community services and have expanded into providing medical care. For example, Tribes operate nearly all of the Community Health Representative Program and community-based alcohol programs. In addition, the number of tribally-operated hospitals has increased to over 42 percent of the hospitals funded by the IHS. With the increase of ambulatory medical facilities, Tribes continue to expand their provision of health care.

Indian Health Service
Self-Governance Funded Compacts FY 2016
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALASKA	**425,913**	**47,301**	**49,465**	**161,399**	**684,078**
Alaska Native Tribal Health Consortium	49,711	22,844	10,880	20,357	103,792
Aleutian Pribilof Islands Association, Inc.	1,424	178	195	1,084	2,880
Arctic Slope Native Association, Ltd	22,555	2,266	3,073	5,968	33,862
Bristol Bay Area Health Corporation	19,239	972	2,060	8,367	30,637
Chickaloon Native Village	56	1	14	13	85
Chugachmiut	3,624	23	209	1,779	5,634
Copper River Native Association	5,420	393	453	2,539	8,804
Council of Athabascan Tribal Governments	1,753	129	93	1,268	3,244
Eastern Aleutian Tribes, Inc.	3,047	25	166	1,729	4,967
Kenaitze Indian Tribe, I.R.A.	11,784	1,077	369	5,261	18,491
Ketchikan Indian Community	5,330	166	513	3,819	9,829
Knik Tribal Council	71	1	10	12	94
Kodiak Area Native Association	6,694	102	425	2,511	9,732
Maniilaq Association	26,462	1,024	2,637	14,221	44,344
Metlakatla Indian Community	6,080	945	444	1,323	8,791
Mount Sanford Tribal Consortium	773	1	76	248	1,098
Native Village of Eklutna	173	302	6	36	516
Native Village of Eyak	767	24	82	235	1,108
Norton Sound Health Corporation	41,473	3,895	4,043	7,509	56,920
Seldovia Village Tribe	1,795	83	81	794	2,754
Southcentral Foundation	78,688	4,789	9,628	31,528	124,633
SouthEast Alaska Regional Health Consortium	35,934	1,755	3,335	16,237	57,261
Tanana Chiefs Conference	58,152	4,045	5,258	13,600	81,055
Yakutat Tlingit Tribe	305	2	29	125	462
Yukon-Kuskokwim Health Corporation	44,603	2,260	5,385	20,837	73,085
ALABAMA	**3,958**	**223**	**142**	**915**	**5,238**
Poarch Band of Creek Indians	3,958	223	142	915	5,238
ARIZONA	**100,535**	**11,734**	**9,215**	**32,346**	**153,830**
Gila River Indian Community	34,651	5,464	1,653	11,477	53,244
Tohono O'Odham Nation	3,954	1,617	4,756	1,694	12,020
Tuba City Regional Health Care Corporation	40,323	3,656	2,043	12,172	58,194
Winslow Indian Health Care Center, Inc.	21,607	998	763	7,004	30,372
CALIFORNIA	**73,574**	**3,353**	**3,421**	**29,702**	**110,050**
Chapa-De Indian Health Program, Inc.	6,503	452	167	3,598	10,720
Consolidated Tribal Health Project, Inc.	3,872	98	96	1,395	5,461
Feather River Tribal Health, Inc.	5,764	202	153	1,824	7,943
Hoopa Valley Tribe	5,184	165	245	2,293	7,886
Indian Health Council, Inc.	8,677	282	258	3,048	12,265
Karuk Tribe of California	3,012	100	88	1,247	4,447
Northern Valley Indian Health, Inc.	4,119	396	104	935	5,554
Redding Rancheria Tribe	6,726	231	535	3,283	10,775
Riverside-San Bernardino County Indian Health,	21,047	1,071	809	8,721	31,649
Santa Ynez Band of Chumash Mission Indians	1,735	85	32	478	2,330
Southern Indian Health Council, Inc.	5,278	231	787	2,121	8,417
Susanville Indian Rancheria	1,658	39	147	759	2,603

Indian Health Service
Self-Governance Funded Compacts FY 2016
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
CONNECTICUT	**2,405**	**87**	**0**	**524**	**3,016**
Mohegan Tribe of Indians of Connecticut	2,405	87	0	524	3,016
FLORIDA	**9,658**	**649**	**908**	**1,572**	**12,787**
Seminole Tribe of Florida	9,658	649	908	1,572	12,787
IDAHO	**15,648**	**648**	**1,763**	**5,293**	**23,352**
Coeur D'Alene Tribe	6,239	247	1,300	3,244	11,030
Kootenai Tribe of Idaho	633	25	70	198	925
Nez Perce Tribe	8,776	376	393	1,851	11,396
KANSAS	**2,556**	**116**	**19**	**451**	**3,143**
Prairie Band Potawatomi Nation	2,556	116	19	451	3,143
LOUISANA	**1,165**	**104**	**116**	**189**	**1,574**
Chitimacha Tribe of Louisiana	1,165	104	116	189	1,574
MASSACHUSETTS	**691**	**36**	**204**	**277**	**1,208**
Wampanoag Tribe of Gay Head	691	36	204	277	1,208
MAINE	**3,281**	**103**	**159**	**823**	**4,365**
Penobscot Indian Nation	3,281	103	159	823	4,365
MICHIGAN	**25,052**	**958**	**2,003**	**2,678**	**30,691**
Grand Traverse Band of Ottawa and Chippewa In	2,834	227	285	559	3,904
Keweenaw Bay Indian Community	3,328	158	758	389	4,633
Little River Band of Ottawa Indians	2,007	66	234	353	2,660
Sault Ste. Marie Tribe of Chippewa Indians	16,883	507	727	1,377	19,494
MINNESOTA	**20,457**	**740**	**2,607**	**2,355**	**26,159**
Bois Forte Band of Chippewa Indians	2,640	90	375	775	3,881
Fond du Lac Band of Lake Superior Chippewa	11,844	451	1,120	771	14,187
Mille Lacs Band of Ojibwe	4,254	188	1,096	491	6,029
Shakopee Mdewakanton Sioux Community	1,719	11	16	317	2,063
MISSISSIPPI	**36,394**	**3,512**	**1,167**	**7,668**	**48,740**
Mississippi Band of Choctaw Indians	36,394	3,512	1,167	7,668	48,740
MONTANA	**20,016**	**1,505**	**1,780**	**3,664**	**26,964**
Chippewa Cree Tribe of the Rocky Boy's Reserva	10,165	577	1,016	2,378	14,136
Confederated Salish and Kootenai Tribes of the F	9,851	928	764	1,286	12,829
NORTH CAROLINA	**19,188**	**1,770**	**936**	**5,952**	**27,845**
Eastern Band of Cherokee Indians	19,188	1,770	936	5,952	27,845
NORTH DAKOTA	**3,779**	**126**	**1,491**	**397**	**5,794**
Spirit Lake Tribe	3,779	126	1,491	397	5,794
NEW MEXICO	**12,279**	**201**	**1,243**	**2,237**	**15,959**
Pueblo of Jemez	9,483	156	906	1,724	12,269
Pueblo of Sandia	1,908	41	139	257	2,345
Taos Pueblo	888	4	198	256	1,346
NEVADA	**25,711**	**1,134**	**2,036**	**4,848**	**33,730**
Duck Valley Shoshone-Paiute Tribes	6,630	516	724	1,522	9,390
Duckwater Shoshone Tribe	1,057	14	188	533	1,792
Ely Shoshone Tribe	1,296	18	59	297	1,670
Las Vegas Paiute Tribe	3,348	56	112	421	3,938
Reno-Sparks Indian Colony	6,511	275	634	1,420	8,839
Washoe Tribe of Nevada and California	4,916	161	221	336	5,635

Indian Health Service
Self-Governance Funded Compacts FY 2016
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
Yerington Paiute Tribe of Nevada	1,954	96	97	318	2,465
NEW YORK	**7,989**	**621**	**301**	**1,746**	**10,657**
St. Regis Mohawk Tribe	7,989	621	301	1,746	10,657
OKLAHOMA	**374,677**	**40,242**	**38,577**	**66,950**	**520,446**
Absentee Shawnee Tribe of Oklahoma	20,280	1,603	1,817	5,144	28,844
Cherokee Nation	125,474	13,552	12,912	12,830	164,768
Chickasaw Nation	81,643	14,116	9,516	18,968	124,244
Choctaw Nation of Oklahoma	59,442	7,586	5,982	16,833	89,843
Citizen Potawatomi Nation	13,638	873	1,697	4,185	20,392
Kaw Nation of Oklahoma	1,112	103	198	327	1,741
Kickapoo Tribe of Oklahoma	7,565	108	273	1,453	9,398
Modoc Tribe of Oklahoma	49	78	5	10	142
Muscogee Creek Nation	41,208	1,925	5,326	3,670	52,129
Northeastern Tribal Health System	7,275	52	144	902	8,373
Osage Nation	4,564	62	293	805	
Ponca Tribe of Oklahoma	3,122	61	222	286	3,691
Sac and Fox Nation of Oklahoma	7,416	73	156	1,102	8,747
Wyandotte Nation	1,889	50	37	434	2,410
OREGON	**28,681**	**1,089**	**2,594**	**9,074**	**41,438**
Confederated Tribes of Grand Ronde	6,681	247	509	2,184	9,621
Confederated Tribes of Siletz Indians of Oregon	7,740	184	713	2,049	10,687
Confederated Tribes of the Coos, Lower Umpqua	1,858	47	280	553	2,739
Confederated Tribes of the Umatilla Reservation	6,794	393	688	2,078	9,954
Coquille Indian Tribe	2,029	74	222	1,398	3,723
Cow Creek Band of Umpqua Tribe of Indians	3,578	143	182	811	4,715
UTAH	**7,576**	**105**	**1,731**	**3,259**	**12,672**
Utah Navajo Health System, Inc.	7,576	105	1,731	3,259	12,672
WASHINGTON	**54,363**	**2,159**	**2,670**	**13,079**	**72,272**
Cowlitz Indian Tribe	3,094	64	22	830	4,010
Jamestown S'Klallam Indian Tribe	1,264	45	86	324	1,719
Kalispel Tribe of Indians	1,074	37	21	61	1,192
Lower Elwha Klallam Tribe	1,828	76	102	322	2,328
Lummi Indian Nation	7,927	479	253	2,173	10,831
Makah Indian Tribe	3,849	218	290	851	5,209
Muckleshoot Tribe	7,181	190	201	0	7,572
Nisqually Indian Tribe	2,259	84	110	535	2,988
Port Gamble S'Klallam Tribe	2,628	121	136	1,302	4,187
Quinault Indian Nation	5,487	327	219	1,584	7,617
Shoalwater Bay Indian Tribe	1,751	16	281	804	2,853
Skokomish Indian Tribe	2,034	56	112	502	2,704
Squaxin Island Indian Tribe	2,696	165	194	958	4,013
Suquamish Tribe	1,881	16	148	655	2,700
Swinomish Indian Tribal Community	2,189	68	177	567	3,000
Tulalip Tribes of Washington	7,223	197	317	1,611	9,348
WISCONSIN	**25,129**	**750**	**1,445**	**1,787**	**29,111**
Forest County Potawatomi Community	2,068	73	695	410	3,246

Indian Health Service
Self-Governance Funded Compacts FY 2016
(Dollars in Thousands)

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
Oneida Tribe of Indians of Wisconsin	19,871	488	300	785	21,443
Stockbridge-Munsee Community	3,190	189	450	593	4,421
Grand Total	**1,300,674**	**119,266**	**125,995**	**359,186**	**1,905,120**

Indian Health Service
FY 2016 Self-Governance Funding
By Area
(Dollars in Thousands)

	Program Tribal Shares	Area Office Tribal Shares	Headquarters Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
ALASKA	451,275	13,139	8,800	49,465	161,399	684,078
ALBUQUERQUE	11,250	902	327	1,243	2,237	15,959
BEMIDJI	69,974	1,614	1,498	6,055	6,821	85,961
BILLINGS	18,817	1,799	905	1,780	3,664	26,964
CALIFORNIA	71,770	3,075	2,083	3,421	29,702	110,050
GREAT PLAINS	3,666	186	53	1,491	397	5,794
NASHVILLE	85,178	5,324	1,330	3,933	19,667	115,431
NAVAJO	70,017	2,609	1,641	4,537	22,435	101,238
OKLAHOMA	395,816	10,752	11,023	38,597	67,401	523,588
PHOENIX	63,620	1,742	1,598	3,689	16,325	86,974
PORTLAND	96,233	3,629	2,726	7,027	27,446	137,062
TUCSON	5,104	222	244	4,756	1,694	12,020
Total, IHS	**1,342,720**	**44,992**	**32,227**	**125,995**	**359,186**	**1,905,120**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2017 Annualized CR	5,724,000
Total estimated budget authority	5,724,000
Less Obligations	(5,724,000)
FY 2018 Estimate	4,735,000
Less Obligations	(4,735,000)
Net Change	(989,000)
Less Obligations	989,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	12,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	33,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	186,000	--	4,000
8	Increased Cost of Transportation & Things	--	1,000	--	0
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	21,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	515,000	--	11,000
12	Increased Cost of Supplies	--	17,000	--	0
13	Increased Cost of Medical or other Equipment	--	58,000	--	1,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,649,000	--	61,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	5,000	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	3,453,000	--	122,000
B. Self-Governance Restoration		--	0	--	11,000
TOTAL INCREASES		--	3,453,000	--	133,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(122,000)
B. Adjustments		--	0	--	(1,000,000)
TOTAL DECREASES		--	0	--	(1,122,000)
NET CHANGE		--	**3,453,000**	--	**(989,000)**

INDIAN HEALTH SERVICE
Contract Support Costs
Summary of Changes

FY 2017 Annualized CR	716,605,000
Total estimated budget authority	716,605,000
Less Obligations	(716,605,000)
FY 2018 Estimate	717,970,000
Less Obligations	(717,970,000)
Net Change	1,365,000
Less Obligations	(1,365,000)

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	0	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12	Increased Cost of Supplies	--	0	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	0
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	716,605,000	--	0
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	716,605,000	--	0
B. CSC Restoration		--	0	--	1,365,000
	TOTAL INCREASES	--	716,605,000	--	1,365,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**716,605,000**	--	**1,365,000**

INDIAN HEALTH SERVICE

FACILITIES

Summary of Changes

FY 2017 Annualized CR	522,237,000
Total budget authority	522,237,000
Less Obligations	(522,237,000)
FY 2018 Estimate	446,956,000
Less Obligations	(446,956,000)
Net Change	(75,281,000)
Less Obligations	75,281,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	156,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	477,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	392,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	1,012,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	1,303,000
7	Increased Cost of Travel	--	2,685,000	--	61,000
8	Increased Cost of Transportation & Things	--	3,334,000	--	78,000
9	Increased Cost of Printing	--	59,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	16,046,000	--	361,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	101,617,000	--	2,337,000
12	Increased Cost of Supplies	--	6,636,000	--	152,000
13	Increased Cost of Medical or other Equipment	--	13,310,000	--	389,000
14	Increased Cost of Land & Structure	--	106,842,000	--	2,456,000
15	Increased Cost of Grants	--	165,714,000	--	4,461,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	n/a	--	7,513,000
	Subtotal, Built-In	--	416,243,000	--	21,148,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	8	2,022,000
C. Program Restoration		--	0	--	795,000
	TOTAL INCREASES	--	416,243,000		23,965,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(21,148,000)
B. Adjustments		--	0	--	(78,098,000)
	TOTAL DECREASES	--	0	--	(99,246,000)
NET CHANGE		--	**416,243,000**	**8**	**(75,281,000)**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2017 Annualized CR	73,474,000
Total budget authority	73,474,000
Less Obligations	(73,474,000)
FY 2018 Estimate	60,000,000
Less Obligations	(60,000,000)
Net Change	(13,474,000)
Less Obligations	13,474,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	58,000	--	1,000
8	Increased Cost of Transportation & Things	--	27,000	--	1,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	352,000	--	8,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	18,713,000	--	431,000
12	Increased Cost of Supplies	--	4,018,000	--	92,000
13	Increased Cost of Medical or other Equipment	--	360,000	--	8,000
14	Increased Cost of Land & Structure	--	6,106,000	--	140,000
15	Increased Cost of Grants	--	43,840,000	--	1,008,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	1,323,000
	Subtotal, Built-In	--	73,474,000	--	3,012,000
B. M&I Restoration		--	0	--	140,000
	TOTAL INCREASES	--	73,474,000	--	3,152,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(3,012,000)
B. Adjustments		--	0	--	(13,614,000)
	TOTAL DECREASES	--	0	--	(16,626,000)
NET CHANGE		**--**	**73,474,000**	**--**	**(13,474,000)**

INDIAN HEALTH SERVICE
Sanitation Facilities Construction
Summary of Changes

FY 2017 Annualized CR	99,234,000
Total budget authority	99,234,000
Less Obligations	(99,234,000)
FY 2018 Estimate	75,423,000
Less Obligations	(75,423,000)
Net Change	(23,811,000)
Less Obligations	23,811,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	102,000	--	2,000
8	Increased Cost of Transportation & Things	--	689,000	--	16,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	12,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	66,763,000	--	1,536,000
12	Increased Cost of Supplies	--	149,000	--	3,000
13	Increased Cost of Medical or other Equipment	--	7,000	--	0
14	Increased Cost of Land & Structure	--	1,499,000	--	34,000
15	Increased Cost of Grants	--	23,397,000	--	538,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	1,786,000
	Subtotal, Built-In	--	92,618,000	--	3,915,000
B. SFC Restoration		--	0	--	189,000
	TOTAL INCREASES	--	92,618,000	--	4,104,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(3,915,000)
B. Adjustments		--	0	--	(24,000,000)
	TOTAL DECREASES	--	0	--	(27,915,000)
NET CHANGE		**--**	**92,618,000**	**--**	**(23,811,000)**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2017 Annualized CR	104,848,000
Total budget authority	104,848,000
Less Obligations	(104,848,000)
FY 2018 Estimate	100,000,000
Less Obligations	(100,000,000)
Net Change	(4,848,000)
Less Obligations	4,848,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2018 Pay Raise CS (9months)	--	n/a		0
5	One Days Pay	--	n/a		0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	0	--	0
8	Increased Cost of Transportation & Things	--	12,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	20,000	--	0
12	Increased Cost of Supplies	--	57,000	--	1,000
13	Increased Cost of Medical or other Equipment	--	5,585,000	--	128,000
14	Increased Cost of Land & Structure	--	99,174,000	--	2,281,000
15	Increased Cost of Grants	--	0	--	0
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	0
	Subtotal, Built-In	--	104,848,000	--	2,410,000
B. HCFC Restoration		--	0	--	0
	TOTAL INCREASES	--	104,848,000	--	2,410,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(2,410,000)
B. Adjustments		--	0	--	(4,848,000)
	TOTAL DECREASES	--	0	--	(7,258,000)
NET CHANGE		**--**	**104,848,000**	**--**	**(4,848,000)**

INDIAN HEALTH SERVICE
Facilities & Environmental Health Support
Summary of Changes

FY 2017 Annualized CR	222,187,000
Total budget authority	222,187,000
Less Obligations	(222,187,000)
FY 2018 Estimate	192,022,000
Less Obligations	(192,022,000)
Net Change	(30,165,000)
Less Obligations	30,165,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE/Pos	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	156,000
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	477,000
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	392,000
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	1,012,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	1,303,000
7	Increased Cost of Travel	--	2,520,000	--	58,000
8	Increased Cost of Transportation & Things	--	2,362,000	--	55,000
9	Increased Cost of Printing	--	59,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	15,421,000	--	349,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	15,104,000	--	347,000
12	Increased Cost of Supplies	--	2,341,000	--	54,000
13	Increased Cost of Medical or other Equipment	--	2,041,000	--	46,000
14	Increased Cost of Land & Structure	--	62,000	--	1,000
15	Increased Cost of Grants	--	82,899,000	--	2,307,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	n/a	--	3,999,000
	Subtotal, Built-In	--	122,809,000	--	10,556,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	8	2,022,000
C. HCFC Restoration		--	0		423,000
	TOTAL INCREASES	--	122,809,000	--	13,001,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(10,556,000)
B. Adjustments		--	0	--	(32,610,000)
	TOTAL DECREASES	--	0	--	(43,166,000)
NET CHANGE		**--**	**122,809,000**	**8**	**(30,165,000)**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2017 Annualized CR	22,494,000
Total budget authority	22,494,000
Less Obligations	(22,494,000)
FY 2018 Estimate	19,511,000
Less Obligations	(19,511,000)
Net Change	(2,983,000)
Less Obligations	2,983,000

		FY 2017 Annualized CR Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2017 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2018 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2017 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2018 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	5,000	--	0
8	Increased Cost of Transportation & Things	--	244,000	--	6,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	261,000	--	4,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	1,017,000	--	23,000
12	Increased Cost of Supplies	--	71,000	--	2,000
13	Increased Cost of Medical or other Equipment	--	5,317,000	--	207,000
14	Increased Cost of Land & Structure	--	1,000	--	0
15	Increased Cost of Grants	--	15,578,000	--	608,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	405,000
	Subtotal, Built-In	--	22,494,000	--	1,255,000
B. Equipment Restoration		--	0	--	43,000
	TOTAL INCREASES	--	22,494,000	--	1,298,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,255,000)
B. Adjustments		--	0	--	(3,026,000)
	TOTAL DECREASES	--	0	--	(4,281,000)
NET CHANGE		**--**	**22,494,000**	**--**	**(2,983,000)**

INDIAN HEALTH SERVICE
Budget Authority by Activity

(Dollars in Thousands)

	2016 Final		2017 Annualized CR		2018 President's Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES						
Hospitals & Health Clinics	6,077	$1,857,225	6,078	$1,853,694	6,078	$1,870,405
Dental Services	571	178,286	571	177,947	571	179,751
Mental Health	196	82,100	196	81,944	196	82,654
Alcohol & Substance Abuse	173	205,305	206	204,915	206	205,593
Contract Health Services	0	914,139	0	912,401	0	914,139
Total, Clinical Services	7,017	3,237,055	7,051	3,230,901	7,051	3,252,542
Public Health Nursing	208	76,623	208	76,477	208	77,498
Health Education	20	18,255	20	18,220	20	18,313
Comm. Health Reps.	3	58,906	3	58,794	3	58,906
Immunization AK	0	1,950	0	1,946	0	1,950
Total, Preventive Health	231	155,734	231	155,438	231	156,667
Urban Health	6	44,741	6	44,656	6	44,741
Indian Health Professions	22	48,342	22	48,250	22	43,342
Tribal Management	0	2,442	0	2,437	0	0
Direct Operations	259	72,338	259	72,200	259	72,338
Self-Governance	14	5,735	14	5,724	14	4,735
Total, Other services	301	173,598	301	173,268	301	165,156
Total, Services	7,549	3,566,387	7,583	3,559,607	7,583	3,574,365
CONTRACT SUPPORT COSTS	0	717,970	0	716,605	0	717,970
FACILITIES						
Maintenance & Improvement	0	73,614	0	73,474	0	60,000
Sanitation Facilities Constr.	137	99,423	137	99,234	137	75,423
Health Care Facs. Constr.	0	105,048	0	104,848	0	100,000
Facil. & Envir. Health Supp.	1,074	222,610	1,077	222,187	1,077	192,022
Equipment	0	22,537	0	22,494	0	19,511
Total, Facilities	1,211	523,232	1,214	522,237	1,214	446,956
Total IHS	8,760	$4,807,589	8,797	$4,798,450	8,797	$4,739,291

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