DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year
2012

Indian Health Service

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville, MD 20852

I am pleased to present the Indian Health Service (IHS) fiscal year (FY) 2012 Congressional Justification. The IHS budget is a fully integrated and transparent performance budget that supports the goals and objectives of the Department of Health and Human Services. Consistent with the Government Performance and Results Act of 1993 (GPRA), this budget justification includes the FY 2012 Annual Performance Plan and the FY 2010 Annual Performance Report, as well as the FY 2011 and FY 2012 Performance targets. Extensive tribal consultations and the annual Tribal budget formulation process exemplify the true IHS and tribal partnership that results in this budget.

For FY 2012, the IHS provides a comprehensive set of performance measures that reflect essential health services with evidence-based linkages to improved health outcomes. The automated monitoring of these performance measures from the local to the national level provides the IHS and our stakeholders with information to assess ongoing progress towards the following Agency-wide priorities:

- To renew and strengthen our partnerships with Tribes
- In the context of national health insurance reform, to bring reform to IHS
- To improve the quality of and access to care
- To make all our work accountable, transparent, fair and inclusive

Effective administration and oversight of clinical, staff, and financial resources is essential to meeting the health care needs of American Indian and Alaska Native (AI/AN) people. Our FY 2012 budget request represents the commitment of the IHS and our stakeholders to the Agency's mission by working to meet the health care needs of AI/AN people more efficiently and effectively.

To the best of my knowledge, the performance data reported by IHS for inclusion in the FY 2012 Online Performance Appendix is accurate, complete and reliable.

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

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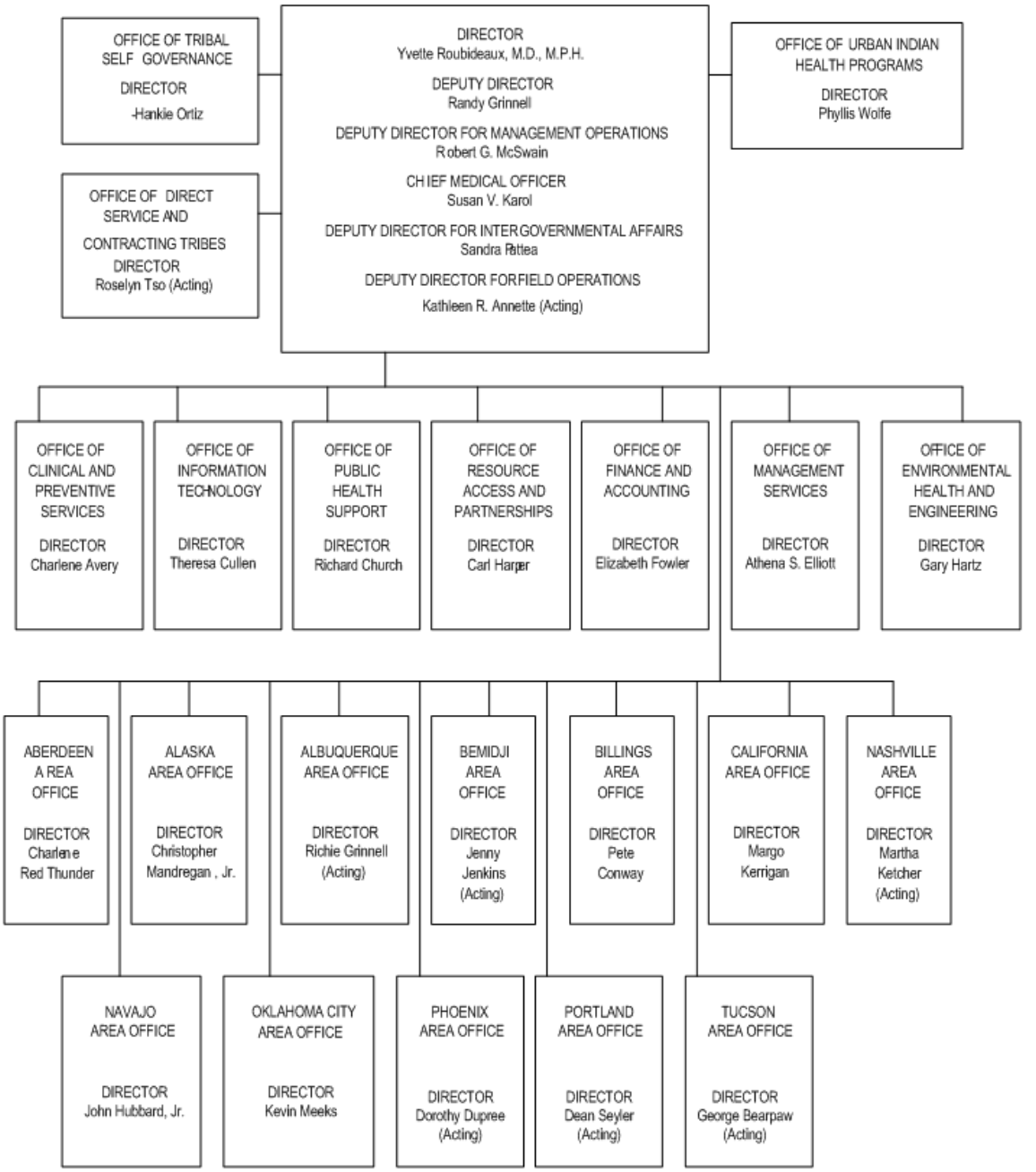
DEPARTMENT OF HEALTH AND HUMAN SERVICES

INDIAN HEALTH SERVICE

Approved /Yvette Roubideaux/
Date: 02/09/2011



EXECUTIVE SUMMARY

Agency Overview

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 Indian Health Service provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who are members or descendents of 565 federally recognized Tribes in 35 states. The IHS fiscal year (FY) 2010 appropriation was $4,052,375,000. The IHS has a total of about 16,120 employees, which includes approximately 2,700 nurses, 900 physicians, 700 engineers and sanitarians, 600 pharmacists, and 300 dentists. The IHS system consists of 12 Area offices, which are further divided into 162 Service Units that provide care at the local level. Health services are provided directly by the IHS, through tribally contracted and operated health programs, and through services purchased from private providers. There are over 600 facilities in the Indian health system. The Federal system consists of 28 hospitals, 58 health centers, and 31 health stations. In addition, 34 Urban Indian health programs provide a variety of health and referral services.

The provision of Federal health services to American Indians and Alaska Natives is based on a Government-to-Government relationship between Indian Tribes and the United States, as well as numerous treaties, court decisions, and legislation. The Snyder Act of 1921 provides the basic authority for health services provided by the Federal Government to American Indians and Alaska Natives. The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), as amended, allows Tribes to assume the administrative and program direction responsibilities that were previously carried out solely by the Federal Government. Tribes currently administer over one-half of IHS resources through ISDEAA contracts and compacts. The IHS administers the remaining resources and manages facilities where Tribes have elected not to contract or compact their health programs. The Indian Health Care Improvement Act of 1976 (IHCIA), as amended, authorizes the provision of health care services by IHS and was reauthorized in 2010.

Through extensive Tribal consultation, the IHS has established four Agency priorities to lead, manage, and support the delivery of comprehensive health care services to American Indians and Alaska Natives. The priorities are as follows:

1. Renew and strengthen our partnership with Tribes.
2. In the context of national health reform, bring reform to IHS.
3. Improve the quality of and access to care the American Indian and Alaska Native patients we serve.
4. Make all work accountable, transparent, fair, and inclusive.

Overview of Budget Request

Although significant reductions in certain mortality rates for American Indians and Alaska Natives have been accomplished since IHS' inception, health disparities continue to persist as compared to the general population:

- alcohol-related deaths are over six times greater for American Indians and Alaska Natives;
- deaths from diabetes and unintentional injuries are nearly three times greater;
- suicide rates are nearly double the U.S. All Races rate; and
- life expectancy at birth is five years less than that of the U.S. All Races population (72.5 vs. 77.5 years).

The FY 2012 President's Budget request for the Indian Health Service is $4,623,808,000 in discretionary budget authority -- a significant increase of $571,433,000, or 14.1 percent, over the FY 2010 Enacted level of $4,052,375,000 and includes the FY 2011 increase of $354,053,000 to maintain current services and to expand important programs. The FY 2011 figures displayed throughout this document represent the annualized Continuing Resolution level. Allocation of funds to programs and activities represent policies in the enacted FY 2010 appropriations.

The FY 2012 request includes funding to support activities identified and strongly supported by Tribes as critical budget priorities including: increases to: maintain the current level of services provided; expand access to care; increase resources for the Contract Health Services program; fund contract support costs; fund Indian Health Care Improvement Fund; fund health care facilities construction projects; and fund business operations support to enhance collections, improve other business practice efficiencies at the Service Unit (SU) levels and provide training and technical assistance. The budget request includes the following specific funding increases, over the 2010 enacted level:

CURRENT SERVICES (+$327.5 million)

Federal Pay Costs (+$4.1 million)
The budget request projects a 1.4 percent pay raise for Commissioned Officers. Federal and Tribal pay costs are under the pay freeze enacted by Congress.

Population Growth (+$96.6 million)
This request will address the increased service need arising from the growth in the American Indian and Alaska Native population. The population is growing at an average rate of 1.3 percent annually and the $96.6 million requested will provide for the additional services needed for these additional patients eligible for care.

Inflation (+$155.3 million)
This request will address the rising costs of providing health care. The $155.3 million is the calculated need to address a 1.5 percent non-medical inflation rate and a 3.6 percent medical inflation rate.

Staffing and Operating Costs for New Facilities (+$71.5 million)
This request will fund the staffing and operating costs for six newly constructed Health Centers scheduled to open in FY 2011 and FY 2012, with potential for two Joint Venture projects to be completed as well. They reflect an investment in the construction of the facilities to expand access to care in locations where existing capacity is overextended.

PROGRAM INCREASES / DECREASES (+$243.9 million)

Contract Health Services (CHS) (+$89.6 million)
CHS +$79,635,000: This increase will enable IHS and Tribal programs to purchase the following additional services over the FY 2010 levels:

- 5,700 Inpatient admissions
- 218,000 Outpatient visits, and
- 8,000 One-way patient travel trips

The purchase of these additional services addresses medically necessary care and relates directly to the Agency's third priority to improve quality and access to care while improving customer service for patients and providers. CHS is the top tribal priority.

These services are critical and will provide needed care to thousands of patients who would otherwise not have access to care. These increases will improve the quality of care for American Indian and Alaska Native patients who require a higher level of care than what is available from a direct service facility. It will provide for needed specialty and secondary care including primary care in those areas with limited direct care services.

Catastrophic Health Emergency Fund (CHEF) +$10,000,000: This increase will fund an additional 400 high cost cases from the CHEF. The CHEF increase will increase access and improve patient care, and lessen the burden of high costs cases, particularly for those smaller IHS and Tribally managed CHS programs with limited budgets.

Indian Health Care Improvement Fund (IHCIF) (+$54 million)
|IHCIF allocations in FY 2009 and FY 2010 increased funding at the 75 most needy sites to a minimum of 45 percent of the target benchmark, approximately$1,692 per person. The $54 million program increase in 2012 will further reduce deficiencies at the most needy sites. The funding will help to diminish health care service backlogs and expand primary care services which are among HHS High Priority Goals for FY 2012. Historical data suggests that access to primary care services is directly linked to improvements in the health status of Indian people, especially where Indians experience significant geographic and financial barriers to health care. Additionally, published research suggests that more comprehensive primary care services can reduce subsequent hospitalizations and realize cost savings.

Contract Support Costs (CSC) (+$50 million)
This increase will be applied to the projected CSC shortfall of $171 million (FY 2012) associated with the ongoing 329 contracts and compacts. After the FY 2012 funding allocation for CSC, the IHS estimates that the FY 2012 CSC shortfall will be approximately $153 million. The projected CSC level of need funded after applying the increase will be 75 percent, a 3.49 percent decrease from FY 2010 funding.

Health Care Facilities Construction (+$54 million)
This increase will ensure the continuance of critical construction projects in remote parts of Indian Country, Barrow, Alaska, Kayenta and San Carlos, Arizona, where access to other sources of health care services are not readily available. Additionally, the design will get underway for the southern California Youth Regional Treatment Center which will provide services to American Indian and Alaska Native youths experiencing alcohol and substance abuse issues.

Health Information Technology Security (+$4 million)
IHS' Health Information Technology (HIT) solution (the Resource and Patient Management System or RPMS) continues to expand to meet additional reporting requirements and provide increased but

essential HIT services to patients, providers and communities. This request will address critical health information technology security maintenance and enhancements. Although RPMS is a secure health information system, the recent government mandates to exchange health information increase the security needed to facilitate the external exchanges. In addition, changes in security standards associated with meaningful use will increase security requirements. Additional resources will be employed to provide expert security management of health information. Certification and Accreditation of enhancements to RPMS and continued funding for the Network and Operations Security Center (NOSC) are also planned for FY 2011.

Chronic Diseases (+$2.5 million)
This request will address the prevention of chronic illness in the American Indian and Alaska Native population through new, targeted efforts aimed at reducing their principal risk factors (smoking, obesity, sedentary lifestyle). These cross-cutting approaches add new capability to the Indian health system and offer the opportunity to reduce the risk of and consequences from these debilitating and costly chronic diseases.

Alcohol and Substance Abuse (+$4 million)
This request is for a new competitive IHS grant program to expand access to and improve the quality of treatment for substance abuse treatment services as part of the national drug control strategy. The program will target sites with the greatest need for substance abuse services. The main goal of the grant program will be to enable Indian Health Service, Tribal and Urban facilities to hire additional staff to provide evidence-based and practice-based culturally competent treatment services.

Improve 3rd Party Collection (+$1 million)
The $1,000,000 program increase will be used for competitive grants to assist urban Indian clinics in improving third party collections. The grants will be used for training, on-site technical assistance, and off-site technical assistance via conference calls and webinars. Additional program support will increase revenue and services for the AI/AN populations served.

Direct Operations (+$3.4 million)
This increase will fund: (a) continuing investments to improve the IHS' capacity for providing oversight and accountability in key administrative areas such as property, financial, and human resources management; (b) addressing unfunded mandates for national initiatives associated with privacy requirements, facilities, and personnel security; and (c) for improving responsiveness to external authorities such as Office of Management and Budget and Congress, including but not limited to the implementation and continuing accountability for new permanent authorities of the reauthorization of the Indian Health Care Improvement Act. Recent congressional oversight as well as reports issued by the General Accountability Office and the Office of Inspector General demonstrate the importance of making improvements in these areas.

Business Operations Support (+$6 million)
Of these funds, $5,000,000 will be distributed to IHS and Tribal Organizations, with the majority of funds going to SU and clinic levels, and limited amounts going to Area Offices (AOs). The purpose of these funds is to improve the processing of Contract Health Service (CHS) claims, to enroll AI/AN patients in new programs created from the major health care reforms Indian Health Care Improvement Act and to improve overall billing efficiency.

The additional $1,033,000 will be used to provide training and technical assistance to Area Office and facility staff on Medicare, Medicaid and private insurance programs and how to best negotiate lower rates for health care services that are contracted to the private sector.

IHCIA Implementation (+$2 million)
Mental Health +$1 million: Section 723 of the Indian Health Care Improvement Act authorizes funding to underwrite demonstration tele-mental health service projects targeting Indian youth suicide prevention. Grants will be awarded to Tribes and Tribal organizations that operate one or more facilities located in an area with documented disproportionately high rates of suicide; reporting active clinical telehealth capabilities; or offering school-based tele-mental health services to Indian youth. Support will be provided to the three sites for up to 4 years and the IHS Tele-behavioral Health Center of Excellence to provide technical assistance to grantees.

Health Care Facilities Construction +$1 million: To ensure that limited health facilities resources are effectively being utilized, the feasibility of using innovative modular construction techniques for health facilities will be examined.

Savings (-$26.6 million)
Grants Savings -$7 million: The agency is proposing a savings in grants awards beginning FY 2012. Approximately $7M will be redirected towards other higher health priority programs that benefit a larger number of patients at more sites.

Sanitation Facilities Construction -$19.6 million: Although the need for water, sewage and solid waste disposal facilities is significant, the influx of Recovery Act funds will lessen the overall impact of the one year decrease in the Sanitation Facilities Construction recurring base and the service to 3,000 fewer American Indian and Alaska Native homes. Despite the reduction, approximately 18,500 homes will receive first or improved sanitation facilities as a result of the FY 2012 request.

Administrative Savings
The IHS continues work on its four Agency priorities including IHS reform. Through change and improvement at all levels of the organization (Headquarters, Area Office, and Service Unit), IHS will achieve administrative costs savings through the following activities:

1. Reduce administrative travel by mandating more use of technologies such as teleconferencing, video conferencing, webinars, social networking options and by conducting more oversight through use of electronic management systems available in finance, acquisition, and human resources, rather than site visits.
2. Consolidate UFMS functions and processes to increase operational efficiency in serving Area Offices and Service Units, and improve financial management through development of specific areas of expertise serving multiple IHS Areas and locations.
3. Improve hiring processes to fill critical clinical provider vacancies in lieu of very costly contract temporaries and locum tenens, thereby increasing quality and continuity of care for American Indian and Alaska Native patients.
4. Centralize IT resources, where practical, and provide consistent service and increased security across the organization and provide increased quality support to the delivery of health care services to American Indians and Alaska Natives.

Summary of Recovery Act Outlays and Performance

(dollars in millions)

ARRA Implementation Plan	Total Resources	FY 2009/2010	FY 2011 Estimate	FY 2012 Estimate
Health Information Technology	$85	$62.7	$16.2	$5.8
Health Care Facilities Construction	$227	$150.5	$43.6	$28.5
Maintenance & Improvement	$100	$67.9	$15.1	$12.0
Sanitation Facilities Construction	$68	$42.0	$60.0	$8.0
Equipment	$20	$10.2	$9.1	$0.7
Total Obligations	**$500**	**$364.1**	**$144.0**	**$55.0**

Source: UFMS

Selected Performance Measures for Implementation Plans Listed Above

Health Information Technology

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target	FY 2012 Target
Percentage of all orders that are electronically entered into the Electronic Health Record	N/A	65%	75%	75%

Explanation of Measure: OIT elected to monitor Computerized Provider Order Entry (CPOE). CPOE is the proportion of medical orders (pharmacy, laboratory, radiology, etc.) that are entered into the electronic system directly by the ordering provider. This is a measure that reflects how completely EHR is being used at a facility, and the nationwide measure reflects how well the system is being utilized across the country. Computerized Provider Order Entry (CPOE) Performance Monitor report of all sites is currently running EHR.

Maintenance & Improvement

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target	FY 2012 Target
Percentage reduction in the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) through Recovery Act Funding	N/A	2.6%	13.7%	16.7%

Explanation of Measure: The Backlog of Maintenance and Repair (BEMAR) is an IHS-wide inventory of needed maintenance and repair projects. As maintenance and repair projects are completed the BEMAR deficiency is reduced (improved). As BEMAR is reduced, system-wide capacity for safe and efficient patient care is increased. The percentage reduction measure is the amount the system-wide BEMAR is reduced by completion of Recovery Act projects (numerator) divided by the original system-wide baseline BEMAR (denominator).

Sanitation Facilities Construction

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target	FY 2012 Target
Number of existing AI/AN homes provided with sanitation facilities funded projects. Cumulative	367	4,425	14,000	16,000

Data Source: Sanitation Tracking and Reporting System (STARS)

Explanation of Measure: The outcome measure is number of currently deficient AI/AN homes that will be served by Recovery Act funded water and sanitation projects. As projects are completed and

certified to begin serving the community, counts of additional homes served by each completed project, will be added to the cumulative total of homes served by all Recovery Act funded projects.

Equipment

Performance Measure	FY 2009 Result	FY 2010 Result	FY 2011 Target	FY 2012 Target
Increased access to diagnostic services with new CT scanners	N/A	N/A	1,300	1,300

Explanation of Measure: The number of diagnostic CT diagnostic services will increase at the 2 sites receiving a new CT scanner. This output indicator measures additional services performed due to Recovery Act funding. CT scanners play an important diagnostic role for providers, especially in treating trauma patients. The purchase and installation of CTs at IHS and tribal emergency departments will enhance quality of care and access to care, and will reduce expensive patient transports to other facilities for services.

Discretionary All Purpose Table
Indian Health Service

(Dollars in Thousands)

Feb 8, 2011

Program	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 Budget Request
SERVICES			
Hospitals & Health Clinics	1,754,383	1,754,383	1,963,886
Dental Services	152,634	152,634	170,859
Mental Health	72,786	72,786	81,117
Alcohol & Substance Abuse	194,409	194,409	211,693
Contract Health Services	779,347	779,347	948,646
Total, Clinical Services	2,953,559	2,953,559	3,376,201
Public Health Nursing	64,071	64,071	70,613
Health Education	16,682	16,682	18,190
Community Health Reps.	61,628	61,628	65,746
Immunization AK	1,934	1,934	2,064
Total, Preventive Health	144,315	144,315	156,613
Urban Health	43,139	43,139	46,745
Indian Health Professions	40,743	40,743	42,016
Tribal Management	2,586	2,586	2,762
Direct Operations	68,720	68,720	73,636
Self-Governance	6,066	6,066	6,329
Contract Support Costs	398,490	398,490	461,837
Total, Other Services	559,744	559,744	633,325
TOTAL, SERVICES	3,657,618	3,657,618	4,166,139
FACILITIES			
Maintenance & Improvement	53,915	53,915	57,078
Sanitation Facilities Construction	95,857	95,857	79,710
Health Care Facilities Construction	29,234	29,234	85,184
Facilities & Environmental Health Support	193,087	193,087	210,992
Equipment	22,664	22,664	24,705
TOTAL, FACILITIES	394,757	394,757	457,669
TOTAL, BUDGET AUTHORITY	4,052,375	4,052,375	4,623,808
COLLECTIONS			
Medicare	192,748	195,034	195,034
Medicaid	617,239	631,695	631,695
Subtotal, M / M	*809,987*	*826,729*	*826,729*
Private Insurance	81,006	81,006	81,006
Total, M / M / PI	*890,993*	*907,735*	*907,735*
Quarters	6,288	6,288	7,500
TOTAL, COLLECTIONS	897,281	914,023	915,235
Special Diabetes Program for Indians	150,000	150,000	150,000
TOTAL, DIABETES	150,000	150,000	150,000
TOTAL, PROGRAM LEVEL	$5,099,656	$5,116,398	$5,689,043

INDIAN HEALTH SERVICE
FY 2012 Budget Request
Detail of Changes

(Dollars in Thousands)

Feb 3, 2011

Sub Sub Activity	FY 2010 Enacted	FY 2011 CR	CURRENT SERVICES: Fed Pay CO 1.4%	Inflation: Non-Med 1.5%	Inflation: Med 3.6%	Inflation: Total	Population Growth 1.3%	Staffing for New Facilities	Curr Svcs Subtotal	PROGRAM EXPANSION: Contract Health Services	Health Care Fac Constr	IHCI Fund	Health IT Security	Chronic Diseases	Alcohol/ Subs Abuse	Improve 3rd Party Collections	Direct Operations	Business Operations Support	Contract Support Costs	IHCIA Implem.	SAVINGS: Grants Savings	SFC Savings	Prog. Expans. Subtotal	FY 2012 Budget Request
SERVICES																								
Hospitals & Health Clinics	1,754,383	1,754,383	2,302	2,518	48,145	50,663	45,891	51,085	149,941	0	0	54,000	4,000	2,529	0	0	0	6,033	0	0	(7,000)	0	59,562	1,963,886
Dental Services	152,634	152,634	544	155	6,097	6,252	4,367	7,062	18,225	0	0	0	0	0	0	0	0	0	0	0	0	0	0	170,859
Mental Health	72,786	72,786	71	87	2,155	2,242	2,094	2,924	7,331	0	0	0	0	0	0	0	0	0	0	1,000	0	0	1,000	81,117
Alcohol & Substance Abuse	194,409	194,409	31	61	7,402	7,463	5,591	199	13,284	0	0	0	0	0	4,000	0	0	0	0	0	0	0	4,000	211,693
Contract Health Services	779,347	779,347	0	8	56,750	56,758	22,906	0	79,664	89,635	0	0	0	0	0	0	0	0	0	0	0	0	89,635	948,646
Total, Clinical Services	2,953,559	2,953,559	2,948	2,829	120,549	123,378	80,849	61,270	268,445	89,635	0	54,000	4,000	2,529	4,000	0	0	6,033	0	1,000	(7,000)	0	154,197	3,376,201
Public Health Nursing	64,071	64,071	114	79	1,714	1,793	1,839	2,796	6,542	0	0	0	0	0	0	0	0	0	0	0	0	0	0	70,613
Health Education	16,682	16,682	3	6	587	593	477	435	1,508	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18,190
Comm. Health Reps	61,628	61,628	2	17	2,343	2,360	1,756	0	4,118	0	0	0	0	0	0	0	0	0	0	0	0	0	0	65,746
Immunization AK	1,934	1,934	0	0	75	75	55	0	130	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,064
Total, Preventive Health	144,315	144,315	119	102	4,719	4,821	4,127	3,231	12,298	0	0	0	0	0	0	0	0	0	0	0	0	0	0	156,613
Urban Health	43,139	43,139	22	81	1,339	1,420	1,164	0	2,606	0	0	0	0	0	0	1,000	0	0	0	0	0	0	1,000	46,745
Indian Health Professions	40,743	40,743	4	1,247	22	1,269	0	0	1,273	0	0	0	0	0	0	0	0	0	0	0	0	0	0	42,016
Tribal Management	2,586	2,586	0	0	176	176	0	0	176	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,762
Direct Operations	68,720	68,720	174	964	374	1,338	0	0	1,512	0	0	0	0	0	0	0	3,404	0	0	0	0	0	3,404	73,636
Self-Governance	6,066	6,066	0	23	240	263	0	0	263	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6,329
Contract Support Cost	398,490	398,490	0	11,907	1,440	13,347	0	0	13,347	0	0	0	0	0	0	0	0	0	50,000	0	0	0	50,000	461,837
Total, Other Services	559,744	559,744	200	14,222	3,591	17,813	1,164	0	19,177	0	0	0	0	0	0	1,000	3,404	0	50,000	0	0	0	54,404	633,325
Total, Services	3,657,618	3,657,618	3,267	17,153	128,859	146,012	86,140	64,501	299,920	89,635	0	54,000	4,000	2,529	4,000	1,000	3,404	6,033	50,000	1,000	(7,000)	0	208,601	4,166,139
FACILITIES																								
Maintenance & Improvement	53,915	53,915	0	1,632	0	1,632	1,531	0	3,163	0	0	0	0	0	0	0	0	0	0	0	0	0	0	57,078
Sanitation Facilities Constr.	95,857	95,857	0	764	0	764	2,708	0	3,472	0	0	0	0	0	0	0	0	0	0	0	0	(19,619)	(19,619)	79,710
Health Care Fac. Constr.	29,234	29,234	0	992	0	992	0	0	992	0	53,958	0	0	0	0	0	0	0	0	1,000	0	0	54,958	85,184
Facil. & Envir. Hlth Supp.	193,087	193,087	835	2,406	2,109	4,515	5,523	7,032	17,905	0	0	0	0	0	0	0	0	0	0	0	0	0	0	210,992
Equipment	22,664	22,664	0	44	1,349	1,393	648	0	2,041	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24,705
Total, Facilities	394,757	394,757	835	5,838	3,458	9,296	10,410	7,032	27,573	0	53,958	0	0	0	0	0	0	0	0	1,000	0	(19,619)	35,339	457,669
TOTAL, IHS	4,052,375	4,052,375	4,102	22,991	132,317	155,308	96,550	71,533	327,493	89,635	53,958	54,000	4,000	2,529	4,000	1,000	3,404	6,033	50,000	2,000	(7,000)	(19,619)	243,940	4,623,808

Statement of Personnel Resources INDIAN HEALTH SERVICE			
	2010	2011	2012
	Enacted	CR	Budget Request
Direct:			
Hospitals & Health Clinics	6,302	6,442	6,531
Dental Health	708	713	718
Mental Health	246	249	253
Alcohol & Substance Abuse	184	184	184
Contract Health Services	6	6	6
Total, Clinical Services	7,446	7,594	7,692
Public Health Nursing	254	254	257
Health Education	26	26	28
Community Health Reps	6	6	6
Immunization, AK	0	0	0
Total, Preventive Health	286	286	291
Urban Health	8	8	8
Indian Health Professions	29	29	29
Tribal Management	0	0	0
Direct Operations	331	336	348
Self Governance	12	12	12
Contract Support Costs	0	0	0
Total, SERVICES	8,112	8,265	8,380
Maint. & Improvement	0	0	0
Sanitation Facilities	192	177	177
Hlth Care Facs Construction	0	0	0
Facil. & Envir. Hlth Support	1,026	1,059	1,069
Facilities Support	562	583	591
Environ. Hlth. Support	387	397	399
OEHE Support	77	79	79
Equipment	0	0	0
Total, FACILITIES	1,218	1,236	1,246
Total, Direct FTE	9,330	9,501	9,626
Reimbursable:			
Buybacks	1,721	1,721	1,721
Medicare	854	854	854
Medicaid	3,345	3,345	3,345
Private Insurance	524	524	524
Quarters	27	27	27
Total, Reimbursable FTE	6,471	6,471	6,471
Trust Funds (Gift)	**23**	**23**	**23**
TOTAL FTE	**15,824**	**15,995**	**16,120**
Total, Civilian FTE	**13,649**	**13,800**	**13,907**
Total, Military FTE	**2,175**	**2,195**	**2,213**

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Jan 17, 2011

Sub Sub Activity	2010 Enacted Budget Authority	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level	2011 CR Budget Authority	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level
SERVICES:										
Hospitals & Health Clinics	1,754,383	81,006	809,987 [2/]	0	2,645,376	1,754,383	81,006	826,732 [2/]	0	2,662,121
Dental Health	152,634	0	0	0	152,634	152,634	0	0	0	152,634
Mental Health	72,786	0	0	0	72,786	72,786	0	0	0	72,786
Alcohol & Substance Abuse	194,409	0	0	0	194,409	194,409	0	0	0	194,409
Contract Health Services	779,347	0	0	0	779,347	779,347	0	0	0	779,347
Total, Clinical Services	2,953,559	81,006	809,987	0	3,844,552	2,953,559	81,006	826,732	0	3,861,297
Public Health Nursing	64,071	0	0	0	64,071	64,071	0	0	0	64,071
Health Education	16,682	0	0	0	16,682	16,682	0	0	0	16,682
Comm. Health Reps.	61,628	0	0	0	61,628	61,628	0	0	0	61,628
Immunization AK	1,934	0	0	0	1,934	1,934	0	0	0	1,934
Total, Preventive Health	144,315	0	0	0	144,315	144,315	0	0	0	144,315
Urban Health	43,139	0	0	0	43,139	43,139	0	0	0	43,139
Indian Health Professions	40,743	0	0	0	40,743	40,743	0	0	0	40,743
Tribal Management	2,586	0	0	0	2,586	2,586	0	0	0	2,586
Direct Operations	68,720	0	0	0	68,720	68,720	0	0	0	68,720
Self-Governance	6,066	0	0	0	6,066	6,066	0	0	0	6,066
Contract Support Costs	398,490	0	0	0	398,490	398,490	0	0	0	398,490
Total, Other Services	559,744	0	0	0	559,744	559,744	0	0	0	559,744
TOTAL, SERVICES	3,657,618	81,006	809,987	0	4,548,611	3,657,618	81,006	826,732	0	4,565,356
FACILITIES:										
Maintenance & Improvement	53,915	0	0	6,288	60,203	53,915	0	0	6,288	60,203
Sanitation Facilities Construction	95,857	0	0	0	95,857	95,857	0	0	0	95,857
Health Care Facs. Constr.	29,234	0	0	0	29,234	29,234	0	0	0	29,234
Facil. & Envir. Health Support	193,087	0	0	0	193,087	193,087	0	0	0	193,087
Equipment	22,664	0	0	0	22,664	22,664	0	0	0	22,664
TOTAL, FACILITIES	394,757	0	0	6,288	401,045	394,757	0	0	6,288	401,045
TOTAL, IHS	4,052,375	81,006	809,987	6,288	4,949,656	4,052,375	81,006	826,732	6,288	4,966,401
Default Recovery Funds	0	0	0	0	0	0	0	0	0	0
Special Diabetes Program for Indians [1/]	150,000	0	0	0	150,000	150,000	0	0	0	150,000
GRAND TOTAL	4,202,375	81,006	809,987	6,288	5,099,656	4,202,375	81,006	826,732	6,288	5,116,401

[1/] The Special Diabetes Program for Indians is reauthorized for a total of $150,000,000 in FY 2011.

[2/] Includes $29,203,000 in Medicaid/Medicare for CMS estimates of tribal collections as well as $160,237,000 in FY2010 & $181,277,000 in FY2011 for tribal direct collection estimates, which began in FY 2002.

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Jan 17, 2011

Sub Sub Activity	2012 Request					Increase/Decrease of 2012 Over 2010				
	Budget Authority	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level	Budget Authority	Private Insurance Collections	Medicare/ Medicaid	Personnel Quarters	Total Program Level
SERVICES:										
Hospitals & Health Clinics	1,963,886	81,006	826,732 [2/]	0	2,871,624	209,503	0	16,745	0	226,248
Dental Health	170,859	0	0	0	170,859	18,225	0	0	0	18,225
Mental Health	81,117	0	0	0	81,117	8,331	0	0	0	8,331
Alcohol & Substance Abuse	211,693	0	0	0	211,693	17,284	0	0	0	17,284
Contract Health Services	948,646	0	0	0	948,646	169,299	0	0	0	169,299
Total, Clinical Services	3,376,201	81,006	826,732	0	4,283,939	422,642	0	16,745	0	439,387
Public Health Nursing	70,613	0	0	0	70,613	6,542	0	0	0	6,542
Health Education	18,190	0	0	0	18,190	1,508	0	0	0	1,508
Comm. Health Reps.	65,746	0	0	0	65,746	4,118	0	0	0	4,118
Immunization AK	2,064	0	0	0	2,064	130	0	0	0	130
Total, Preventive Health	156,613	0	0	0	156,613	12,298	0	0	0	12,298
Urban Health	46,745	0	0	0	46,745	3,606	0	0	0	3,606
Indian Health Professions	42,016	0	0	0	42,016	1,273	0	0	0	1,273
Tribal Management	2,762	0	0	0	2,762	176	0	0	0	176
Direct Operations	73,636	0	0	0	73,636	4,916	0	0	0	4,916
Self-Governance	6,329	0	0	0	6,329	263	0	0	0	263
Contract Support Costs	461,837	0	0	0	461,837	63,347	0	0	0	63,347
TOTAL, SERVICES	4,166,139	81,006	826,732	0	5,073,877	508,521	0	16,745	0	525,266
FACILITIES:										
Maintenance & Improvement	57,078	0	0	7,500	64,578	3,163	0	0	1,212	4,375
Sanitation Facilities Construction	79,710	0	0	0	79,710	(16,147)	0	0	0	(16,147)
Health Care Facs. Constr.	85,184	0	0	0	85,184	55,950	0	0	0	55,950
Facil. & Envir. Health Support	210,992	0	0	0	210,992	17,905	0	0	0	17,905
Equipment	24,705	0	0	0	24,705	2,041	0	0	0	2,041
TOTAL, FACILITIES	457,669	0	0	7,500	465,169	62,912	0	0	1,212	64,124
TOTAL, IHS	4,623,808	81,006	826,732	7,500	5,539,046	571,433	0	16,745	1,212	589,390
Default Recovery Funds	0	0	0	0	0	0	0	0	0	0
Special Diabetes Program for Indians [1/]	150,000	0	0	0	150,000	0	0	0	0	0
GRAND TOTAL	4,773,808	81,006	826,732	7,500	5,689,046	571,433	0	16,745	1,212	589,390

[1/] The Special Diabetes Program for Indians is pending in Congress for Fiscal Years 2012 - 2016.

[2/] Includes $29,203,000 in Medicaid/Medicare for CMS estimates of tribal collections as well as $181,277,000 for tribal direct collection estimates, which began in FY 2002.

INDIAN HEALTH SERVICE
STAFFING AND OPERATING COSTS FOR NEW / EXPANDED FACILITIES
FY 2012 Request
(Dollars in Thousands)

Feb 9, 2011

	Placeholder	Ada, OK Carl Albert Hospital Replacement Joint Venture		Lakeport, CA Lake County Tribal Health Center Joint Venture		New Town, ND Elbowoods Health Center		Eagle Butte, SD Cheyenne River Health Center		Little Axe, OK Absentee Shawnee Health Center Joint Venture		Vinita, OK Cherokee Nation Vinita Health Center Joint Venture		TOTAL	
Opening Date (cal. yr):		Aug 2010		Aug 2010		Aug 2011		Sep 2011		Apr 2012		Apr 2012			
Sub Sub Activity		Pos	Amount	Pos	Amount	Pos	Amount	FTE	Amount	Pos	Amount	Pos	Amount	FTE/Pos.	Amount
Hospitals & Health Clinics	$9,843	38	$4,045	21	$1,948	73	$6,436	184	$17,935	61	$5,522	58	$5,356	435	$51,085
Dental Health	0	8	$836	2	$195	6	$614	25	$2,545	15	$1,466	14	$1,406	70	$7,062
Mental Health	0	5	$564	4	$353	0	$0	9	$812	9	$785	5	$410	32	$2,924
Alcohol & Substance Abuse	0	0	$0	0	$0	0	$0	0	$0	0	$0	2	$199	2	$199
Total, Clinical Services	$9,843	51	$5,445	27	$2,496	79	$7,050	218	$21,292	85	$7,773	79	$7,371	539	$61,270
Public Health Nursing	0	3	$303	2	$235	2	$230	10	$1,133	4	$453	4	$442	25	$2,796
Health Education	0	1	$106	0	$0	1	$86	2	$177	0	$0	1	$66	5	$435
Total, Preventive Health	0	4	$409	2	$235	3	$316	12	$1,310	4	$453	5	$508	30	$3,231
Total, Services	$9,843	55	$5,854	29	$2,731	82	$7,366	230	$22,602	89	$8,226	84	$7,879	569	$64,501
Facilities Support	0	3	$678	2	$305	3	$648	24	$3,103	4	$755	5	$786	41	$6,275
Environmental Health Support	0	0	$0	0	$0	3	$373	3	$384	0	$0	0	$0	6	$757
Total, FEHS	0	3	$678	2	$305	6	$1,021	27	$3,487	4	$755	5	$786	47	$7,032
Total, Facilities	0	3	$678	2	$305	6	$1,021	27	$3,487	4	$755	5	$786	47	$7,032
Grand Total [1]	**$9,843**	**58**	**$6,532**	**31**	**$3,036**	**88**	**$8,387**	**257**	**$26,089**	**93**	**$8,981**	**89**	**$8,665**	**616**	**$71,533**

[1] Includes utilities

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

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2010 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	890,697	0	0	0	0	0	0	890,697	863,686	0	0	0	0	0	0	863,686	1,754,383
Dental Health	82,281	0	0	0	0	0	0	82,281	70,353	0	0	0	0	0	0	70,353	152,634
Mental Health	33,811	0	0	0	0	0	0	33,811	38,975	0	0	0	0	0	0	38,975	72,786
Alcohol & Substance Abuse	31,713	0	0	0	0	0	0	31,713	162,696	0	0	0	0	0	0	162,696	194,409
Contract Health Services	352,922	0	0	0	0	0	0	352,922	426,425	0	0	0	0	0	0	426,425	779,347
Subtotal (CS)	1,391,424	0	0	0	0	0	0	1,391,424	1,562,135	0	0	0	0	0	0	1,562,135	2,953,559
Public Health Nursing	0	0	33,557	0	0	0	0	33,557	0	30,514	0	0	0	0	0	30,514	64,071
Health Education	0	0	4,374	0	0	0	0	4,374	0	12,308	0	0	0	0	0	12,308	16,682
Community Health Repr.	0	0	1,570	0	0	0	0	1,570	0	60,058	0	0	0	0	0	60,058	61,628
Immunization AK	0	0	0	0	0	0	0	0	0	1,934	0	0	0	0	0	1,934	1,934
Subtotal (PH)	0	0	39,501	0	0	0	0	39,501	0	104,814	0	0	0	0	0	104,814	144,315
Urban Health Project	0	15,110	0	0	0	0	0	15,110	0	0	28,029	0	0	0	0	28,029	43,139
Indian Health Professions	0	0	0	40,743	0	0	0	40,743	0	0	0	0	0	0	0	0	40,743
Tribal Management	0	0	0	39	0	0	0	39	0	0	0	2,547	0	0	0	2,547	2,586
Direct Operations	0	0	0	0	51,031	0	0	51,031	0	0	0	17,689	0	0	0	17,689	68,720
Self-Governance	0	0	0	0	0	3,171	0	3,171	0	0	0	0	2,895	0	0	2,895	6,066
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	398,490	0	398,490	398,490
Subtotal (OS)	0	15,110	0	40,782	51,031	3,171	0	110,094	0	0	28,029	20,236	2,895	398,490	0	449,650	559,744
Total, Services	1,391,424	15,110	39,501	40,782	51,031	3,171	0	1,541,019	1,562,135	104,814	28,029	20,236	2,895	398,490	0	2,116,599	3,657,618
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	29,157	29,157	0	0	0	0	0	0	24,758	24,758	53,915
Sanitation Facilities Constr.	0	0	0	0	0	0	33,550	33,550	0	0	0	0	0	0	62,307	62,307	95,857
Health Care Facs. Constr.	0	0	0	0	0	0	7,000	7,000	0	0	0	0	0	0	22,234	22,234	29,234
Facs. & Env. Health Sup	0	0	0	0	0	0	131,766	131,766	0	0	0	0	0	0	61,321	61,321	193,087
Equipment	0	0	0	0	0	0	13,104	13,104	0	0	0	0	0	0	9,560	9,560	22,664
Total, Facilities	0	0	0	0	0	0	214,579	214,578	0	0	0	0	0	0	180,179	180,179	394,757
TOTAL, IHS	1,391,424	15,110	39,501	40,782	51,031	3,171	214,579	1,755,596	1,562,135	104,814	28,029	20,236	2,895	398,490	180,179	2,296,779	4,052,375

FY 2011 Crosswalk
Budget Authority
CR Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								FY 2011 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	890,697	0	0	0	0	0	0	890,697	863,686	0	0	0	0	0	0	863,686	1,754,383
Dental Health	82,281	0	0	0	0	0	0	82,281	70,353	0	0	0	0	0	0	70,353	152,634
Mental Health	33,811	0	0	0	0	0	0	33,811	38,975	0	0	0	0	0	0	38,975	72,786
Alcohol & Substance Abuse	31,713	0	0	0	0	0	0	31,713	162,696	0	0	0	0	0	0	162,696	194,409
Contract Health Services	352,922	0	0	0	0	0	0	352,922	426,425	0	0	0	0	0	0	426,425	779,347
Subtotal (CS)	1,391,424	0	0	0	0	0	0	1,391,424	1,562,135	0	0	0	0	0	0	1,562,135	2,953,559
Public Health Nursing	0	0	33,557	0	0	0	0	33,557	0	30,514	0	0	0	0	0	30,514	64,071
Health Education	0	0	4,374	0	0	0	0	4,374	0	12,308	0	0	0	0	0	12,308	16,682
Community Health Repr.	0	0	1,570	0	0	0	0	1,570	0	60,058	0	0	0	0	0	60,058	61,628
Immunization AK	0	0	0	0	0	0	0	0	0	1,934	0	0	0	0	0	1,934	1,934
Subtotal (PH)	0	0	39,501	0	0	0	0	39,501	0	104,814	0	0	0	0	0	104,814	144,315
Urban Health Project	0	15,110	0	0	0	0	0	15,110	0	0	28,029	0	0	0	0	28,029	43,139
Indian Health Professions	0	0	0	40,743	0	0	0	40,743	0	0	0	0	0	0	0	0	40,743
Tribal Management	0	0	0	39	0	0	0	39	0	0	0	2,547	0	0	0	2,547	2,586
Direct Operations	0	0	0	0	51,031	0	0	51,031	0	0	0	17,689	0	0	0	17,689	68,720
Self-Governance	0	0	0	0	0	3,171	0	3,171	0	0	0	0	2,895	0	0	2,895	6,066
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	398,490	0	398,490	398,490
Subtotal (OS)	0	15,110	0	40,782	51,031	3,171	0	110,094	0	0	28,029	20,236	2,895	398,490	0	449,650	559,744
Total, Services	1,391,424	15,110	39,501	40,782	51,031	3,171	0	1,541,019	1,562,135	104,814	28,029	20,236	2,895	398,490	0	2,116,599	3,657,618
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	29,157	29,157	0	0	0	0	0	0	24,758	24,758	53,915
Sanitation Facilities Constr.	0	0	0	0	0	0	33,550	33,550	0	0	0	0	0	0	62,307	62,307	95,857
Health Care Facs. Constr.	0	0	0	0	0	0	7,000	7,000	0	0	0	0	0	0	22,234	22,234	29,234
Facs. & Env. Health Sup	0	0	0	0	0	0	131,766	131,766	0	0	0	0	0	0	61,321	61,321	193,087
Equipment	0	0	0	0	0	0	13,104	13,104	0	0	0	0	0	0	9,560	9,560	22,664
Total, Facilities	0	0	0	0	0	0	214,579	214,578	0	0	0	0	0	0	180,179	180,179	394,757
TOTAL, IHS	1,391,424	15,110	39,501	40,782	51,031	3,171	214,579	1,755,596	1,562,135	104,814	28,029	20,236	2,895	398,490	180,179	2,296,779	4,052,375

FY 2012 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration								Tribal Health Administration								DY 2012 Estimate
	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	969,271	0	0	0	0	0	0	969,271	994,615	0	0	0	0	0	0	994,615	1,963,886
Dental Health	88,122	0	0	0	0	0	0	88,122	82,737	0	0	0	0	0	0	82,737	170,859
Mental Health	36,349	0	0	0	0	0	0	36,349	44,768	0	0	0	0	0	0	44,768	81,117
Alcohol & Substance Abuse	34,921	0	0	0	0	0	0	34,921	176,772	0	0	0	0	0	0	176,772	211,693
Contract Health Services	430,578	0	0	0	0	0	0	430,578	518,068	0	0	0	0	0	0	518,068	948,646
Subtotal (CS)	1,559,242	0	0	0	0	0	0	1,559,242	1,816,959	0	0	0	0	0	0	1,816,959	3,376,201
Public Health Nursing	0	0	35,532	0	0	0	0	35,532	0	35,081	0	0	0	0	0	35,081	70,613
Health Education	0	0	4,645	0	0	0	0	4,645	0	13,545	0	0	0	0	0	13,545	18,190
Community Health Repr.	0	0	1,651	0	0	0	0	1,651	0	64,095	0	0	0	0	0	64,095	65,746
Immunization AK	0	0	0	0	0	0	0	0	0	2,064	0	0	0	0	0	2,064	2,064
Subtotal (PH)	0	0	41,828	0	0	0	0	41,828	0	114,785	0	0	0	0	0	114,785	156,613
Urban Health Project	0	16,251	0	0	0	0	0	16,251	0	0	30,494	0	0	0	0	30,494	46,745
Indian Health Professions	0	0	0	42,016	0	0	0	42,016	0	0	0	0	0	0	0	0	42,016
Tribal Management	0	0	0	43	0	0	0	43	0	0	0	2,719	0	0	0	2,719	2,762
Direct Operations	0	0	0	0	54,740	0	0	54,740	0	0	0	18,896	0	0	0	18,896	73,636
Self-Governance	0	0	0	0	0	3,322	0	3,322	0	0	0	0	3,007	0	0	3,007	6,329
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	461,837	0	461,837	461,837
Subtotal (OS)	0	16,251	0	42,059	54,740	3,322	0	116,373	0	0	30,494	21,614	3,007	461,837	0	516,952	633,325
Total, Services	1,559,242	16,251	41,828	42,059	54,740	3,322	0	1,717,443	1,816,959	114,785	30,494	21,614	3,007	461,837	0	2,448,696	4,166,139
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	18,958	18,958	0	0	0	0	0	0	38,120	38,120	57,078
Sanitation Facilities Constr.	0	0	0	0	0	0	27,899	27,899	0	0	0	0	0	0	51,811	51,811	79,710
Health Care Facs. Constr.	0	0	0	0	0	0	13,000	13,000	0	0	0	0	0	0	72,184	72,184	85,184
Facs. & Env. Health Sup	0	0	0	0	0	0	147,359	147,359	0	0	0	0	0	0	63,633	63,633	210,992
Equipment	0	0	0	0	0	0	10,618	10,618	0	0	0	0	0	0	14,087	14,087	24,705
Total, Facilities	0	0	0	0	0	0	217,835	217,834	0	0	0	0	0	0	239,836	239,836	457,669
TOTAL, IHS	1,559,242	16,251	41,828	42,059	54,740	3,322	217,835	1,935,277	1,816,959	114,785	30,494	21,614	3,007	461,837	239,836	2,688,532	4,623,808

INDIAN HEALTH SERVICE

Federal Funds

General and Special Funds:

INDIAN HEALTH SERVICES

For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination Act, the Indian Health Care Improvement Act, and titles II and III of the Public Health Service Act with respect to the Indian Health Service, [$3,657,618,000] $4,166,139,000, 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 [$779,347,000] $948,646,000 for contract medical care, including [$48,000,000] $58,000,000 for the Indian Catastrophic Health Emergency Fund, shall remain available until expended: Provided further, That of the funding provided for information technology activities and, notwithstanding any other provision of law, [$4,000,000] $4,000,000 shall be allocated at the discretion of the Director of the Indian Health Service: Provided further, That of the funds provided, up to [$36,000,000] $42,000,000 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 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 [$16,391,000] $16,391,000 is provided for the methamphetamine and suicide prevention and treatment initiative and [$10,000,000] $10,000,000 is provided for the domestic violence prevention initiative and, notwithstanding any other provision of law, the amounts available under this proviso shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended: Provided further, That [$4,000,000] $4,000,000 is provided for a substance abuse treatment grant program and, notwithstanding any other provision of law, the amounts available under this proviso shall be allocated at the discretion of the

Director of the Indian Health Service and shall remain available until September 30, 2013: Provided further, That funds provided in this Act may be used for annual contracts and grants that fall within two 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, notwithstanding any other provision of law, of the amounts provided herein, not to exceed [$398,490,000] $461,837,000 shall be for payments to tribes and tribal organizations for contract or grant support costs associated with contracts, grants, self-governance compacts, or annual funding agreements between the Indian Health Service and a tribe or tribal organization pursuant to the Indian Self-Determination Act of 1975, as amended, prior to or during fiscal year [2011] 2012, of which not to exceed [$10,000,000] $10,000,000 may be used for contract support costs associated with new or expanded self-determination contracts, grants, self-governance compacts, or annual funding agreements: Provided further, That the Bureau of Indian Affairs may collect from the Indian Health Service, tribes and tribal organizations operating health facilities pursuant to Public Law 93-638, such individually identifiable health information relating to disabled children as may be necessary for the purpose of carrying out its functions under the Individuals with Disabilities Education Act (20 U.S.C. 1400, et seq.): Provided further, That the Indian Health Care Improvement Fund may be used, as needed, to carry out activities typically funded under the Indian Health Facilities account.

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, [$394,757,000] $457,669,000, 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 a federally-recognized 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] $500,000 shall be used by the Indian Health Service to purchase TRANSAM equipment from the Department of Defense for distribution to the Indian Health Service and tribal facilities: Provided further, That none of the funds appropriated to the Indian Health Service may be used for sanitation facilities construction for new homes funded with grants by the housing programs of the United States Department of Housing and Urban Development: Provided further, That not to exceed [$2,700,000] $2,700,000 from this account and the ``Indian Health Services'' account shall be used by the Indian Health Service to obtain ambulances for the Indian Health Service and tribal facilities in conjunction with an existing interagency agreement between the Indian Health Service and the General Services Administration: Provided further, That not to exceed [$500,000] $500,000 shall 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.

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.

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

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

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

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

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

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

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

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

GENERAL PROVISIONS

Sec. 408. Notwithstanding any other provision of law, amounts appropriated to or otherwise designated in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-

138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, 108-447, 109-54, 109-289, division B and Continuing Appropriations Resolution, 2007 (division B of Public Law 109-289, as amended by Public Laws 110-5 and 110-28), Public Laws 110-92, 110-116, 110-137, 110-149, 110-161, 110-329, 111-6, 111-8, 111-88, and _____ for payments for contract support costs associated with self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded by such Acts, are the total amounts available for fiscal years 1994 through [2010] 2011 for such purposes, except that the Bureau of Indian Affairs, tribes and tribal organizations may use their tribal priority allocations for unmet contract support costs of ongoing contracts, grants, self-governance compacts, or annual funding agreements.

Language Analysis

Language Provision	*Explanation*
GENERAL PROVISIONS	
Sec. 408. Notwithstanding any other provision of law, amounts appropriated to or otherwise designated in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, 108-447, 109-54, 109-289, division B and Continuing Appropriations Resolution, 2007 (division B of Public Law 109-289, as amended by Public Law 110-5 and 110-28), Public Laws 110-92, 110-116, 110-137, 110-149, 110-161, 110-329, 111-6, 111-8, and 111-88, and _____ for payments for contract support costs associated with self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded by such Acts, are the total amounts available for fiscal years 1994 through [2010] 2011 for such purposes, except that for the Bureau of Indian Affairs, tribes and tribal organizations may use their tribal priority allocations for unmet contract support costs of ongoing contracts, grants, self-governance compacts or annual funding agreements.	*Added to continue provision to limit payments for Contract Support Costs in past years (FY 1994 through 2010) to the funds available in law and accompanying the report language in those years for the Bureau of Indian Affairs and Indian Health Service.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
SERVICES

Amounts Available for Obligations

	FY 2010	FY 2011	FY 2012
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$3,657,618,000	$3,657,618,000	$4,166,139,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$3,657,618,000	$3,657,618,000	$4,166,139,000
Subtotal, adjusted appropriation	$3,657,618,000	$3,657,618,000	$4,166,139,000
Mandatory Appropriation:			
Appropriation	$150,000,000	$150,000,000	$150,000,000
Offsetting Collections:			
Federal sources	($365,000,000)	($365,000,000)	($370,000,000)
Non-federal sources	($756,000,000)	($756,000,000)	($767,000,000)
Subtotal	($1,121,000,000)	($1,121,000,000)	($1,137,000,000)
Unobligated Balance, Start of Year	392,000,000	392,000,000	372,000,000
Unobligated Balance End of Year	433,000,000	433,000,000	310,000,000
Total Obligations	$2,495,618,000	$2,495,618,000	$3,091,139,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FACILITIES

Amounts Available for Obligations

	FY 2010	FY 2011	FY 2012
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$394,757,000	$394,757,000	$457,669,000
Across-the-board reductions (Interior)	$0	$0	$0
Subtotal, Appropriation (Interior)	$394,757,000	$394,757,000	$457,669,000
Subtotal, adjusted appropriation	$394,757,000	$394,757,000	$457,669,000
Offsetting Collections:			
Federal sources	($4,000,000)	($4,000,000)	($6,000,000)
Subtotal	($4,000,000)	($4,000,000)	($6,000,000)
Unobligated Balance, Start of Year	346,000,000	346,000,000	186,000,000
Unobligated Balance End of Year	180,000,000	180,000,000	192,000,000
Total Obligations	$556,757,000	$556,757,000	$445,669,000

INDIAN HEALTH SERVICE
SERVICES
Summary of Changes

FY 2010 Enacted	$3,657,618,000
Total estimated budget authority	3,657,618,000
Less Obligations	(3,657,618,000)
FY 2012 Estimate	4,166,139,000
Less Obligations	(4,166,139,000)
Net Change	508,521,000
Less Obligations	(508,521,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
2	2012 Pay Raise at 1.4% for CO	--	n/a	--	3,267,000
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
6	Increased Cost of Travel	--	40,084,000	--	2,334,000
7	Increased Cost of Transportation & Things	--	9,237,000	--	309,000
8	Increased Cost of Printing	--	499,000	--	11,000
9	Increased Cost of Rents, Communications, & Utilities	--	29,366,000	--	1,124,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	621,701,000	--	52,397,000
11	Increased Cost of Supplies	--	130,663,000	--	8,020,000
12	Increased Cost of Medical or other Equipment	--	11,954,000	--	403,000
13	Increased Cost of Land & Structure	--	(85,000)	--	(1,000)
14	Increased Cost of Grants	--	2,143,138,000	--	81,389,000
15	Increased Cost of Insurance / Indemnities	--	1,212,000	--	24,000
16	Increased Cost of Interest / Dividends	--	87,000	--	2,000
17	Population Growth	--	n/a	--	86,140,000
	Subtotal, Built-In	--	2,987,856,000	--	235,419,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	569	64,501,000
C. Program Increases		--	0	--	215,601,000
TOTAL INCREASES		--	2,987,856,000	569	515,521,000
DECREASES					
A. Built-In					
Grants Savings		--	0	--	(7,000,000)
TOTAL DECREASES		--	0	--	(7,000,000)
NET CHANGE		--	**$2,987,856,000**	**569**	**$508,521,000**

INDIAN HEALTH SERVICE
Clinical Services
Summary of Changes

FY 2010 Enacted	
Total estimated budget authority	$2,953,559,000
Less Obligations	(2,953,559,000)
FY 2012 Estimate	3,376,201,000
Less Obligations	(3,376,201,000)
Net Change	422,642,000
Less Obligations	(422,642,000)

	FY 2010 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2012 Pay Raise at 1.4% for CO	--	n/a	--	2,948,000
2 Tribal Pay Cost	--	n/a	--	-
3 Within Grade Increase	--	n/a	--	-
4 Increased Cost of Travel	--	37,287,000	--	2,249,000
6 Increased Cost of Transportation & Things	--	7,755,000	--	264,000
7 Increased Cost of Printing	--	463,000	--	11,000
8 Increased Cost of Rents, Communications, & Utilities	--	28,649,000	--	1,097,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	609,228,000	--	50,789,000
10 Increased Cost of Supplies	--	127,710,000	--	7,874,000
11 Increased Cost of Medical or other Equipment	--	10,227,000	--	362,000
12 Increased Cost of Land & Structure	--	(85,000)	--	(1,000)
13 Increased Cost of Grants	--	1,537,970,000	--	60,711,000
14 Increased Cost of Insurance / Indemnities	--	1,038,000	--	20,000
15 Increased Cost of Interest / Dividends	--	29,000	--	2,000
16 Population Growth	--	n/a	--	80,849,000
Subtotal, Built-In	--	2,360,271,000	--	207,175,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	539	61,270,000
C. Indian Health Care Improvement Fund	--	0	--	54,000,000
D. Health IT Security	--	0	--	4,000,000
E. Chronic Diseases	--	0	--	2,529,000
F. Business Operations Support	--	0	--	6,033,000
G. IHCIA Implementation	--	0	--	1,000,000
H. Alcohol/Substance Abuse	--	0	--	4,000,000
I. CHS Increase	--	0	--	89,635,000
TOTAL INCREASES	--	2,360,271,000	539	429,642,000
DECREASES				
A. Built-In				
Grant Savings	--	0	--	(7,000,000)
TOTAL DECREASES	--	0	--	(7,000,000)
NET CHANGE	--	**$2,360,271,000**	**539**	**$422,642,000**

INDIAN HEALTH SERVICE
Hospitals & Health Clinics
Summary of Changes

FY 2010 Enacted	$1,754,383,000
Total estimated budget authority	1,754,383,000
Less Obligations	(1,754,383,000)
FY 2012 Estimate	1,963,886,000
Less Obligations	(1,963,886,000)
Net Change	209,503,000
Less Obligations	(209,503,000)

	FY 2010 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2012 Pay Raise at 1.4% for CO	--	n/a	--	2,302,000
2 Tribal Pay Cost	--	n/a	--	0
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	9,601,000	--	324,000
6 Increased Cost of Transportation & Things	--	6,812,000	--	231,000
7 Increased Cost of Printing	--	451,000	--	11,000
8 Increased Cost of Rents, Communications, & Utilities	--	28,310,000	--	1,085,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	187,548,000	--	17,333,000
10 Increased Cost of Supplies	--	110,632,000	--	6,813,000
11 Increased Cost of Medical or other Equipment	--	8,140,000	--	271,000
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	914,340,000	--	24,582,000
14 Increased Cost of Insurance / Indemnities	--	688,000	--	13,000
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Population Growth	--	n/a	--	45,891,000
Subtotal, Built-In	--	1,266,522,000	--	98,856,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	435	51,085,000
C. Indian Health Care Improvement Fund	--	0	--	54,000,000
D. Health IT Security	--	0	--	4,000,000
E. Chronic Diseases*	--	0	--	2,529,000
F. Business Operations Support	--	0	--	6,033,000
TOTAL INCREASES	--	1,266,522,000	435	216,503,000
DECREASES				
A. Built-In				
Grants Savings	--	0	--	(7,000,000)
TOTAL DECREASES	--	0	--	(7,000,000)
NET CHANGE	--	**$1,266,522,000**	**435**	**$209,503,000**

* Chronic Diseases increase is to address obesity and tobacco, not to expand chronic care initiative grants.

INDIAN HEALTH SERVICE
Dental Health
Summary of Changes

FY 2010 Enacted	$152,634,000
Total estimated budget authority	152,634,000
Less Obligations	(152,634,000)
FY 2012 Estimate	170,859,000
Less Obligations	(170,859,000)
Net Change	18,225,000
Less Obligations	(18,225,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	544,000
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	1,037,000	--	33,000
6	Increased Cost of Transportation & Things	--	476,000	--	16,000
7	Increased Cost of Printing	--	6,000	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	126,000	--	4,000
9	Increased Cost of Health Care Provided under Contracts & Grants	--	10,289,000	--	1,339,000
10	Increased Cost of Supplies	--	6,297,000	--	376,000
11	Increased Cost of Medical or other Equipment	--	1,559,000	--	51,000
12	Increased Cost of Land & Structure	--	(85,000)	--	(1,000)
13	Increased Cost of Grants	--	69,860,000	--	4,434,000
14	Increased Cost of Insurance / Indemnities	--	0	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Population Growth	--	n/a	--	4,367,000
	Subtotal, Built-In	--	89,565,000	--	11,163,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	70	7,062,000
	TOTAL INCREASES	--	89,565,000	70	18,225,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$89,565,000**	**70**	**$18,225,000**

INDIAN HEALTH SERVICE
Mental Health
Summary of Changes

FY 2010 Enacted	
Total estimated budget authority	$ 72,786,000
Less Obligations	(72,786,000)
FY 2012 Estimate	81,117,000
Less Obligations	(81,117,000)
Net Change	8,331,000
Less Obligations	(8,331,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	71,000
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	468,000	--	15,000
6	Increased Cost of Transportation & Things	--	348,000	--	13,000
7	Increased Cost of Printing	--	2,000	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	16,000	--	0
9	Increased Cost of Health Care Provided under Contracts & Grants	--	5,418,000	--	770,000
10	Increased Cost of Supplies	--	1,151,000	--	27,000
11	Increased Cost of Medical or other Equipment	--	316,000	--	8,000
12	Increased Cost of Land & Structure	--	0	--	0
13	Increased Cost of Grants	--	37,378,000	--	1,406,000
14	Increased Cost of Insurance / Indemnities	--	102,000	--	3,000
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Population Growth	--	n/a	--	2,094,000
	Subtotal, Built-In	--	45,199,000	--	4,407,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	32	2,924,000
C. IHCIA Implementation		--	0	--	1,000,000
	TOTAL INCREASES	--	45,199,000	32	8,331,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$45,199,000**	**32**	**$8,331,000**

INDIAN HEALTH SERVICE
Alcohol & Substance Abuse
Summary of Changes

FY 2010 Enacted	$194,409,000
Total estimated budget authority	194,409,000
Less Obligations	(194,409,000)
FY 2012 Estimate	211,693,000
Less Obligations	(211,693,000)
Net Change	17,284,000
Less Obligations	(17,284,000)

	FY 2010 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 2012 Pay Raise at 1.4% for CO	--	n/a	--	31,000
2 Tribal Pay Cost	--	n/a	--	0
3 Within Grade Increase	--	n/a	--	0
4 Increased Cost of Travel	--	348,000	--	10,000
6 Increased Cost of Transportation & Things	--	99,000	--	4,000
7 Increased Cost of Printing	--	4,000	--	0
8 Increased Cost of Rents, Communications, & Utilities	--	196,000	--	8,000
9 Increased Cost of Health Care Provided under Contracts & Grants	--	9,224,000	--	965,000
10 Increased Cost of Supplies	--	1,158,000	--	71,000
11 Increased Cost of Medical or other Equipment	--	186,000	--	6,000
12 Increased Cost of Land & Structure	--	0	--	0
13 Increased Cost of Grants	--	168,874,000	--	6,399,000
14 Increased Cost of Insurance / Indemnities	--	13,000	--	0
15 Increased Cost of Interest / Dividends	--	0	--	0
16 Population Growth	--	n/a	--	5,591,000
Subtotal, Built-In	--	180,102,000	0	13,085,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	2	199,000
B. Alcohol/Substance Abuse	--	0	--	4,000,000
TOTAL INCREASES	--	180,102,000	2	17,284,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	0
TOTAL DECREASES	--	0	--	0
NET CHANGE	--	**$180,102,000**	**2**	**$17,284,000**

INDIAN HEALTH SERVICE
Contract Health Services
Summary of Changes

FY 2010 Enacted	$779,347,000
Total estimated budget authority	779,347,000
Less Obligations	(779,347,000)
FY 2012 Estimate	948,646,000
Less Obligations	(948,646,000)
Net Change	169,299,000
Less Obligations	(169,299,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	0
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	25,833,000	--	1,867,000
6	Increased Cost of Transportation & Things	--	20,000	--	0
7	Increased Cost of Printing	--	0	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	1,000	--	0
9	Increased Cost of Health Care Provided under Contracts & Grants	--	396,749,000	--	30,382,000
10	Increased Cost of Supplies	--	8,472,000	--	587,000
11	Increased Cost of Medical or other Equipment	--	26,000	--	26,000
12	Increased Cost of Land & Structure	--	0	--	0
13	Increased Cost of Grants	--	347,518,000	--	23,890,000
14	Increased Cost of Insurance / Indemnities	--	235,000	--	4,000
15	Increased Cost of Interest / Dividends	--	29,000	--	2,000
16	Population Growth	--	n/a	--	22,906,000
	Subtotal, Built-In	--	778,883,000	--	79,664,000
B. CHS Increase		--	0	--	89,635,000
	TOTAL INCREASES	--	778,883,000	--	169,299,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$778,883,000**	--	**$169,299,000**

INDIAN HEALTH SERVICE
Preventive Health
Summary of Changes

FY 2010 Enacted	$144,315,000
Total estimated budget authority	144,315,000
Less Obligations	(144,315,000)
FY 2012 Estimate	156,613,000
Less Obligations	(156,613,000)
Net Change	12,298,000
Less Obligations	(12,298,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	$119,000
2	Tribal Pay Cost	--	n/a	--	$0
3	Within Grade Increase	--	n/a	--	$0
4	Increased Cost of Travel	--	618,000	--	$20,000
6	Increased Cost of Transportation & Things	--	1,109,000	--	$36,000
7	Increased Cost of Printing	--	7,000	--	$0
8	Increased Cost of Rents, Communications, & Utilities	--	231,000	--	$10,000
9	Increased Cost of Health Care Provided under Contracts & Grants	--	3,731,000	--	$589,000
10	Increased Cost of Supplies	--	2,671,000	--	$142,000
11	Increased Cost of Medical or other Equipment	--	948,000	--	$27,000
12	Increased Cost of Land & Structure	--	0	--	$0
13	Increased Cost of Grants	--	106,142,000	--	$3,997,000
14	Increased Cost of Insurance / Indemnities	--	0	--	$0
15	Increased Cost of Interest / Dividends	--	0	--	$0
16	Population Growth	--	n/a	--	$4,127,000
	Subtotal, Built-In	--	115,457,000	0	9,067,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	30	3,231,000
	TOTAL INCREASES	--	115,457,000	30	12,298,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$115,457,000**	**30**	**$12,298,000**

INDIAN HEALTH SERVICE
Public Health Nursing
Summary of Changes

FY 2010 Enacted	$64,071,000
Total estimated budget authority	64,071,000
Less Obligations	(64,071,000)
FY 2012 Estimate	70,613,000
Less Obligations	(70,613,000)
Net Change	6,542,000
Less Obligations	(6,542,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	114,000
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	417,000	--	14,000
6	Increased Cost of Transportation & Things	--	1,017,000	--	33,000
7	Increased Cost of Printing	--	7,000	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	214,000	--	9,000
9	Increased Cost of Health Care Provided under Contracts & Grants	--	2,810,000	--	494,000
10	Increased Cost of Supplies	--	1,916,000	--	97,000
11	Increased Cost of Medical or other Equipment	--	880,000	--	19,000
12	Increased Cost of Land & Structure	--	0	--	0
13	Increased Cost of Grants	--	31,283,000	--	1,127,000
14	Increased Cost of Insurance / Indemnities	--	0	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Population Growth	--	n/a	--	1,839,000
	Subtotal, Built-In	--	38,544,000	0	3,746,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	25	2,796,000
	TOTAL INCREASES	--	38,544,000	25	6,542,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$38,544,000**	**25**	**$6,542,000**

INDIAN HEALTH SERVICE
Health Education
Summary of Changes

FY 2010 Enacted	$16,682,000
Total estimated budget authority	16,682,000
Less Obligations	(16,682,000)
FY 2012 Estimate	18,190,000
Less Obligations	(18,190,000)
Net Change	1,508,000
Less Obligations	(1,508,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	3,000
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	158,000	--	4,000
6	Increased Cost of Transportation & Things	--	55,000	--	2,000
7	Increased Cost of Printing	--	0	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	11,000	--	0
9	Increased Cost of Health Care Provided under Contracts & Grants	--	279,000	--	60,000
10	Increased Cost of Supplies	--	747,000	--	42,000
11	Increased Cost of Medical or other Equipment	--	52,000	--	6,000
12	Increased Cost of Land & Structure	--	0	--	0
13	Increased Cost of Grants	--	12,491,000	--	479,000
14	Increased Cost of Insurance / Indemnities	--	0	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Population Growth	--	n/a	--	477,000
	Subtotal, Built-In	--	13,793,000	0	1,073,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	5	435,000
	TOTAL INCREASES	--	13,793,000	5	1,508,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$13,793,000**	**5**	**$1,508,000**

INDIAN HEALTH SERVICE
Community Health Representatives
Summary of Changes

FY 2010 Enacted	$61,628,000
Total estimated budget authority	61,628,000
Less Obligations	(61,628,000)
FY 2012 Estimate	65,746,000
Less Obligations	(65,746,000)
Net Change	4,118,000
Less Obligations	(4,118,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	2,000
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	43,000	--	2,000
6	Increased Cost of Transportation & Things	--	37,000	--	1,000
7	Increased Cost of Printing	--	0	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	6,000	--	1,000
9	Increased Cost of Health Care Provided under Contracts & Grants	--	642,000	--	35,000
10	Increased Cost of Supplies	--	8,000	--	3,000
11	Increased Cost of Medical or other Equipment	--	16,000	--	2,000
12	Increased Cost of Land & Structure	--	0	--	0
13	Increased Cost of Grants	--	60,434,000	--	2,316,000
14	Increased Cost of Insurance / Indemnities	--	0	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Population Growth	--	n/a	--	1,756,000
	Subtotal, Built-In	--	61,186,000	0	4,118,000
	TOTAL INCREASES	--	61,186,000	0	4,118,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$61,186,000**	--	**$4,118,000**

INDIAN HEALTH SERVICE
Immunization AK
Summary of Changes

FY 2010 Enacted	$1,934,000
Total estimated budget authority	1,934,000
Less Obligations	(1,934,000)
FY 2012 Estimate	2,064,000
Less Obligations	(2,064,000)
Net Change	130,000
Less Obligations	(130,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	0
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	0	--	0
6	Increased Cost of Transportation & Things	--	0	--	0
7	Increased Cost of Printing	--	0	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
9	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
10	Increased Cost of Supplies	--	0	--	0
11	Increased Cost of Medical or other Equipment	--	0	--	0
12	Increased Cost of Land & Structure	--	0	--	0
13	Increased Cost of Grants	--	1,934,000	--	75,000
14	Increased Cost of Insurance / Indemnities	--	0	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Population Growth	--	n/a	--	55,000
	Subtotal, Built-In	--	1,934,000	0	130,000
	TOTAL INCREASES	--	1,934,000	0	130,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$1,934,000**	--	**$130,000**

INDIAN HEALTH SERVICE
Other
Summary of Changes

FY 2010 Enacted	$559,744,000
Total estimated budget authority	559,744,000
Less Obligations	(559,744,000)
FY 2012 Estimate	633,325,000
Less Obligations	(633,325,000)
Net Change	73,581,000
Less Obligations	(73,581,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	200,000
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	2,179,000	--	65,000
6	Increased Cost of Transportation & Things	--	373,000	--	9,000
7	Increased Cost of Printing	--	29,000	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	486,000	--	17,000
9	Increased Cost of Health Care Provided under Contracts & Grants	--	8,742,000	--	1,019,000
10	Increased Cost of Supplies	--	282,000	--	4,000
11	Increased Cost of Medical or other Equipment	--	779,000	--	14,000
12	Increased Cost of Land & Structure	--	0	--	0
13	Increased Cost of Grants	--	499,026,000	--	16,681,000
14	Increased Cost of Insurance / Indemnities	--	174,000	--	4,000
15	Increased Cost of Interest / Dividends	--	58,000	--	0
16	Population Growth	--	n/a	--	1,164,000
	Subtotal, Built-In	--	512,128,000	--	19,177,000
B. Improve 3rd Party of Collections		--	0	--	1,000,000
C. Direct Operations		--	0	--	3,404,000
D. Contract Support Costs		--	0	--	50,000,000
TOTAL INCREASES		--	512,128,000	--	73,581,000
DECREASES					
A. Built-In					
Absorption of Built-In Increases		--	0	--	0
B. Program Decreases:		--	0	--	0
TOTAL DECREASES		--	0	--	0
NET CHANGE		--	**$512,128,000**	--	**$73,581,000**

INDIAN HEALTH SERVICE
Urban Indian Health
Summary of Changes

FY 2010 Enacted	$43,139,000
Total estimated budget authority	43,139,000
Less Obligations	(43,139,000)
FY 2012 Estimate	46,745,000
Less Obligations	(46,745,000)
Net Change	3,606,000
Less Obligations	(3,606,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	22,000
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	129,000	--	5,000
6	Increased Cost of Transportation & Things	--	2,000	--	0
7	Increased Cost of Printing	--	0	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	83,000	--	1,000
9	Increased Cost of Health Care Provided under Contracts & Grants	--	3,277,000	--	126,000
10	Increased Cost of Supplies	--	31,000	--	1,000
11	Increased Cost of Medical or other Equipment	--	15,000	--	1,000
12	Increased Cost of Land & Structure	--	0	--	0
13	Increased Cost of Grants	--	38,323,000	--	1,286,000
14	Increased Cost of Insurance / Indemnities	--	0	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Population Growth	--	n/a	--	1,164,000
	Subtotal, Built-In	--	41,860,000	--	2,606,000
B. Improve 3rd Party of Collections		--	0	--	1,000,000
	TOTAL INCREASES	--	41,860,000	--	3,606,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$41,860,000**	--	**$3,606,000**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2010 Enacted	$40,743,000
Total estimated budget authority	40,743,000
Less Obligations	(40,743,000)
FY 2012 Estimate	42,016,000
Less Obligations	(42,016,000)
Net Change	1,273,000
Less Obligations	(1,273,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	4,000
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	43,000	--	1,000
6	Increased Cost of Transportation & Things	--	1,000	--	0
7	Increased Cost of Printing	--	0	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
9	Increased Cost of Health Care Provided under Contracts & Grants	--	264,000	--	146,000
10	Increased Cost of Supplies	--	9,000	--	0
11	Increased Cost of Medical or other Equipment	--	4,000	--	0
12	Increased Cost of Land & Structure	--	0	--	0
13	Increased Cost of Grants	--	39,009,000	--	1,121,000
14	Increased Cost of Insurance / Indemnities	--	0	--	1,000
15	Increased Cost of Interest / Dividends	--	58,000	--	0
16	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	39,388,000	--	1,273,000
	TOTAL INCREASES	--	39,388,000	--	1,273,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$39,388,000**	--	**$1,273,000**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2010 Enacted	$2,586,000
Total estimated budget authority	2,586,000
Less Obligations	(2,586,000)
FY 2012 Estimate	2,762,000
Less Obligations	(2,762,000)
Net Change	176,000
Less Obligations	(176,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	0
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	9,000	--	0
6	Increased Cost of Transportation & Things	--	1,000	--	0
7	Increased Cost of Printing	--	0	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	1,000	--	0
9	Increased Cost of Health Care Provided under Contracts & Grants	--	46,000	--	0
10	Increased Cost of Supplies	--	3,000	--	0
11	Increased Cost of Medical or other Equipment	--	0	--	0
12	Increased Cost of Land & Structure	--	0	--	0
13	Increased Cost of Grants	--	2,499,000	--	176,000
14	Increased Cost of Insurance / Indemnities	--	0	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	2,559,000	--	176,000
	TOTAL INCREASES	--	2,559,000	--	176,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$2,559,000**	--	**$176,000**

INDIAN HEALTH SERVICE
Direct Operations
Summary of Changes

FY 2010 Enacted	$68,720,000
Total estimated budget authority	68,720,000
Less Obligations	(68,720,000)
FY 2012 Estimate	73,636,000
Less Obligations	(73,636,000)
Net Change	4,916,000
Less Obligations	(4,916,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	174,000
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	1,860,000	--	55,000
6	Increased Cost of Transportation & Things	--	350,000	--	9,000
7	Increased Cost of Printing	--	29,000	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	392,000	--	16,000
9	Increased Cost of Health Care Provided under Contracts & Grants	--	4,483,000	--	686,000
10	Increased Cost of Supplies	--	231,000	--	3,000
11	Increased Cost of Medical or other Equipment	--	735,000	--	13,000
12	Increased Cost of Land & Structure	--	0	--	0
13	Increased Cost of Grants	--	17,622,000	--	553,000
14	Increased Cost of Insurance / Indemnities	--	174,000	--	3,000
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	25,876,000	--	1,512,000
C. Direct Operations		--	0	--	3,404,000
	TOTAL INCREASES	--	25,876,000	--	4,916,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$25,876,000**	--	**$4,916,000**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2010 Enacted	$6,066,000
Total estimated budget authority	6,066,000
Less Obligations	(6,066,000)
FY 2012 Estimate	6,329,000
Less Obligations	(6,329,000)
Net Change	263,000
Less Obligations	(263,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	0
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	138,000	--	4,000
6	Increased Cost of Transportation & Things	--	19,000	--	0
7	Increased Cost of Printing	--	0	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	10,000	--	0
9	Increased Cost of Health Care Provided under Contracts & Grants	--	671,000	--	61,000
10	Increased Cost of Supplies	--	6,000	--	0
11	Increased Cost of Medical or other Equipment	--	25,000	--	0
12	Increased Cost of Land & Structure	--	0	--	0
13	Increased Cost of Grants	--	3,086,000	--	198,000
14	Increased Cost of Insurance / Indemnities	--	0	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	3,955,000	--	263,000
	TOTAL INCREASES	--	3,955,000	--	263,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$3,955,000**	--	**$263,000**

INDIAN HEALTH SERVICE
Contract Support Costs
Summary of Changes

FY 2010 Enacted	$398,490,000
Total estimated budget authority	398,490,000
Less Obligations	(398,490,000)
FY 2012 Estimate	461,837,000
Less Obligations	(461,837,000)
Net Change	63,347,000
Less Obligations	(63,347,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	0
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	0	--	0
6	Increased Cost of Transportation & Things	--	0	--	0
7	Increased Cost of Printing	--	0	--	0
8	Increased Cost of Rents, Communications, & Utilities	--	0	--	0
9	Increased Cost of Health Care Provided under Contracts & Grants	--	1,000	--	0
10	Increased Cost of Supplies	--	2,000	--	0
11	Increased Cost of Medical or other Equipment	--	0	--	0
12	Increased Cost of Land & Structure	--	0	--	0
13	Increased Cost of Grants	--	398,487,000	--	13,347,000
14	Increased Cost of Insurance / Indemnities	--	0	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Increased Cost of Service & Supply Fund	--	0	--	0
17	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	398,490,000	--	13,347,000
B. Contract Support Costs		--	113,418,000	--	50,000,000
	TOTAL INCREASES	--	511,908,000	--	63,347,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		--	**$511,908,000**	--	**$63,347,000**

INDIAN HEALTH SERVICE
FACILITIES
Summary of Changes

FY 2010 Enacted	$394,757,000
Total budget authority	394,757,000
Less Obligations	(394,757,000)
FY 2012 Estimate	457,669,000
Less Obligations	(457,669,000)
Net Change	62,912,000
Less Obligations	(62,912,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	835,000
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	3,863,000	--	108,000
6	Increased Cost of Transportation & Things	--	2,451,000	--	69,000
7	Increased Cost of Printing	--	97,000	--	1,000
8	Increased Cost of Rents, Communications, & Utilties	--	20,682,000	--	682,000
9	Increased Cost of Health Care Provided under Contracts & Grants	--	121,801,000	--	2,338,000
10	Increased Cost of Supplies	--	3,129,000	--	187,000
11	Increased Cost of Medical or other Equipment	--	6,809,000	--	430,000
12	Increased Cost of Land & Structure	--	23,012,000	--	326,000
13	Increased Cost of Grants	--	123,493,000	--	5,155,000
14	Increased Cost of Insurance / Indemnities	--	2,000	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Increased Cost of Service & Supply Fund	--	0	--	0
17	Population Growth	--	n/a	--	10,410,000
	Subtotal, Built-In	--	305,339,000	--	20,541,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	47	7,032,000
C. Program Increaes		--	0	--	54,958,000
	TOTAL INCREASES	--	305,339,000		82,531,000
DECREASES					
A. Built-In					
	SFC Savings	--	0	--	(19,619,000)
	TOTAL DECREASES	--	0	--	(19,619,000)
NET CHANGE		**--**	**$305,339,000**	**47**	**$62,912,000**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2010 Enacted	$53,915,000
Total budget authority	53,915,000
Less Obligations	(53,915,000)
FY 2012 Estimate	57,078,000
Less Obligations	(57,078,000)
Net Change	3,163,000
Less Obligations	(3,163,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	0
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	0	--	0
6	Increased Cost of Transportation & Things	--	0	--	0
7	Increased Cost of Printing	--	0	--	0
8	Increased Cost of Rents, Communications, & Utilties	--	0	--	0
9	Increased Cost of Health Care Provided under Contracts & Grants	--	29,787,000	--	628,000
10	Increased Cost of Supplies	--	7,000	--	75,000
11	Increased Cost of Medical or other Equipment	--	47,000	--	7,000
12	Increased Cost of Land & Structure	--	17,808,000	--	317,000
13	Increased Cost of Grants	--	6,266,000	--	605,000
14	Increased Cost of Insurance / Indemnities	--	0	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Increased Cost of Service & Supply Fund	--	0	--	0
17	Population Growth	--	0	--	1,531,000
	Subtotal, Built-In	--	53,915,000	--	3,163,000
	TOTAL INCREASES	--	53,915,000	--	3,163,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		**--**	**$53,915,000**	**--**	**$3,163,000**

INDIAN HEALTH SERVICE
Sanitation Facilities Construction
Summary of Changes

FY 2010 Enacted	$95,857,000
Total budget authority	95,857,000
Less Obligations	(95,857,000)
FY 2012 Estimate	79,710,000
Less Obligations	(79,710,000)
Net Change	(16,147,000)
Less Obligations	16,147,000

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	0
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	45,000	--	2,000
6	Increased Cost of Transportation & Things	--	29,000	--	0
7	Increased Cost of Printing	--	0	--	0
8	Increased Cost of Rents, Communications, & Utilties	--	1,000	--	0
9	Increased Cost of Health Care Provided under Contracts & Grants	--	77,699,000	--	522,000
10	Increased Cost of Supplies	--	11,000	--	0
11	Increased Cost of Medical or other Equipment	--	0	--	0
12	Increased Cost of Land & Structure	--	4,818,000	--	0
13	Increased Cost of Grants	--	7,868,000	--	240,000
14	Increased Cost of Insurance / Indemnities	--	0	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Increased Cost of Service & Supply Fund	--	0	--	0
17	Population Growth	--	0	--	2,708,000
	Subtotal, Built-In	--	90,471,000	--	3,472,000
	TOTAL INCREASES	--	90,471,000	--	3,472,000
DECREASES					
A. Built-In					
	SFC Savings	--	0	--	(19,619,000)
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	(19,619,000)
NET CHANGE		**--**	**$90,471,000**	**--**	**($16,147,000)**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2010 Enacted	$29,234,000
Total budget authority	29,234,000
Less Obligations	(29,234,000)
FY 2012 Estimate	85,184,000
Less Obligations	(85,184,000)
Net Change	55,950,000
Less Obligations	(55,950,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	0
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	0	--	0
6	Increased Cost of Transportation & Things	--	0	--	0
7	Increased Cost of Printing	--	0	--	0
8	Increased Cost of Rents, Communications, & Utilties	--	0	--	0
9	Increased Cost of Health Care Provided under Contracts & Grants	--	84,000	--	4,000
10	Increased Cost of Supplies	--	0	--	0
11	Increased Cost of Medical or other Equipment	--	18,000	--	0
12	Increased Cost of Land & Structure	--	323,000	--	7,000
13	Increased Cost of Grants	--	28,742,000	--	981,000
14	Increased Cost of Insurance / Indemnities	--	0	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Increased Cost of Service & Supply Fund	--	0	--	0
17	Population Growth	--	0	--	0
	Subtotal, Built-In	--	29,167,000	--	992,000
B. HCFC Increase		--	0	--	53,958,000
C. IHCIA Implementation		--	0	--	1,000,000
	TOTAL INCREASES	--	29,167,000	--	55,950,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		**--**	**$29,167,000**	**--**	**$55,950,000**

INDIAN HEALTH SERVICE
Facilities & Environmental Health Support
Summary of Changes

FY 2010 Enacted	$193,087,000
Total budget authority	193,087,000
Less Obligations	(193,087,000)
FY 2012 Estimate	210,992,000
Less Obligations	(210,992,000)
Net Change	17,905,000
Less Obligations	(17,905,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	835,000
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	3,818,000	--	106,000
6	Increased Cost of Transportation & Things	--	2,331,000	--	69,000
7	Increased Cost of Printing	--	97,000	--	1,000
8	Increased Cost of Rents, Communications, & Utilties	--	20,644,000	--	673,000
9	Increased Cost of Health Care Provided under Contracts & Grants	--	12,775,000	--	1,155,000
10	Increased Cost of Supplies	--	2,822,000	--	107,000
11	Increased Cost of Medical or other Equipment	--	1,033,000	--	35,000
12	Increased Cost of Land & Structure	--	61,000	--	2,000
13	Increased Cost of Grants	--	65,539,000	--	2,367,000
14	Increased Cost of Insurance / Indemnities	--	2,000	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Increased Cost of Service & Supply Fund	--	0	--	0
17	Population Growth	--	n/a	--	5,523,000
	Subtotal, Built-In	--	109,122,000	--	10,873,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	47	7,032,000
C. FY 2011 Current Services		--	0	--	0
	TOTAL INCREASES	--	109,122,000	--	17,905,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Base Adjustment:		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		**--**	**$109,122,000**	**47**	**$17,905,000**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2010 Enacted	$22,664,000
Total budget authority	22,664,000
Less Obligations	(22,664,000)
FY 2012 Estimate	24,705,000
Less Obligations	(24,705,000)
Net Change	2,041,000
Less Obligations	(2,041,000)

		FY 2010 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	2012 Pay Raise at 1.4% for CO	--	n/a	--	0
2	Tribal Pay Cost	--	n/a	--	0
3	Within Grade Increase	--	n/a	--	0
4	Increased Cost of Travel	--	0	--	0
6	Increased Cost of Transportation & Things	--	91,000	--	0
7	Increased Cost of Printing	--	0	--	0
8	Increased Cost of Rents, Communications, & Utilties	--	37,000	--	9,000
9	Increased Cost of Health Care Provided under Contracts & Grants	--	1,456,000	--	29,000
10	Increased Cost of Supplies	--	289,000	--	5,000
11	Increased Cost of Medical or other Equipment	--	5,711,000	--	388,000
12	Increased Cost of Land & Structure	--	2,000	--	0
13	Increased Cost of Grants	--	15,078,000	--	962,000
14	Increased Cost of Insurance / Indemnities	--	0	--	0
15	Increased Cost of Interest / Dividends	--	0	--	0
16	Increased Cost of Service & Supply Fund	--	0	--	0
17	Population Growth	--	0	--	648,000
	Subtotal, Built-In	--	22,664,000	--	2,041,000
	TOTAL INCREASES	--	22,664,000	--	2,041,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	0
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	0
NET CHANGE		**--**	**$22,664,000**	**--**	**$2,041,000**

INDIAN HEALTH SERVICE
Budget Authority by Activity
(Dollars in Thousands)

	2010 Enacted		2011 CR		2012 Estimate	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES:						
Hospitals & Health Clinics	6,302	$1,754,383	6,442	$1,754,383	6,531	$1,963,886
Dental Services	708	152,634	713	152,634	718	170,859
Mental Health	246	72,786	249	72,786	253	81,117
Alcohol & Substance Abuse	184	194,409	184	194,409	184	211,693
Contract Health Services	6	779,347	6	779,347	6	948,646
Total Clinical Services	7,446	2,953,559	7,594	2,953,559	7,692	3,376,201
Public Health Nursing	254	64,071	254	64,071	257	70,613
Health Education	26	16,682	26	16,682	28	18,190
Comm. Health Reps.	6	61,628	6	61,628	6	65,746
Immunization AK	0	1,934	0	1,934	0	2,064
Total Preventive Health	286	144,315	286	144,315	291	156,613
Urban Health	8	43,139	8	43,139	8	46,745
Indian Health Professions	29	40,743	29	40,743	29	42,016
Tribal Management	0	2,586	0	2,586	0	2,762
Direct Operations	331	68,720	336	68,720	348	73,636
Self-Governance	12	6,066	12	6,066	12	6,329
Contract Support Costs	0	398,490	0	398,490	0	461,837
Total Services	8,112	3,657,618	8,265	3,657,618	8,380	4,166,139
FACILITIES:						
Maintenance & Improvement	0	53,915	0	53,915	0	57,078
Sanitation Facilities Constr.	192	95,857	177	95,857	177	79,710
Health Care Facs. Constr.	0	29,234	0	29,234	0	85,184
Facil. & Envir. Health Supp.	1,026	193,087	1,059	193,087	1,069	210,992
Equipment	0	22,664	0	22,664	0	24,705
Total Facilities	1,218	394,757	1,236	394,757	1,246	457,669
Total IHS	9,330	$4,052,375	9,501	$4,052,375	9,626	$4,623,808

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

INDIAN HEALTH SERVICE

Authorizing Legislation

(Dollars in Thousands)

Feb 8, 2011

	FY 2011		FY 2012	
	Amount Authorized	Continuing Resolution	Amount Authorized	President's Budget
1. Services Appropriation:	3,657,618	3,657,618	4,166,139	4,166,139
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. Facilities Appropriation:	394,757	394,757	457,669	457,669
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).	6,288	6,288	7,500	7,500
3. Public and Private Collections:	890,993	907,735	907,735	907,735
IHCIA sec. 206, 25 U.S.C. 1621e.				
Social Security Act, sec. 1880 & 1911, 42 U.S.C. 1395qq & 1396j.				
4. Special Diabetes Program for Indians:	150,000	150,000	150,000	150,000
42 U.S.C. 245c-3.				
Unfunded authorizations:	0	0	0	0
Total appropriations:	5,099,656	5,116,398	5,689,043	5,689,043
Total appropriations against Definite authorizations:	5,099,656	5,116,398	5,689,043	5,689,043

INDIAN HEALTH SERVICE
Appropriation History Table
Services

Jan 20, 2011

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
Rescission (PL 107-206)	-	-	-	($1,009,000)
2003	$2,513,668,000	$2,508,756,000	$2,466,280,000	$2,492,115,000
Rescission (PL 108-7)	-	-	-	($16,199,000)
2004	$2,502,393,000	$2,556,082,000	$2,546,524,000	$2,561,932,000
Rescission (PL 108-108)	-	-	-	($16,550,000)
Rescission (PL 108-199)	-	-	-	($15,018,000)
2005	$2,612,824,000	$2,627,918,000	$2,633,624,000	$2,632,667,000
Rescission (PL 108-447, Sec. 501)				($15,638,000)
Rescission (PL 108-447, Sec. 122)				($20,936,000)
2006	$2,732,298,000	$2,732,298,000	$2,732,323,000	$2,732,298,000
Rescission (PL 109-54)				($13,006,000)
Rescission (PL 109-148)				($27,192,000)
2007	$2,822,449,000	$2,830,085,000	$2,835,493,000	$2,818,871,000
2008	$2,931,530,000	$3,023,532,000	$2,991,924,000	$3,018,624,000
Rescission (PL 110-161)				($47,091,000)
2009 Omnibus	$2,971,533,000	-	-	$3,190,956,000
2009 ARRA (PL 111-5)	-	-	-	$85,000,000
2010	$3,639,868,000	$3,657,618,000	$3,639,868,000	$3,657,618,000
2011	$3,657,618,000			
2012	$4,166,139,000			

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

Jan 20, 2011

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2003	$370,475,000	$362,571,000	$391,865,000	$376,190,000
Rescission (PL 108-7)	-	-	-	($2,445,000)
2004	$387,269,000	$392,560,000	$391,188,000	$396,232,000
Rescission (PL 108-108)	-	-	-	($2,560,000)
Rescission (PL 108-199)	-	-	-	($2,322,000)
2005	$354,448,000	$405,453,000	$364,148,000	$394,453,000
Rescission (PL 108-447, Sec. 501)				($2,343,000)
Rescission (PL 108-447, Sec. 122)				($3,137,000)
2006	$315,668,000	$370,774,000	$335,643,000	$358,485,000
Rescission (PL 109-54)				($1,706,000)
Rescission (PL 109-148)				($3,569,000)
2007	$347,287,000	$363,573,000	$357,287,000	$361,226,000
2008	$339,196,000	$360,895,000	$375,475,000	$380,583,000
Rescission (PL 110-161)				($5,937,000)
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			
2012	$457,669,000			

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

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$2,953,559	$2,953,559	$3,376,201	+$442,642
FTE	7,446	7,594	7,692	+246

SUMMARY OF THE BUDGET REQUEST

The FY 2012 budget request for Clinical Services is $3,376,201,000, an increase of $442,642,000 over the FY 2010 Enacted level. This change represents increases of $268,445,000 for pay increases for Commissioned Officers, inflation, population growth and staffing two new/expanded facilities. The detailed explanation of the request is described in each of the budget narratives that follow.

- $1.964 billion for **Hospitals and Health Clinics**, an increase of $149.9 million for Commissioned Officer's pay costs, population growth, and staffing new facilities, and $59.6 million for program increases to support the Indian Health Care Improvement Fund and address the new requirements of Indian Health Care Improvement Act implementation. These funds are necessary to prepare the agency to adhere to new legislation requirements which will strengthen access to essential personal health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, etc. Funds will also support access to public/community health initiatives targeting health conditions disproportionately affecting AI/ANs such as specialized programs for diabetes, maternal and child health, youth services, women's health, and communicable diseases including influenza, HIV/AIDS, tuberculosis, and hepatitis.
- $170.9 million for **Dental Health**, an increase of $18.2 million for Commissioned Officers' pay costs, population growth, inflation, and staffing new facilities. These funds are necessary to provide preventive and basic care as over 90 percent of the dental services provided are basic and emergency care. Basic services are prioritized over more complex rehabilitative care such as root canals, crown and bridge, dentures, and surgical extractions. The demand for dental treatment remains high due to the high dental caries rate in the AI/AN children; however, a continuing emphasis on community oral health promotion/disease prevention is essential to long-term improvement of the oral health of AI/AN people.
- $81.1 million for **Mental Health**, an increase of $7.3 million for Commissioned Officers' pay costs, population growth, inflation, and staffing new facilities and $1 million for a program increase to support demonstration tele-mental health service projects targeting Indian youth suicide prevention. Three sites will be awarded at $250,000 each for a period of up to 4 years, future appropriations allowing. The Tele-Behavioral Health Center of Excellence will be awarded $250,000 to provide technical assistance, implementation, training, and evaluation support over the same period and is also dependent upon future appropriations. These funds are necessary to provide a community-oriented clinical and preventive mental health service program that provides outpatient mental health and related services, crisis triage, case management, prevention programming and outreach services.

Mental Health is crucial for the well being of American Indian and Alaska Native individuals and their communities; it is integral to the healing process.

- $211.7 million for **Alcohol and Substance Abuse**, an increase of $13.3 million for Commissioned Officers' pay costs, population growth, inflation and staffing new facilities to maintain current service levels for the Alcohol and Substance Abuse Program. The requested budget amount will provide alcohol and substance abuse prevention, educational, and treatment services within both rural and urban community settings. These funds are necessary to provide preventive and treatment services at both the community and clinic levels. These programs provide alcohol and substance abuse treatment and prevention services within rural and urban communities, with a focus on holistic and culturally-based approaches. The Alcohol and Substance Abuse Program (ASAP) exists as part of an integrated behavioral health team that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in AI/AN communities.
- $948.6 million for **Contract Health Services**, an increase of $79.7 million for population growth and inflation, and $79.6 million to fund 5,732 inpatient admissions, 218,070 outpatient visits, 7,930 one-way ambulance trips via ground or air and $10 million to fund an additional 400 catastrophic cases. These funds are necessary to purchase essential health care services not available in IHS/Tribal facilities including inpatient and outpatient care, routine emergency ambulatory care, transportation, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, etc. The demand for CHS remains high as the cost of medical care increases. The CHS program continues to emphasize adherence to medical priorities, enrolling patients in alternate resources available to them and negotiating discounted rates with medical providers.

The bulk of clinical services funds are provided to 12 Area (regional) Offices which in turn provide resource distribution, program monitoring and evaluation activities, and administrative and technical support to 163 Federal and Tribal service units (local level) for 597 health care facilities providing care to 1.9 million AI/ANs primarily in service areas that are rural, isolated and underserved.

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

Long Term Measure	Most Recent Result	Long Term Target
31: Childhood Weight Control: Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher. IHS – All (Outcome)	FY 2010: 25.0%	FY 2013: 24.0%
31: Tribally Operated Health Programs (Outcome)	FY 2009: 24.0% (Context Only)	N/A
28: Unintentional Injury Rates: Unintentional injury mortality rate in AI/AN population[1]. IHS – All (Outcome)	FY 2004: 94.0	FY 2012: 94.0 (Results available Dec 2016)
FAA-3: Unintentional Injury Rates: Unintentional mortality rate in AI/AN population[2]. (Outcome)	FY 2004: 90.5	FY 2012: 90.5 (Results available Dec 2016)

[1] Targets and results are expressed as age-adjusted rates per 100,000 population.

[2] Targets and results are expressed as age-adjusted rates per 100,000 population.

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

HOSPITALS AND HEALTH CLINICS

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$1,754,383	$1,754,383	$1,963,886	$209,503
FTE	6,302	6,442	6,531	+229

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 2012 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Hospitals and Health Clinics (H&HC) funds essential personal health services for 1.9 million American Indians and Alaska Natives (AI/AN) including 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. In addition, the program includes public/community health initiatives targeting health conditions disproportionately affecting AI/ANs such as programs for diabetes; maternal and child health; communicable diseases including influenza, HIV/AIDS, tuberculosis, and hepatitis; women's and elders' health; and a recent focus on planning and organizing regional trauma/emergency medical services delivery systems. The IHS system of care is unique in that personal health care services are integrated with community health services. Collecting, analyzing, and interpreting health information is done through a network of Tribally-operated epidemiology centers in collaboration with a national IHS coordinating center leading to the identification of health conditions as well as promoting interventions. Information technology that supports both personal health services (including the electronic health record and telemedicine) and public health initiatives is primarily funded through the H&HC budget.

Slightly more than one-half 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 these individual and community health services. This is reflected in the outputs table which shows that approximately 58 percent of the outpatient workload and 50 percent of the inpatient workload is performed by Tribally managed hospitals and clinics. Most of the remainder is managed by direct Federal programs providing health care at the Service Unit (SU) and community level.

Although the health status of AI/ANs has increased significantly in the past 50 years since the inception of the IHS, the average life expectancy at birth is 72.5 years compared to the U.S. all races life expectancy of 77.5 years[1]. The IHS and Tribes primarily serve small, rural populations with mainly

[1] US Department of Health and Human Services. Indian Health Service. Trends in Indian Health, 2002-2003 Edition. Washington: Government Printing Office, Released October 2009. ISSN 1095-2896. p.150.

primary medical care and community-health services through approximately 700 locations, relying on the private sector for much of the secondary and all of the tertiary medical care needs. A few of the IHS and Tribal hospitals provide secondary medical services such as ophthalmology and orthopedics. Of 45 IHS and Tribal hospitals, only one has an average daily census of greater than 45 patients. Nineteen of these 45 hospitals have operating rooms, which demonstrates their focus on primary and community based care rather than secondary or tertiary care.

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) – The IHS has a successful history of addressing public health challenges and acute, infectious diseases. Today, however, increasing chronic disease burdens are challenging the Indian health system. Addressing this challenge requires a redesign of the delivery of primary care services to advance reliable and evidence-based care, to better integrate all of the health programs available to patients, and to put patients and families at the center of care.

The IHS has four agency priorities; one of these priorities is improving access and quality of care. The IPC program supports Tribal, IHS, and Urban Indian Health programs to improve quality and access to care through the development of an Indian health system medical home. Elements of this medical home have been defined over the past three years by the original 38 IHS, Tribal, and Urban pilot site participants and have enabled them to provide better preventive care, improve management of chronic conditions, produce a better care experience for patients, families and communities, and maintain financial viability in a resource limited health care system. A broad and comprehensive measurement plan guides improvement in four domains: clinical prevention, care of chronic conditions, patient experience of care, and the cost of care. Improvements have occurred in clinical prevention (screening for elevated blood pressure, depression, intimate partner violence, alcohol misuse, tobacco abuse, and obesity); in cancer screening (colorectal, breast, and cervical cancer); in chronic disease treatment (control of blood pressure), and in patient experience of care (patients who would recommend their healthcare facility to friends and relatives). The IPC Evaluation Team is providing further analysis of the participating sites and has demonstrated statistically significant improvement in a number of measures after 18-36 months of participation.

The IPC sites are working together within a “collaborative,” utilizing peer-to-peer learning with faculty guidance that is increasingly provided by Indian Health leaders who have emerged in the early phases of the initiative. The collaborative uses virtual meeting technology, allowing staff to reach larger numbers of professionals in a cost-efficient way and to open the health care improvement process to greater involvement by community members and Tribal leadership.

Area and regional Tribal staff have been trained to support a significant dissemination effort. The work will be made available to an additional 100 IHS, Tribal, and Urban sites over a three-year period beginning in FY 2011 and will spread the improvements in primary care identified as effective components of the Indian Health medical home.

Trauma Care - The IHS is focusing more attention on trauma care and injury prevention. Combined, they bring greater synergy for reducing death and disability and controlling the high costs of traumatic injuries with their many chronic health sequelae. Trauma remains the largest cause of death and disability in Indian country for those under age 45, AI/AN trauma death rates are three times higher than U.S. all races rates.

A trauma care program encompasses injury prevention, emergency medical services (EMS), emergency medicine, surgery, rehabilitation, hospital planning and the regionalization of acute medical care. IHS and Tribal trauma care is dependent on distant regional hospitals with advanced critical care capabilities for definitive care. The strength of the interrelationships developed between IHS and Tribal hospitals with their regional trauma centers influences patient outcomes. The goal is to insure optimal trauma care through transfer agreements with a "first option" regional trauma center. Development began in the Southwest in FY 2010 and continues in FY 2011**.** These interrelationships are comprehensive and include patient care, patient care information sharing, health professional training, technical assistance, use of trauma registries, data coordination and problem solving on a regional basis.

The closest facility for EMS providers to transport individuals with traumatic injuries is frequently the local IHS or Tribal hospital. Staffing capacity and capabilities as well as state of the art equipment are essential. The role of diagnostic (e.g., CT scanners, ultrasound) and surgical and emergency department treatment equipment cannot be overstated. The CT is now the standard of care in trauma and many acute illnesses. Emergency medicine physicians, nurses, and other highly trained staff are essential for improving patient care and disaster management. Emergency room nurses are an essential and often underappreciated element in every trauma emergency plan and program. To address this critical need, IHS established a registered nurse "mini-residency" trauma and emergency medicine management course at the University of New Mexico (UNM) Regional Trauma Center in July 2010.

Programs and activities of public education are important. IHS and Tribes in conjunction with hospital staff, EMS and law enforcement personnel, and community leaders have sponsored "Trauma Day" local events across Indian Country. In these settings, health care professionals and community leaders develop and strengthen commonality of purpose and cooperative efforts. A Trauma Day emphasizes the complementary nature of active health care management with more subtle prevention strategies. Tribes locally and national Indian organizations can impact the trauma problem in Indian Country. The IHS has also established supporting relationships with national trauma, emergency medicine, EMS, and injury control professional organizations. The overall control of the trauma problem in Indian Country will require professional and public recognition of the problem, support and utilization of proven trauma care, injury prevention and mitigating measures.

Domestic Violence Prevention Initiative - Congress appropriated $7.5 million to the IHS in the Omnibus Appropriations Act of 2009, Public Law 111-8, to implement a nationally-coordinated Domestic Violence Prevention Initiative (DVPI). In FY 2010, Congress appropriated an additional $2.5 million, for a total of $10 million for this initiative. The purpose of the initiative is to support a national effort by the IHS and Tribes to address domestic violence and sexual assault within AI/AN communities. The DVPI funding represents an opportunity to effectively address the dual crises of domestic violence and sexual assault in Indian Country. The IHS is using these funds to further expand its outreach advocacy programs into AI/AN communities, expand the Domestic Violence and Sexual Assault Pilot project, and provide for training and the purchase of forensic equipment to support the Sexual Assault Nurse Examiner (SANE) and Sexual Assault Forensic Examiner (SAFE) programs. The funding has been distributed via a competitive process to ensure funds are targeted to communities with the greatest need. The sixty-five awarded projects will adhere to reporting requirements established by the IHS and report on data and evidence-based outcome measures designed to help determine the most effective means for combating these issues in Tribal communities. The completion of a national, independent evaluation of the DVPI will allow identification of successful evidence-based and practice-based programs that can be replicated across the Indian health system.

FUNDING HISTORY

Fiscal Year	Amount	
2007	$1,411,336,000	
2008	$1,484,016,000	
2009 Recovery Act	$85,000,000*	Health IT, P.L. 111-5
2009 Omnibus	$1,597,777,000	
2010 Enacted	$1,754,383,000	
2011 Continuing Resolution	$1,754,383,000	

* see HIT narrative (separate)

BUDGET REQUEST

The FY 2012 budget request for Hospitals and Health Clinics is $1,963,886,000, an increase of $209,503,000 over the FY 2010 Enacted level of $1,754,383,000. The request includes:

Current Services +$149,941,000

Federal Pay Costs +$2,302,000 – to cover federal Commissioned Officer pay costs. Federal and tribal pay costs are under the pay freeze enacted by Congress.

Inflation +$50,663,000 – to cover inflationary costs of providing health care services.

Population growth +$45,891,000 – to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.3 percent in FY 2012 based on State births and deaths data.

Staffing/Operating Cost Requirements for Newly Constructed Facilities +$51,805,000 – will fund staffing and operating costs for newly constructed facilities. Funding these facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

Staff for New Facility	Amount	FTE/Tribal Positions
Joint Venture Place Holder (2)	$9,843,000	TBD
Absentee Shawnee Health Center (JV), Little Axe, OK	$5,522,000	61
Elbowoods Health Center, New Town, ND	$6,436,000	73
Carl Albert Hospital, Replacement (JV), Ada, OK	$4,045,000	38
Lake County Tribal Health Center (JV), Lakeport, CA	$1,948,000	21
Cherokee Nation Health Center (JV), Vinita, OK	$5,356,000	58
Cheyenne River Health Center, Eagle Butte, SD	$17,935,000	184*
Grand Total:	$51,085,000	435

* Federal FTE

Program Increases +$59,562,000

Indian Health Care Improvement Fund (IHCIF): +$54,000,000

The Indian Health Care Improvement Fund is authorized by the Indian Health Care Improvement Act, amended in 2010, for "… eliminating deficiencies in health status and resources … eliminating backlogs in services … meeting needs in efficient equitable manner … eliminating inequities in funding … augmenting services where deficiencies are highest … ." The Act further specifies that the service take into account the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances. Each year, if appropriations are available, funding is allocated to IHS or Tribal facilities with the greatest level of need or resource deficiencies according to a distribution formula. Funding for the IHCIF is a top tribal priority.

Resource deficiencies for medical care services at 271 IHS and tribal health care delivery areas are calculated with per person costs benchmarked to a blend of Federal Employee Health Plans (FEHP) and adjusted for lower health status of Indians, remote locations of delivery sites, and regional price variations. The benchmark cost is then discounted for alternate resources available for the subset of Indian people who are also eligible for Medicare, Medicaid, and private insurance. An evaluation of the methodology completed in 2010 proposed 6 technical improvements.

The Director has initiated tribal consultation on 4 topics related to the Indian Health Care Improvement Fund (IHCIF) and potentially updating the formula:

1. Should IHS change the IHCIF formula?
2. Should IHS adopt technical improvements recommended by a joint IHS/Tribal evaluation of the formula that was completed in 2010?
3. Should services newly authorized in IHCIA, be added to the formula before or after funding for all tribes reach a minimum funding percentage of 55 percent?
4. How should IHS consult with Tribes on the questions above?

The existing formula will be used until any changes are adopted as a result of tribal consultation on the questions listed above.

According to 2010 projections and after deducting alternate coverage sources, the methodology estimates approximately $3,613 per person would be required for IHS to assure medical services to Indians that are equivalent in scope and extent to the FEHP. IHS estimates that funding is lower than 50 percent of this benchmark for approximately one third of its service population.

Anticipated Accomplishments**:** IHCIF allocations in FY 2009 and FY 2010 increased funding at the 75 most needy sites to a minimum of 45 percent of the target benchmark, approximately $1,692 per person. The $54 million program increase in 2012 will further reduce deficiencies at the most needy sites. The funding will help to diminish health care service backlogs and expand primary care services which are among HHS High Priority Goals for FY 2012. Historical data suggests that access to primary care services is directly linked to improvements in the health status of Indian people, especially where Indians experience significant geographic and financial barriers to health care. Additionally, published research suggests that more comprehensive primary care services can reduce subsequent hospitalizations and realize cost savings.

Health IT Security +$4,000,000

The $4,000,000 program increase will be used for health information technology security maintenance and enhancements. Although RPMS is a secure health information system, the recent government mandates to exchange health information increase the security needed to facilitate the external exchanges. In addition, changes in security standards associated with meaningful use will increase security requirements. Additional resources will be employed to provide expert security management of health information. Certification and Accreditation of enhancements to RPMS and continued funding for the Network and Operations Security Center (NOSC) are planned for FY 2011. Local, regional, and national support for these essential security enhancements has come from the hospital and health clinics budget.

The establishment of additional Health Information Technology funding within the Hospital and Health Clinics budget ensures sustainability of the ongoing and essential IHS health information technology efforts that are critical to our goal of improving the health status for AI/AN people. Additional details regarding the request are available in the separate HIT narrative.

Chronic Diseases: +$2,529,000

The burden of chronic illness remains disproportionately large among AI/AN, contributing to increased rates of disability, a reduction in life expectancy, spiraling costs, and suffering. Tribal leaders have identified diabetes, cancer, heart disease and stroke as national Tribal health priorities. This priority list is consistent with mortality data, which shows that heart disease and cancer are the top two causes of death for AI/AN, [IHS Program Statistics, Trends in Indian Health] and with diabetes prevalence data, which show that AI/AN people suffer from among the highest rates of diabetes in the world [IHS Diabetes Program Fact Sheets]. In addition to the Improved Patient Care and Health Promotion/Disease Prevention programs, the IHS strategy in addressing these needs is to prevent the diseases through new, targeted efforts aimed at reducing their principal risk factors (smoking, obesity, sedentary lifestyle). These cross-cutting approaches add new capability to the Indian health system and offer the opportunity to reduce the risk of and consequences from these debilitating and costly chronic diseases.

I. Preventing and treating overweight and obesity -- $1,500,000

- Primary care strategies to address pediatric overweight and obesity to prevent and treat chronic illness in AI/AN communities ($1,250,000): Pilot test and evaluate an intervention by pediatricians and primary care teams in medical office and school-based health center settings in rural communities to promote early identification and treatment of childhood overweight and obesity through a systematic overweight screening process, in-depth medical assessment, counseling, appropriate follow-up and referral, patient education, and staff training.[2]

    1. Up to 25 sites representative of the entire Indian Health System will be selected for participation, including 4 sites currently participating in a pilot project to reduce childhood obesity and overweight with the National Initiative for Children's Health Quality (NICHQ). Sites will be selected that have a high likelihood of success in identifying the set of interventions most likely to result in improvement in reduction of childhood obesity and overweight in AI/AN

[2] Pediatrics Vol. 123June 2009 S253-S316. Web.7 Sep 2009. http://pediatrics.aappublications.org/content/vol123/Supplement_5/

communities. The lessons learned from these pilot sites will be disseminated to other IHS, Tribal, and Urban Indian health programs.

2. Staff training will also included a telemedicine link between the I/T/U pediatricians and primary care teams with multiple pediatric subspecialists at University of New Mexico for biweekly case reviews and educational programs on topics pertinent to the diagnosis and management of obesity and obesity-related health complications as is currently being done with the 4 pilot project sites.
3. Sites will share expertise, tools, and results with each other throughout the pilot phase.
4. Sites will track and report on both process and outcome measures (see below). Data will be obtained through IHS' Resource and Patient Management System (RPMS) and manually.
5. These funds will support training, local coordination and data reporting at the participating sites, and an evaluation of the effectiveness of the program. If the program is determined to be effective, the evaluation will include an assessment of the cost of system-wide dissemination.

Outcomes:

a. Increase the percentage of children age 2 – 18 years that have been screened for overweight with documentation of BMI percentile

b. Increase the percentage of children age 2 – 18 years with documented diagnosis of overweight/obesity in the active problem list

c. Increase the percentage of children age 2 – 18 years that are treated and counseled for overweight/obesity

d. Increase the percentage of children age 2 – 18 years that receive follow-up and referral for more intensive weight management counseling

e. Long-term: Decrease the rates of pediatric overweight and obesity in participating sites, and develop a refined, multifaceted set of interventions that other sites can employ to reduce rates of childhood overweight and obesity.

- Create a standing body of I/T/U staff, the Indian Health System **Healthy Weight for Life Workgroup**, to facilitate marketing, implementation and evaluation of the Healthy Weight for Life Strategy ($250,000).

Outcome: Revise and disseminate the **"**Healthy Weight for Life: A Comprehensive Strategy Across the Lifespan of American Indians and Alaska Natives" to provide individuals, families, schools worksites, communities, Tribal leaders and organizations, Indian health care delivery system providers, and IHS leadership and staff with guidance for taking action to promote healthy weight across the lifespan. The strategic plan will be a dynamic document that guides the Indian Health Care System in implementing and sustaining multifaceted approaches for individuals, communities, organizations and society that decreases the rates of overweight and obesity across the lifespan in AI/AN people.

II. Reduce smoking rates through provider training, clinic-based cessation programs, and public education -- $1,029,000

American Indians and Alaska Natives have the highest rates of tobacco abuse of any racial or ethnic group in the United States. IHS patient data show rates of tobacco use (over age 5) of between 30% and 45% in areas outside the Southwest, compared to national all-races rates of about 20%. In the Southwest, rates vary from 8% to 20%, but there are published reports of increasing rates among youth.

These figures agree closely with published Behavioral Risk Factor Surveillance Survey (BRFSS) data. Rates and geographic distribution of lung cancer and heart disease correspond with these regional differences in tobacco use. Analysis of AI/AN mortality data shows that tobacco abuse is the second largest preventable cause of death for AI/AN people, after diet and exercise (obesity). In 2005, in response to this need, the IHS Tobacco Task Force developed a strategic plan for tobacco control. In the first phase of this plan, the Task Force developed a comprehensive Fieldbook for implementing tobacco control in the IHS primary healthcare setting. A systems-change model was piloted at four sites using these materials, with American Legacy Foundation and CDC/Office on Smoking and Health funding. The Fieldbook, in conjunction with expert consultation and support, will be used as the foundation of a program to ensure that every IHS, Tribal and Urban facility offers evidence-based treatment for tobacco users.

Our strategy will be:

1. Train and certify staff at IHS, Tribal and Urban Indian health facilities to employ evidence-based intervention strategies for every individual currently using commercial tobacco products.
2. Develop and disseminate materials, including on-line educational modules, to educate I/T/U providers in various aspects of the treatment of tobacco dependence.
3. Establish evidence-based tools to integrate tobacco dependence treatment with the Improving Patient Care/Chronic Care program improvement process, using the Fieldbook as well as expert consultation and support.
4. Support enhancements to the health IT applications that will assist in managing cessation patients and collecting rates of tobacco use.
5. Develop and disseminate community health education messages that are appropriate for AI/AN cultures and beliefs.

Outputs and Outcomes:

1. Increase in the number of tobacco users who are treated or counseled (current GPRA performance measure).
2. Decrease in smoking rates as measured by IHS patient records and national BRFSS data (CDC).
3. Long-term: decrease in rates of tobacco-related cancers, heart disease, and chronic lung disease, as measured by cancer and cardiovascular disease registries, and death certificate surveillance.

Business Operations Support: +$6,033,000

Of these funds, $5,000,000 will be distributed to IHS and Tribal Organizations, with the majority of funds going to SU and clinic levels, and limited amounts going to Area Offices (AOs). The purpose of these funds is to improve the processing of Contract Health Service (CHS) claims, to enroll AI/AN patients in new programs created from the major health care reforms Indian Health Care Improvement Act and to improve overall billing efficiency. Specifically, new positions will be established at SUs to: 1) improve the time required for payment of CHS claims that have significantly increased due to recent increases in CHS funds, 2) improve the payment of claims by assuring only billable procedures are paid, 3) improve community education and outreach assisting patients with understanding alternate resources enrollment and appeals in Medicare, Medicaid, CHIP and private insurance, 4) assist patients with enrollment in new State and Federal programs available to them, 5) improve billing efficiency as the billing office work load increases with public and private insurance expansions and 6) improve the Internal Controls for Unified Financial Management System (UFMS) tracking of third party account receivables, debt management, and reconciliation of aging accounts.

Additional staff hired to process the increased CHS claim volume resulting from increased funding will help improve effectiveness and customer satisfaction as well as reduce healthcare disparities. Enrolling more patients in Medicare, Medicaid and private insurance programs will increase the availability of CHS funds for patients without alternate resources. Improved UFMS and RPMS posting and reconciliation should improve days to collection and provide revenue for hospital and clinic operations in a timely manner.

In order to ensure successful implementation of the increased staffing at the SU level, it is important to establish staffing at Area Offices (AOs) to support these IHS wide activities through leadership, planning, policy development, and training. It is essential that this expanded function have IHS wide leadership support. It is anticipated that one position would be added to each of the AOs.

The additional $1,033,000 will be used to provide training and technical assistance to Area Office and facility staff on Medicare, Medicaid and private insurance programs and how to best negotiate lower rates for health care services that are contracted to the private sector. The training will be instrumental in increasing the skill sets of the employees that directly impact managing contract health fee negotiation and expanding alternate resources. Many CHS and third party collection features are unique to the Indian Health system, so the courses will be specifically designed for Indian Health programs. On-site technical assistance will be offered on the same subjects.

Grants Savings -$7,000,000

The agency is proposing a savings in grants awards beginning FY 2012. Approximately $7.0M will be redirected towards other higher health priority programs that benefit a larger number of patients at more sites.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
5: Diabetes: Nephropathy Assessment: Proportion of patients with diagnosed diabetes assessed for nephropathy. IHS-All	FY 2010: 55% (Target Exceeded)	54%	53.2%	-0.8%
5: Tribally Operated Health Programs	FY 2010: 43% (Target Exceeded)	39%	41.5%	+ 2.5%
20: Accreditation: Percent of hospitals and outpatient clinics accredited (excluding tribal and urban facilities)	FY 2010: 100% (Target Met)	100%	100%	+ 0%
6: Diabetic Retinopathy: Proportion of patients with diagnosed diabetes who receive an annual retinal examination. IHS-All	FY 2010: 53% (Target Not Met but Improved)	55%	51.4%	-3.6%
6: Tribally Operated Health Programs	FY 2010: 48% (Target Not Met)	51%	46.5%	- 4.5%
7: Pap Smear Rates: Proportion of eligible women who have had a Pap screen within the previous three years. IHS-All	FY 2010: 59% (Target Not Met)	60%	57.1%	-2.9%
7: Tribally Operated Health Programs	FY 2010: 59% (Target Not Met)	61%	57.1%	-3.9%
8: Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. IHS-All	FY 2010: 48% (Target Exceeded)	47%	48.8%	+ 1.8%
8: Tribally Operated Health Programs	FY 2010: 49% (Target Met)	49%	48.1%	-0.9%

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
9: Colorectal Cancer Screening Rates: Proportion of eligible patients who have had appropriate colorectal cancer screening. IHS-All	FY 2010: 37% (Target Exceeded)	36%	38.2%	+2.2%
9: Tribally Operated Health Programs	FY 2010: 40% (Target Exceeded)	39%	39.3%	+ 0.3%
TOHP-2: Number of designated annual clinical performance goals met. (Outcome)	FY 2010: 10/17 (Target Not Met)	16/17	13/17	-3
TOHP-4: Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) populations served by tribal health Programs (Outcome)[1]	2005 63.8	N/A	55.3 Reportable In FY 2015	N/A
FAA-2: Years of Potential Life Lost (YPLL) in American Indian/Alaska Native population (Outcome) 2	2005 80.9	N/A	62.3 Reportable in FY 2015	N/A
24: Combined (4:3:1:3:3:1:4) Childhood Immunization rates: AI/AN children patients aged 19-35 months IHS - All (Outcome)	FY 2010: 79% (Target Not Met)	80%	76.5%	-3.5%
24: Tribally Operated Health Programs	FY 2010: 76% (Target Met)	76%	73.5%	-2.58%
FAA-E: Hospital Admissions per 100,000 service population for long term complications of diabetes in federally administered facilities. (Efficiency)	FY 2009: 185.8 (Target Not Met)	130.7	N/A	N/A
FAA-1: Children ages 2-5 years with a BMI at the 95th percentile or higher.	FY 2010: 25.5% (Target Not Met)	24%	N/A	N/A
TOHP-3: Percentage of AI/AN patients with diagnosed diabetes served by tribal health programs that achieve ideal blood sugar control[3]	FY 2009: 35% (No Target Long-term Measure)	N/A	N/A	N/A
16: Domestic (Intimate Partner) Violence Screening: Proportion of women who are screened for domestic violence at health care facilities. IHS-All	FY 2010: 53% (Target Met)	53%	52.8%	-0.2%
16: Tribally Operated Health Programs	FY 2010: 44% (Target Not Met but Improved)	45%	44.5%	-0.5%
25: Adult Immunizations: Influenza: Influenza vaccination rates among adult patients aged 65 years and older. IHS-All	FY 2010: 62% (Target Exceeded)	60%	59.9%	-0.1%
25: Tribally Operated Health Programs	FY 2010: 60% (Target Exceeded)	57%	58.0%	+ 1.0%
26: Adult Immunizations: Pneumovax: Pneumococcal vaccination rates among adult patients aged 65 years and older. IHS-All	FY 2010: 84% (Target Exceeded)	83%	81.3%	-1.7%
26: Tribally Operated Health Programs	FY 2010: 80% (Target Exceeded)	77%	77.3%	+ 0.3%
33: HIV Screening: Proportion of pregnant women screened for HIV	FY 2010: 78% (Target Exceeded)	77%	75.4%	-1.6%
FAA-4: Breastfeeding Rates: Proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed.	FY 2010: 26% (Target Not Met)	33%	29.3%	-3.7%
21: **Patient Safety**: Percent of patient falls in an IHS-funded facility in persons age 65 and older as a result of taking high risk medication.	3.6%	Baseline	Under Construction	N/A

[1]Long term measure; reportable in 2015 for FY 2012 with a target of 55.3

[2]Long term measure; reportable in 2015 for FY 2012 with a target of 62.3

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

OUTPUTS

Measure	Most Recent Result FY 2009	FY 2010 Target*	FY 2012 Target	FY 2012 +/- FY 2010
Inpatient Admissions - IHS Direct	27,214	27,200	28,400	+1,200
Inpatient Admissions - Tribal Direct	23,135	23,100	24,200	+1,100
Total Admissions	**50,349**	**50,300**	**52,600**	**+2,300**
Outpatient Visits - IHS Direct	4,813,024	4,813,000	5,029,000	+216,000
Outpatient Visits - Tribal Direct	6,034,216	6,034,200	6,305,000	+270,800
Total Outpatient Visits	**10,847,240**	**10,847,200**	**11,334,000**	**+486,800**
Domestic Violence Prevention Initiative				
Percentage of Domestic Violence Prevention Initiative-funded programs providing case management services to victims and children of victims	N/A	FY2011: Baseline	TBD	N/A
Percentage of sexual assault community developed model programs that have an active interdisciplinary Sexual Assault Response Team (SART)	N/A	FY 2011: Baseline	TBD	N/A
Percentage of SANE/SART Programs with written sexual assault response policies and procedures	N/A	FY 2011: Baseline	TBD	N/A
Program Level Funding ($ in millions)	**$1,754.4**	**$1,754.4**	**$1,963.9**	**+$209.5**
ARRA Level Funding ($ in millions)	**$85.0**		**$0**	**$0**

*FY 2010 targets are revised based on actual Inpatient/Outpatient admission data.

GRANTS AWARDS FUNDED BY HOSPITALS AND HEALTH CLINIC: Up to FY 2011, a small percentage of the funds (<0.5 percent) has been distributed to Tribes via many small competitive grant programs; examples include eldercare, children and youth, women's health, and health promotion and disease prevention grants.

(whole dollars)

	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 Request*
Number of Awards	55	55	0
Average Award	$135,455	$135,455	0
Range of Awards	$24,975-$1,040,000	$24,975-$1,040,000	0
Total Awards	**$7,450,000**	**$7,450,000**	**0**

* The grants awards funded under Hospitals and Health Clinics will be redirected to other budget priorities by FY 2012.

AREA ALLOCATION – Hospitals and Health Clinics

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2011
Aberdeen	$144,934,572	$144,934,572	$182,392,934	$37,458,362
Alaska	259,634,676	259,634,676	283,079,275	23,444,599
Albuquerque	76,297,765	76,297,765	83,187,332	6,889,567
Bemidji	88,255,597	88,255,597	96,224,937	7,969,340
Billings	65,670,583	65,670,583	71,600,532	5,929,949
California	65,381,889	65,381,889	73,233,770	7,851,881
Nashville	57,410,557	57,410,557	62,594,639	5,184,082
Navajo	228,387,651	228,387,651	249,010,693	20,623,042
Oklahoma	301,957,497	301,957,497	344,146,780	42,189,283
Phoenix	163,949,276	163,949,276	178,753,635	14,804,359
Portland	72,846,844	72,846,844	79,424,798	6,577,954
Tucson	20,683,063	20,683,063	22,550,711	1,867,648
Headquarters	208,973,030	208,973,030	237,685,963	28,712,933
Total, H&HC	**$1,754,383,000**	**$1,754,383,000**	**$1,963,886,000**	**+$209,503,000**

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

HOSPITALS AND HEALTH CLINICS

Epidemiology Centers

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA – H&HC	$1,754,383	$1,754,383	$1,963,886	$209,503
Epi Ctrs	*$4,686*	*$4,686*	$5,700	*+$1,013*
FTE	13	13	13	0

Note: *Italicized* dollar amounts and FTE are non-add.

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 2012 Authorization.....Permanent

Allocation Method ..... Cooperative Agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Congress authorized funding for the innovative Indian Health Service (IHS) Tribal Epidemiology Center (TEC) program in FY 1996. The intent was to develop public health infrastructure by augmenting existing tribal organizations with expertise in epidemiology and public health through the establishment of Epidemiology Centers. Funding is distributed to the TECs through Cooperative Agreements to Tribes and Tribal organizations such as Indian health boards.

Operating from within Tribal organizations, TECs are in a unique position 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 tribes in their region, producing reports annually or biannually for constituent tribes. TECs provide critical support to Tribes who self-govern their health programs. Data generated locally and analyzed by TECs enable their constituent 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. TECs support national public health goals by working to improve data for GPRA reporting and monitoring of the Healthy People 2020 objectives. Standardization of health status reports across all TECs will lead to a more comprehensive picture of Indian health.

The IHS Division of Epidemiology and Disease Prevention (DEDP) functions as the national coordinating center and provides technical support and guidance to TECs. DEDP and TECs collect, analyze, interpret, and disseminate health information in addition to identifying diseases to target for intervention, suggesting strategies for successful interventions and testing the effectiveness of implemented health interventions. The TECs play a critical role in IHS' overall public health infrastructure.

FUNDING HISTORY

Over 90 percent of the TEC Program budget is distributed through Cooperative Agreements. Funding for each TEC is authorized up to $1,000,000. Initially, four tribal organizations competed and received

funding based on recommendations from an objective review panel. These first TECs each received $155,000 through cooperative agreements. In FY 2000, the four original TECs plus two new centers received funding for five years. In FY 2006, after the most recent competitive 5-year cooperative agreement award process, the IHS TEC program expanded to include 11 TECs. In FY 2008, the California Area established a TEC. All 12 existing TECs now serve a major portion of the AI/AN population in 12 regions comparable to the IHS Administrative Area service population.

Fiscal Year	Amount
2007	$4,549,669
2008	$4,548,361
2009	$4,609,489
2010	$4,686,346
2011 Continuing Resolution	$4,686,346

BUDGET REQUEST

The FY 2012 budget request for Epidemiology Centers under Hospitals and Health Clinics is $5,700,000, an increase of $1,013,654 over the FY 2010 Enacted level of $4,686,346.

The increase in funding will add to the 12 TEC cooperative agreements to address inflation and augment their public health activities. The TEC program was recently evaluated by an external company to highlight strengths and address weaknesses. Preliminary results indicate the number one recommendation for strengthening the TEC Program Performance is to: "Increase Core Funding," to continue to build on public health capacity, improve data collection and analysis, and provide services to assist Tribes.

FY 2012 Tribal Epidemiology Centers Allocation (Estimated)			
1	Alaska Native Tribal Health Consortium	Anchorage, AK	$440,000
2	Albuquerque American Indian Health Board	Albuquerque, NM	$440,000
3	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI	$440,000
4	Inter Tribal Council of Arizona	Phoenix, AZ	$440,000
5	Montana/Wyoming Tribal Leaders Council	Billings, MT	$440,000
6	Navajo Nation Division of Health	Window Rock, AZ	$440,000
7	Northern Plains – Aberdeen Area	Rapid City, SD	$440,000
8	Northwest Portland Area Indian Health Board	Portland, OR	$440,000
9	Oklahoma City Area Inter-Tribal Health Board	Oklahoma City, OK	$440,000
10	Seattle Indian Health Board	Seattle, WA	$440,000
11	United South and Eastern Tribes, Inc.	Nashville, TN	$440,000
12	California Rural Indian Health Board - NEW	Sacramento, CA	$440,000
	Administrative and technical support	Albuquerque, NM	$420,000
	TOTAL		**$5,700,000**

Addressing Agency Priorities:

1. <u>To renew and strengthen our partnership with tribes</u>:
   The TECs are fundamental to the IHS' partnership with Tribes by supporting epidemiology and public health functions critical to the delivery of healthcare services. Each TEC sets goals and determines outcomes independently as directed by their constituent tribes and health boards. DEDP tracks the TECs' goals and objectives written in their cooperative agreements such as establishing disease and control programs, and collecting epidemiological data for use in determining health

status of tribal communities. DEDP sets a national outcome for each TEC to develop and disseminate regional health profiles for their constituent tribes and communities.

2. To bring reform to the IHS
   TECs represent an important link to IHS reform efforts through their efforts to build capacity in the Indian health system to evaluate and monitor the effectiveness of health programs.
3. To improve the quality of and access to care
   In the expanding environment of Tribally-operated health programs, epidemiology centers provide additional public health services, such as disease control and prevention programs in the areas including sexually transmitted disease control, HIV and cancer prevention. TECs assist Tribes with projects such as conducting behavioral risk factor surveys in order to establish baseline data for successfully evaluating intervention and prevention activities. 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. DEDP works with the National Institutes of Health and the Centers for Disease Control and Prevention to supplement the TECs, create stronger interagency partnerships, and prevent costly duplication of effort.
4. To make all our work accountable, transparent, fair and inclusive
   The DEDP continues to make all our work accountable, transparent, fair and inclusive to IHS, tribes, TECs, other Federal agencies, and the public through reports, meetings and the recent TEC program evaluation.

DEDP/TEC projects promote three HHS High Priority Performance Goals: Tobacco–Supportive Policy & Environments; Emergency Preparedness; and Health Information Technology.

OUTPUTS TABLE

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Health Status & Monitoring* **Measured by surveys, assessments, reports*	12of 12 TECs	12of 12 TECs	12 of 12 TECs	0
Provide regional health profiles	12 of 12 TECs	12 of 12 TECs	12 of 12 TECs	0
Develop/Implement disease control & prev. programs	12of 12 TECs	12of 12 TECs	12 of 12 TECs	0
Contribute to nat'l measures, i.e. GPRA & HP 2020	12 of 12 TECs	12 of 12 TECs	12 of 12 TECs	0
Tribal support -tech training in public health practice	12of 12 TECs	12of 12 TECs	12 of 12 TECs	0
Program Level Funding ($ in millions)	**$4.7**	**$4.7**	**$5.7**	**+$1.0**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

GRANTS AWARDS (whole dollars)

Cooperative Agreements	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of TEC Awards	12	12	12
Average Award *	$390,000	$360,000	$440,000
IHS Director's Management Fund **	$250,000	$0	$0

* Administrative and technical support of the IHS national coordinating center in Albuquerque is included in average.

** In FY 2010, the Director's Management Fund continued to partially fund the California TEC until the next competitive funding cycle in FY 2011.

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 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$1,754,383	$1,754,383	$1,963,886	$209,503
HIT	*$172,405**	*$172,405**	*$179,133*	*$6,728*

*FY 2012 HIT funding reflects a revised methodology that aligns with the IHS IT Exhibit 300s and Exhibit 53s. FY 2010 and FY 2011 are comparably adjusted.

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 2012 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Service (IHS) Health Information Technology (HIT) program uses secure IT to improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions consistent with the Department of Health and Human Services (HHS) enterprise initiatives. IHS has over 25 years of experience with HIT as a major enabler of clinical care that ensures the achieving of health equity and improving clinical outcomes for the American Indians and Alaska Natives (AI/AN). Continued investment in HIT has the ongoing potential to transform health care delivery by lowering costs and improving quality. The use of HIT increases and improves the quality of the care that physicians and other caregivers provide as well as patients' safety within Indian Health System.

IHS HIT is dedicated to providing the most innovative, effective, and cost-efficient HIT system in the federal government. IHS HIT is comprised of three major IT strategic investments that are fully integrated with the agency's programs and critical to carrying out the IHS mission: the Resource and Patient Management System (RPMS); Infrastructure, Office Automation, and Telecommunication (IOAT); and the National Patient Information Reporting System (NPIRS).

- **RPMS** is the key IHS enterprise health information system that facilitates healthcare providers to generate and process information as they provide care directly to patients. RPMS is used at approximately 400 IHS, tribal and urban (I/T/U) Indian Health program facilities and is a Certified[1] Electronic Health Record (EHR) used in a meaningful way at over 200 of these facilities with continued deployment activities underway. The IHS-wide adoption of RPMS provides substantial

1 The ambulatory care component of the RPMS EHR has been certified by the Certification Commission for Healthcare Information Technology.

savings to IHS by lowering the cost of providing health care, eliminating unnecessary health care services, and improving the quality of care.

- IOAT is the foundation upon which RPMS is delivered to IHS healthcare facilities. IOAT is IHS IT infrastructure, which includes computers, communications, and IT security. The IHS IT infrastructure incorporates government and industry standards for the collection, processing, storage, and transmission of information.
- NPIRS is an enterprise-wide data warehouse environment that produces various reports required by statute and regulation and provides a broad range of clinical and administrative information to managers at all levels of the Indian health system.

IHS HIT continues to meet and in some cases exceed its performance measures as described in the Outcomes table. The IHS has been able to develop and implement important applications and processes that are critical to improving the health care delivery for AI/AN, including: preparing for meeting Stage 1 Meaningful Use criteria; development, deployment and support of the RPMS-EHR; deploying enterprise-wide central e-mail system; improving the IHS network security posture; mitigating high risk vulnerabilities; and upgrading the network to meet increasing bandwidth demands.

IHS HIT uses available resources to implement critically important initiatives that are aimed at meeting federal mandates and improving the overall delivery of care that IHS provides. IHS HIT faces increased demands and costs in FY2011 and FY2012, including the following:

- achieving Meaningful Use,
- supporting health care reform,
- implementing the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10), which will require modifying over 64 RPMS applications,
- upgrading the IHS network to achieve the Federal Communications Commission (FCC) recommended capability,
- expanding and developing additional Behavioral Health applications to meet IHCIA requirements,
- expanding telehealth initiatives, and
- implementing mandates from the Health Information Technology for Economic and Clinical Health Act (HITECH) to expand the RPMS-EHR to meet stage 2 and stage 3 requirements of Meaningful Use.

IHS HIT will endeavor to provide the highest-quality support and necessary modernization of HIT within available resources as well as the balancing of mandates and enhancements, including cloud based solutions.

FUNDING HISTORY

Fiscal Year	Amount *
2007	$98,243,000
2008	$112,006,000
2009 Recovery Act	$10,985,000
2009 Omnibus	$114,506,000
2010 Recovery Act	$74,015,000
2010 Enacted	$172,405,000
2011 Continuing Resolution	$172,405,000

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

BUDGET REQUEST
The FY 2012 budget request for Health Information Technology under Hospitals and Health Clinics is $179,133,000, an increase of $48,376,000 over the FY 2010 Enacted level of $130,757,000.

Current Services +$2,728,000

Inflation +$2,728,000 —will fund inflationary costs to maintain the current level of operations due to anticipated obligated acquisition cost increases. Current services for HIT includes inflation, which is essential to maintain the current program operational requirements.

The budget request includes a $4,000,000 program increase for HIT security in FY 2011. The increase for HIT security is critical to fund mandatory security initiatives such as Continuous Monitoring, standard configuration, and malware detection.

Program Increase +$4,000,000

An effective health information technology system including improved infrastructure, an electronic health record, and data warehousing is critical for IHS to deliver quality care and to more efficiently manage and support the health programs. For the past 25 years, the IHS has developed, deployed, and supported a certified and award-winning health information technology system (the Resource and Patient Management System - RPMS) throughout the Indian health care system, in addition to a large integrated wide-area network and national data warehouse.

The $4,000,000 program increase will be used for health information technology security maintenance and enhancements. Although RPMS is a secure health information system, the recent government mandates to exchange health information increase the security needed to facilitate the external exchanges. In addition, changes in security standards associated with meaningful use will increase security requirements. Additional resources will be employed to provide expert security management of health information. Certification and Accreditation of enhancements to RPMS and continued funding for the Network and Operations Security Center (NOSC) are planned for FY 2011. Local, regional, and national support for these essential security enhancements has come from the hospital and health clinics budget. This increased funding will facilitate the transition of some of this need throughout IHS to the proposed HIT funding.

The FY 2012 budget also reflects an update to HIT reporting which now aligns with the IHS IT Exhibit 300s and Exhibit 53s (submitted separately). As a result of changes in reporting, the budget request reflects $41,648,000 for HIT funding within the base that was not included in previous budgets. The change is not the result of new funding for HIT; it is a more accurate display of HIT costs in IHS that were previously reflected only in facility budgets. This change will align the IHS IT Exhibit 300s and Exhibit 53s.

HIT funding will be used to support the following critical functions:

- **$107,479,800 will be used to support the RPMS investment** and its continuing development and maintenance to meet the ever increasing needs of a data-driven healthcare system. RPMS will require extensive modifications to meet several federal requirements, including HITECH and IHCIA. These improvements require significant budgetary commitments over several fiscal years but will result in significant cost savings and improvements in patient care:

- Meaningful Use: In 2012, Stage 2 Certification and Meaningful Use criteria will be published; RPMS will require numerous enhancements to address the new criteria. In 2013, Stage 3 Meaningful Use criteria will be published and, again, RPMS will require additional numerous enhancements to address the new criteria. Continued support for application development and user support to meet these critical Meaningful Use criteria will require recurring funding increases to maintain current services.
- Practice Management: The Practice Management suite of applications supports business processes associated with patient administrative, fiscal, and business intelligence for health care facilities. Funding is necessary for implementation of these applications that can substantially improve efficiency and business practices system-wide.

- **$53,739,900 will be used to support the IHS IOAT investment.** IHS has one of the most geographically diverse IT networks in the country. IHS must provide Internet connectivity and other IT resources to extremely remote, rural communities that struggle with extreme poverty. IHS HIT must provide reliable connectivity to provide healthcare providers serving the AI/AN communities with the most up-to-date patient information as possible. The funding requested will provide for the proper operation and maintenance, refreshment of existing equipment, delivery of essential services and business operations that are dependent on a viable and reliable information technology infrastructure. Additional funding will help IHS meet new federal requirements and initiatives, such as voice over IP (VoIP), Internet Protocol v6 (IPv6), e-mail journaling, cloud computing and server/desktop virtualization. The IHS IT Security Program continues to require increasingly more funding to ensure compliance with the Federal Information Security Management Act (FISMA) and high-priority projects, such as Continuous Monitoring. In addition, the IHS IT infrastructure faces increasingly sophisticated and coordinated cyber security threats and as a result increased funding is needed to mitigate these threats.
- **$17,913,300 will be used to support the NPIRS investment.** The maintenance of an Agency-wide data repository that supports a collective database from all AI/AN health programs is critical to meet national reporting requirements. NPIRS will continue to support current operations while continuing to enhance the quality, accuracy, availability and delivery of NPIRS information.

All targeted measures were met during 2010 and the funding request will help maintain the gains over time. The IHS has been able to develop and implement many important applications and processes that are critical to improving the health care delivery for AI/AN. Future challenges in 2012 include the rising costs of the IHS IT infrastructure (development, support, licensing, contracts, bandwidth, training of staff, and others) over the past decade, continuing costs associated with the enhanced HIT that are essential to achieve Meaningful Use and support health care reform, and the development of RPMS, IOAT, and NPIRS enhancements.

The IHS HIT request includes ongoing funding to support the President's information technology initiatives and HHS enterprise information technology initiatives identified through the HHS strategic planning process. IHS HIT continues to make progress on Meaningful Use, certification of the Electronic Health Record, practice management, improving security and privacy, and replacing aging equipment, but faces many challenges.

HIT in IHS is a conduit by which efficiency and quality can be achieved. IHS HIT has made important and momentous strides in the past few years by driving innovation to improve the IHS' aging infrastructure and to provide healthcare providers with the tools and information they need to make life-saving decisions at the point of care.

HIT contributes to improvements in the quality of health care that providers deliver, and with Meaningful Use, IHS can receive incentive payments for using RPMS, which benefits all of IHS. IHS HIT has a real, tangible opportunity to improve health care delivery throughout Indian Country through assisting with Meaningful Use. RPMS is the most cost-effective EHR that is available to Indian Country and will provide a method for eligible providers and health care facilities to receive Medicaid and Medicare incentive payments.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
RPMS-E1 and E2: Average days in accounts receivable for hospitals. *(Efficiency)*	FY 2010: 64 (Target Met)	64	62	-2
RPMS-E2: Average days in accounts receivable for small ambulatory clinics. *(Efficiency)*	FY 2010: 62 (Target Met)	62	59	-3
RPMS-2: Derive all clinical measures from RPMS and integrate with EHR (Clinical Measures/Areas) (RPMS Program Assessment)	FY 2010: 65/12 (TargetExceeded)	63/12	65/12	+2/0
RPMS-7: Number of patients with clinical images captured or displayed for use in the RPMS Electronic Health Record (RPMS Program Assessment)	FY 2010: 307,407 (TargetExceeded)	196,486	424,222	+227,736
Program Level Funding ($ in millions)		**$130.8**	**$179.1**	**+$48.3**
ARRA Level Funding ($ in millions)	**$0**	**$74.0**	**$0**	**$0**

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

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

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$152,634	$152,634	$170,859	+$18,225
FTE	708	713	718	+10

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 2012 Authorization ..... Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The purpose of the Dental Program 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 Dental Program is oriented toward preventive and basic care. Over 90 percent of the dental services provided are basic and emergency care. More complex rehabilitative care (i.e., root canals, crown and bridge, dentures and surgical extractions) are provided where resources allow. The demand for dental treatment remains high due to the high dental caries rate in the AI/AN children; however, a continuing emphasis on community oral health promotion/disease prevention is essential to the long term improvement of the oral health of AI/AN people. Prevention activities reduce the cost of subsequent dental care and improve oral health.

The dental program maintains data and tracking of the three key program objectives – dental sealant, dental access, and topical fluorides. During FY 2010, the Dental Program met the GPRA performance goal of patients receiving topical fluoride and dental sealants. Topical fluorides and dental sealants are proven, widely utilized preventive interventions to reduce tooth decay. The high prevalence of sealants represents a significant victory for the IHS Dental Program, as greater numbers of susceptible tooth surfaces have been protected by dental sealants.

In recent years, the IHS Dental Program has utilized field dental programs in conjunction with the Dental Clinical and Preventive Support Centers (DSC) to achieve program performance measures. The DSC were designed and implemented in FY 1999 and FY 2000 to help augment the dental public health infrastructure necessary to best meet the oral health needs of the AI/AN community. At present there are 8 DSCs, 4 funded by program awards and 4 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 the AI/AN community. As a direct result of the advocacy efforts of the DSC, the number of key preventive procedures has increased significantly in recent years. The number of dental sealants placed per year has tripled in the last

decade. The number of patients receiving topical fluoride treatments has more than doubled in the last five years.

Congressional appropriations were earmarked for the creation of the DSC in both 1999 and 2000. In the ensuing years these Centers had an immediate positive impact on the direct delivery of dental care in a number of ways:

- Several centers provided direct clinical services.
- All centers advocated for a proper focus on the Dental GPRA 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, Joint Commission Accreditation and Certification preparedness, 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 Areas they serve. These materials have increased the quality of our oral health education efforts throughout Indian Country.

The aggregate accomplishments of our DSC 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.

Although the targeted percentage of patients receiving dental services was not met during FY 2010, the actual number of patients receiving preventive dental care exceeded FY 2010 targets. The most recent results indicate an increase in the number of patients receiving at least one topical fluoride application and number of sealants. The IHS Dental program will continue its efforts to recruit and retain dental providers to improve dental access and to meet the set target.

FUNDING HISTORY

Fiscal Year	Amount
2007	$125,396,000
2008	$133,637,000
2009 Omnibus	$141,936,000
2010 Enacted	$152,634,000
2011 Continuing Resolution	$170,859,000

BUDGET REQUEST

The FY 2012 budget request for Dental Health is $170,859,000, an increase of $18,225,000 over the FY 2010 Enacted level of $152,634,000.

Current Services +$18,225,000

Pay Costs + $544,000 will fund pay increases for Federal Commissioned Officers employed by the Agency. Federal and tribal pay costs are under the pay freeze enacted by Congress.

Inflation + $6,252,000 will fund inflationary costs.

Population Growth + $4,367,000 will fund costs related to anticipated population growth.

Staffing/Operating Cost Requirements for New/Expanded Facilities + $7,062,000 will fund increases in workforce necessary to staff newly constructed facilities.

Staff for New Facility	Amount	FTE/Tribal Positions
Absentee Shawnee Health Center (JV), Little Axe, OK	$1,466,000	15
Elbowoods Health Center, New Town, ND	$614,000	6
Carl Albert Hospital Replacement (JV), Ada, OK	$836,000	8
Lake County Tribal Health Center (JV), Lakeport, CA	$195,000	2
Cherokee Nation Health Center (JV), Vinita, OK	$1,406,000	14
Cheyenne River Health Center, Eagle Butte, SD	$2,545,000	25*
Grand Total:	**$7,062,000**	**70**

* Federal FTE

Current services are necessary costs to sustain valuable programs and maintain improvements made in performance measures in recent years.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
12: **Topical Fluorides:** Number of American Indian and Alaska Native patients receiving at least one topical fluoride application.	FY 2010: 145,181 (Target Exceeded)	136,978	135,604	-1,374
13: **Dental Access:** Percent of patients who receive dental services.	FY 2010: 25% (Target Not Met)	27%	23%	-4.0
14: **Dental Sealants:** Number of sealants placed per year in AI/AN patients.	FY 2010: 275,459 (Target Exceeded)	257,920	257,261	-659
Program Level Funding ($ in millions)	**$152.6**	**$**	**$**	**+$**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	Most Recent Result FY 2009	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Dental Vacancy Rates	26%	26%	20%	-6%
Patient Visits	1,053,300	1,053,300	1,094,900	+216,000
# of Services	3,209,600	3,209,600	3,336,500	+270,800
Program Level Funding ($ in millions)	**$152.6**	**$152.6**	**$170.8**	**+$18.2**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

GRANTS AWARDS:

(whole dollars)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	4	4	4
Average Award	$249,998	$249,998	$249,998
Range of Awards	$249,996-250,000	$249,996-250,000	$249,996-250,000
Total Awards	**$1,000,000**	**$1,000,000**	**$1,000,000**

AREA ALLOCATION – Dental Services

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2011
Aberdeen	$14,054,793	$14,054,793	$18,241,701	$4,186,908
Alaska	19,091,894	$19,091,894	20,488,194	1,396,300
Albuquerque	8,518,665	$8,518,665	9,141,684	623,019
Bemidji	4,362,824	$4,362,824	4,681,902	319,078
Billings	7,621,988	$7,621,988	8,179,428	557,440
California	1,737,814	$1,737,814	2,059,910	322,096
Nashville	2,885,615	$2,885,615	3,096,657	211,042
Navajo	30,093,813	$30,093,813	32,294,746	2,200,933
Oklahoma	30,887,030	$30,887,030	36,853,976	5,966,946
Phoenix	13,745,099	$13,745,099	14,750,357	1,005,258
Portland	7,802,224	$7,802,224	8,372,845	570,621
Tucson	1,897,151	$1,897,151	2,035,901	138,750
Headquarters	9,935,090	$9,935,090	10,661,700	726,610
Total, DENTAL	**$152,634,000**	**$152,634,000**	**170,859,000**	**+$18,225,000**

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

MENTAL HEALTH

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$72,786	$72,786	$81,117	$8,331
FTE	246	249	253	+7

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 2012 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS Mental Health/Social Services (MH/SS) program is a community-based clinical and preventive service program that provides 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 acute, crisis-oriented outpatient service staffed by one or more mental health professionals providing primarily individual, family, and group psychotherapeutic services and case management. After hour emergency services are generally provided through local emergency departments and service units will often contract out to non-IHS hospitals and crisis centers for such services. Inpatient services are generally purchased from non-IHS hospitals or provided by State or County mental health hospitals. Intermediate level services such as group homes, transitional living support, intensive case management, and related activities are sometimes available, but generally are not reimbursable through IHS mechanisms, thus access to intermediate level services is typically offered through state and local resources.

Tribal contracting and compacting has allowed behavioral health programs to transition from IHS to local community control. Over half the Tribes now administer the delivery of their own mental health programs. The IHS MH/SS program assists Tribes in bringing programs and program collaborations to their own communities.

Across Indian Country today, the high incidence of alcohol and substance abuse, mental health disorders, suicide, violence, and behavior-related chronic diseases is well documented. Each of these serious behavioral health issues has a profound impact on the health of individuals, public health, and community wellbeing both on- and off-reservations. American Indians and Alaska Natives (AI/AN) are at higher risk for certain mental health disorders than other racial/ethnic groups. For example, the Office of Minority Health reports that AI/ANs experience higher rates than all races in the following areas:

- serious psychological distress;
- feelings of sadness, hopelessness, and worthlessness;
- feelings of nervousness or restlessness, and;
- suicide.

AI/ANs are also overrepresented among high-need populations requiring mental health services (e.g., people who are homeless, incarcerated, drug/alcohol abusers, and exposed to trauma as well as children who are in foster care) (Surgeon General's Report, 1999). Behavioral health issues are a top tribal priority for both treatment and prevention.

Specific focus areas for the IHS MH/SS program are:

Suicide Prevention: The American Indian and Alaska Native suicide rate (17.9) for the three year period (2002-2004) in the IHS service areas is 1.7 times that of U.S. all races rate (10.8) for 2003. Suicide is the second leading cause of death behind unintentional injuries for Indian youth ages 15-24 residing in IHS service areas and is 3.5 times higher than the national average. Suicide is the sixth leading cause of death overall for males residing in IHS service areas and ranks ahead of homicide. American Indian and Alaska Native young people ages 15-34 commit 64 percent of all suicides in Indian Country.

IHS has developed a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion. The suicide surveillance tool captures data related to a specific incident of suicide, including date and location of act, method, contributing factors, and other useful epidemiological information to better understand the problem and target resources appropriately. Use of the suicide surveillance form is an IHS performance measure and the FY 2010 target for the use of the suicide surveillance form was met and exceeded.

Tele-behavioral Health: The MH/SS program model also includes tele-behavioral health technology. Over 50 IHS and Tribal facilities in eight IHS Areas offer some level of tele-behavioral health services. Another eight facilities in the remaining four IHS Areas are developing tele-behavioral health services or have recently used tele-behavioral health services. The newly established Tele-Behavioral Health Center of Excellence in Albuquerque has already negotiated service support agreements with the Aberdeen Area to help meet the urgent need for behavioral health services. The Center of Excellence continues to be active in providing these services to regional southwest tribal sites. Improvements in the availability of videoconferencing units and supporting bandwidth are significantly lowering the barriers to using telehealth-based services generally. The central limitation of expanding tele-behavioral health services is not the current state of technology, but the lack of adequate IHS infrastructure and need for clinical professionals and employees at remote sites to effectuate service delivery. The expansion of tele-behavioral health cannot be separated from the need for infrastructure and staffing resources.

BH Management Information System (MIS): The IHS Resource and Patient Management System (RPMS) is a national health information system that effectively captures diagnostic, treatment, outcomes, and referral information regarding significant health issues electronically. To support clinical best practices and disease surveillance, RPMS includes standardized tools for screening as well as clinical decision support tools to facilitate routine and effective screening and treatment. Tools also exist for depression screening. RPMS output reports and clinical quality performance measurement tools provide information from local facility to national level data on screening results and screening rates. The MIS is used to share patient care documents and electronic charts across wide geographic areas in real-time and in accordance with the Health Insurance Portability and Accountability Act regulations. Future MIS-related activities will focus on further development and collection of suicide event-related data collection as well as improvements in the ability to monitor and respond to clinically actionable health information.

Child/Family Protection: Child abuse and the cycle of repeat abuse in adulthood are well documented in the AI/AN literature. Family violence affects all members of the community, but AI/AN women and children are particularly vulnerable to abuse. To help victims of violence, the IHS provides direct

services, advocacy, interagency consultation, and collaboration with other federal agencies to provide AI/AN child/family protection services.

FUNDING HISTORY

Fiscal Year	Amount
2007	$60,882,000
2008	$63,531,000
2009 Omnibus	$67,748,000
2010 Enacted	$72,786,000
2011 Continuing Resolution	$72,786,000

BUDGET REQUEST

The FY 2012 budget request for Mental Health is $81,117,000, an increase of $8,331,000 over the FY 2010 Enacted level of $72,786,000.

Current Services +$7,331,000

Current services are necessary costs to sustain valuable programs and maintain improvements made in performance measures in recent years. The overall funding increase will be used to maintain current service levels for the MH/SS program. The requested budget amount will allow for the implementation of the community-oriented clinical and preventive mental health service program that provides primarily outpatient mental health and related services, crisis triage, case management, prevention programming, and outreach services.

Federal Pay Costs +$71,000 – to cover federal Commissioned Officer pay costs. Federal and Tribal pay costs are under the pay freeze enacted by Congress.

Inflation +$2,242,000 to cover inflationary costs of providing mental health care services.

Population Growth +$2,094,000 to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.3 percent in FY 2012 based on State births and deaths data.

Staffing/Operating Cost Requirements for New/Expanded Facilities +$2,924,000 will fund staffing and operating costs for newly constructed facilities.

Staff for New Facility	Amount	FTE/Tribal Positions
Absentee Shawnee Health Center (JV), Little Axe, OK	$785,000	9
Carl Albert Hospital Replacement (JV), Ada, OK	$564,000	5
Lake County Tribal Health Center (JV), Lakeport, CA	$353,000	4
Cherokee Nation Health Center (JV), Vinita, OK	$410,000	5
Cheyenne River Health Center, Eagle Butte, SD	$812,000	9*
Grand Total:	**$2,924,000**	**32**

* Federal FTE

The IHS depression screening target supports the HHS Strategic plan. Although the depression screening target was improved but not met during FY 2010, the suicide surveillance target (1,700) was exceeded. The Agency has made great strides in addressing suicide but the challenge to keep pace with a growing AI/AN population may be reflected in the depression screening results.

In FY 2012, IHS will continue to focus on integration of behavioral health into primary care. IHS supports changing the paradigm of mental health services from being specialty and disease focused to being a part of primary care and the "Medical Home." This offers new opportunities for interventions

that identify high-risk individuals before their actions or behavior becomes more clinically significant. There will continue to be a focus on a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors. This effort will continue to bring together multiple disciplines, perspectives, and resources to create an integrated system where services can be accessed across multiple settings. To help victims of violence, the IHS provides direct services, advocacy, interagency consultation, and collaboration with other federal agencies to provide child and family protection services to American Indian and Alaska Native children and families. Plans also include improving the Resource and Patient Management System to support clinical best practices and disease surveillance.

Program Increase +$1,000,0000

IHCIA Implementation - Behavioral Health Youth Telemed + $1,000,000

Section 723 of the Indian Health Care Improvement Act authorizes funding to underwrite demonstration tele-mental health service projects targeting Indian youth suicide prevention. The grants will be awarded to Tribes and Tribal organizations that operate one or more facilities located in an area with documented disproportionately high rates of suicide; reporting active clinical telehealth capabilities; or offering school-based tele-mental health services to Indian youth. Tele-mental health services may include mental health services provided through technological means remotely; educational material distribution; and data collection. In addition, such services may include activities intended to support and promote traditional health care practices as identified by the tribal communities served. Three sites will be awarded $250,000 each for a period of up to 4 years, renewable upon availability of appropriations in subsequent years. The Tele-Behavioral Health Center of Excellence will be awarded $250,000 to provide technical assistance, implementation, training, and evaluation support over the same period. Priority consideration will be given to Tribes and Tribal organizations that serve a particular community or geographic area in which there is a demonstrated need to address Indian youth suicide; enter into collaborative partnerships with IHS and other Tribal health programs or facilities to provide services under this demonstration project, serve isolated communities or geographic areas that have limited or no access to behavioral health services; or operate detention facilities where Indian youth are detained. IHS will consult with SAMHSA in the development and planning of this demonstration project.

There are many benefits to the use of tele-mental health for the treatment of youth suicide. This technology promises to connect widely separated and often isolated programs of varying sizes together in a web of support. Such a system could potentially move some clinics with limited to no service times to systems where clinic time is available whenever the patient presents. This could translate into 24/7 access to emergency behavioral health service regardless of distance or remote area need. Such a system can offer opportunities for mutual provider support, reduce or eliminate discontinuities in patient care, reduce burn out due to professional isolation, and can support clinical supervision and case management conferences. Families can participate in care even when at a distance from their youth. The National Tele-Behavioral Health Center of Excellence will also help us understand how to effectively deliver such services, and in particular, will provide more focused experience in providing services to Indian youth. Tele-mental health programs can become an integral part of the IHS behavioral health services, strengthen our clinical expertise in using tele-health services, and expand access to needed behavioral healthcare.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
29. **Suicide Surveillance:** Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals.	FY 2010: 1,908 (Target Exceeded)	1,700	1,807	+107
18. **Behavioral Health:** Proportion of adults ages 18 and over who are screened for depression. IHS-All	FY 2010: 52% (Target Not Met but Improved)	53%	51.9%	-1.1%
18. Tribally Operated Health Programs	FY 2010: 45% (Target Exceeded)	41%	45.4%	+4.4%
Program Level Funding ($ in millions)	**$72.8**	**$72.8**	**$81.1**	**+$8.3**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

The FY 2012 suicide surveillance target is 1,807 forms completed. The Suicide Reporting Database is beginning to provide a more detailed picture of who is completing or attempting suicide and identifies salient factors contributing to the events. Completion of forms should provide more complete information about the incidence of suicidal ideation, attempts and completions, which will provide far more accurate and timely data to national policy makers and will allow interventions to be evaluated for effectiveness in ways not previously possible.

The FY 2012 depression screening target is 51.9 percent. Depression screening improves detection, referral, and treatment of mental health needs. Depression is often an underlying component contributing to suicide, accidents, domestic/intimate partner violence, and alcohol and substance abuse. Early identification of depression will contribute to reducing incidence, and allow providers to plan interventions and treatment to improve the mental health and well-being of AI/AN people who experience depression. Tools have been selected to assess depression, monitor response, track such a response over time, and are incorporated into the IHS Electronic Health Record. The system is now deployed and in operation in over 250 clinical sites across the country.

GRANT AWARDS – The program does not anticipate any grant awards for FY 2011 or FY 2012.

AREA ALLOCATION – Mental Health

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2011
Aberdeen	$8,917,478	$8,917,478	$10,391,924	$1,474,446
Alaska	6,374,460	6,374,460	6,847,995	473,535
Albuquerque	4,432,714	4,432,714	4,762,004	329,290
Bemidji	2,324,780	2,324,780	2,497,479	172,699
Billings	3,939,931	3,939,931	4,232,614	292,683
California	1,559,612	1,559,612	2,028,470	468,858
Nashville	1,776,300	1,776,300	1,908,255	131,955
Navajo	14,658,286	14,658,286	15,747,195	1,088,909
Oklahoma	10,810,138	10,810,138	13,372,183	2,562,045
Phoenix	7,694,234	7,694,234	8,265,810	571,576
Portland	4,198,852	4,198,852	4,510,769	311,917
Tucson	1,487,229	1,487,229	1,597,710	110,481
Headquarters	4,611,986	4,611,986	4,954,593	342,607
Total, MENTAL Hlth	**$72,786,000**	**$72,786,000**	**$81,117,000**	**+$8,331,000**

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

ALCOHOL AND SUBSTANCE ABUSE

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$194,409	$194,409	$211,693	+$17,284
FTE	184	184	184	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 2012 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The purpose of the Indian Health Service (IHS) Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral health status of American Indians and Alaska Natives (AI/ANs) to the highest possible level through the provision of preventive, educational, and treatment services at both the community and clinic levels. These programs provide alcohol and substance abuse prevention, educational, and treatment services within both rural and urban community settings. The ASAP exists as part of an integrated behavioral health approach to reduce the incidence of alcoholism and substance abuse in AI/AN communities by working collaboratively with medical and behavioral health providers. The ASAP addresses the Agency's priorities to renew and strengthen our partnership with Tribes, improve the quality of and access to care through these collaborative activities, and work to integrate behavioral health into primary care.

Alcoholism is a major public health disparity for AI/AN people. Alcohol abuse and dependence contribute to high rates of mortality from liver disease, unintentional injury, and suicide. AI/AN communities suffer from some of the highest rates of Fetal Alcohol Spectrum Disorders (FASD) in the nation, and the damaging effects of alcohol use to an unborn baby during pregnancy are permanent. Drug abuse and in particular methamphetamine abuse have emerged as significant problems among AI/AN people and have a devastating impact on families and communities. In these areas, there are marked disparities in behavioral health morbidity and resulting mortality between the AI/AN population and the nation as a whole. The following are examples:

- The age-adjusted[1] alcohol related death rate for AI/ANs is 43.3 (2003-2005) and is over six times the US all races rate of 7.0 (2004)[2].
- The age-adjusted drug related death rate for AI/ANs is 15.0 (2002-2004) and is 1.5 times greater than the US all races rate of 9.9 (2003)[3].

1 Age-adjusted rate per 100,000 population. Rates have been adjusted to compensate for misreporting of AI/AN race on state death certificates.

2 Unpublished data. OPHS/Division of Program Statistics (2003-2005 AI/AN age- adjusted rates based on 2000 census with bridged – race categories.)

3 US Department of Health and Human Services. Indian Health Service. Trends in Indian Health, 2002-2003 Edition. Washington: Government Printing Office, Released October 2009. ISSN 1095-2896. p. 195.

Additionally, over the last 15 years, ASAP programs have transitioned from IHS to local community control via Tribal contracting and compacting. In FY 2010, the majority of the ASAP programs were Tribally-managed. To support this shift, IHS is transitioning from direct service only to primarily direct service support to enable communities to plan, develop, and implement culturally-informed ASAP programming. Organized to develop not only programs, but program leadership, the major ASAP activities and focus areas are:

Integration into Primary Care: IHS continues to support the integration of behavioral health into primary care. This offers new opportunities for interventions that identify high-risk individuals before their actions or behavior becomes more clinically significant. One primary care based behavioral health intervention is the Alcohol Screening Brief Intervention (ASBI) which IHS is broadly promoting as an integral part of a primary care-based behavioral health program.

Youth Regional Treatment Centers (YRTCs): There are 11 YRTCs which provide 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. Some Tribes within certain IHS areas (e.g., Bemidji and Billings) elected not to construct YRTCs but to contract for similar services. The Alaska Area divided their funds to provide residential treatment services for two programs. The newest YRTC, Nevada Skies Youth Wellness Center, opened its doors in May 2009.

Fetal Alcohol Spectrum Disorders (FASD): IHS supports two projects that target FASD through the Northwest Portland Area Indian Health Board (NWPAIHB). The FASD Training Project with the University of Washington, School of Medicine is a research-based project that focuses on FASD interventions. The Parent Child Assistance Program (PCAP) is an intervention that serves high-risk, substance-abusing pregnant and parenting women and their families at 10 sites throughout the state of Washington.

Methamphetamine and Suicide Prevention Initiative (MSPI): The MSPI is a Congressionally appropriated, nationally-coordinated demonstration/pilot program, focusing on providing targeted methamphetamine and suicide prevention and intervention resources to communities in Indian Country with the greatest need for these programs. The $16.391 million annual appropriation supports 127 pilot projects throughout Indian Country to promote the development of innovative evidence-based and practice-based models created and managed by communities themselves, but connected to the entire national network of recipients to share program, service, and evaluation information. All MSPI pilot programs are community developed and delivered and represent the developing support from IHS to help communities address the dual crises of methamphetamine abuse and suicide in Indian Country.

Partnerships: Strategies to address suicide and methamphetamine include collaborations and partnerships with consumers and their families, Tribes and Tribal organizations, Urban Indian health programs, Federal (e.g., SAMHSA, NIH, Bureau of Indian Affairs [BIA], and others), State, and local agencies, as well as public and private organizations. This effort seeks to establish effective long-term strategic approaches to address suicide and methamphetamine reduction in Indian Country.

Tele-Behavioral Health: The ASAP program model also includes tele-behavioral health technology. Over 50 IHS and Tribal facilities in eight IHS Areas offer some level of tele-behavioral health services. Another eight facilities in the remaining four IHS Areas are developing tele-behavioral health services or have recently used tele-behavioral health services. The newly established Tele-Behavioral Health Center of Excellence in Albuquerque has already negotiated service support agreements with the Aberdeen Area to help meet the urgent need for behavioral health services. The Center of Excellence continues to be active in providing these services to regional southwest tribal sites. Improvements in the

availability of videoconferencing units and supporting bandwidth are significantly lowering the barriers to using telehealth-based services generally. The central limitation of expanding tele-behavioral health services is not the current state of technology, but the lack of adequate IHS infrastructure and need for clinical professionals and employees at remote sites to effectuate service delivery. The expansion of tele-behavioral health cannot be separated from the need for infrastructure and staffing resources.

BH Management Information System (MIS): The IHS Resource and Patient Management System (RPMS) is a national health information system that effectively captures diagnostic, treatment, outcomes, and referral information regarding significant health issues electronically. To support clinical best practices and disease surveillance, RPMS includes standardized tools for screening as well as clinical decision support tools to facilitate screening and treatment. Alcohol misuse screening allows for early detection of substance abuse and the recently developed Alcohol Screening Brief Interview (ASBI) codes allows for documentation of brief interventions. Tools also exist for depression and domestic violence screening. RPMS output reports and clinical quality performance measurement tools provide information from local facility to national level data on screening results and screening rates. In addition, the Behavioral Health MIS is used to share patient care documents and electronic charts across wide geographic areas in real-time (in full accordance with the Health Insurance Portability and Accountability Act regulations).

FUNDING HISTORY

Fiscal Year	Amount	Program Increases
2007	$148,226,000	
2008	$173,243,000	$13,782,000 – MSPI
2009 Omnibus	$183,769,000	$2,609,000 - MSPI
2010 Enacted	$194,409,000	
2011 Continuing Resolution	$194,409,000	

BUDGET REQUEST

The FY 2012 budget request for Alcohol and Substance Abuse is $211,693,000, an increase of $17,284,000 over the FY 2010 Enacted level of $194,409,000.

Current Services +$13,284,000

Federal Pay Costs +$31,000 – to cover federal Commissioned Officer pay costs. Federal and Tribal pay costs are under the pay freeze enacted by Congress.

Inflation +$7,463,000 to cover the inflationary costs of providing alcohol and substance abuse services.

Population Growth +$5,591,000 to fund the additional services need arising from the growing AI/AN population. The growth rate is projected to be 1.3 percent in FY 2012 based on State births and deaths data.

Staffing for New Facilities +$199,000 with 2 Tribal positions to staff one Joint Venture construction project. Funding new facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs.

Staff for New Facility	Amount	FTE/Tribal Positions
Cherokee Nation Health Center (JV), Vinita, OK	$199,000	2
Grand Total:	**$199,00**	**2**

Program Increase +$4,000,000

The $4 million increase is for a new competitive IHS grant program to expand access to and improve the quality of treatment for substance abuse treatment services. The program will target sites with the greatest need for substance abuse services. The main goal of the grant program will be to enable I/T/Us to hire additional staff to provide evidence-based and practice-based culturally competent treatment services. All grant recipients will be required to report on appropriate performance measures, including mandatory reporting of the number of addicted patients that received services. The FY 2012 request includes $4 million to add qualified and trained behavioral health counselors and other addiction specialists to enhance substance abuse care in Federal, Tribal, and Urban facilities. IHS will collaborate with SAMHA by utilizing agency's technical assistance expertise. This request is part of the National Drug Control Strategy: Objective Three: Integrate Treatment for Substance Use Disorders into Health Care and Expand Support for Recovery. The main goal of the grant program is to expand the use of a specialized Alcohol Screening Brief Intervention protocol in Indian Health System facilities.

This funding will be used to maintain current service levels for the Alcohol and Substance Abuse Program. The requested budget amount will provide alcohol and substance abuse prevention, educational, and treatment services within both rural and urban community settings.

The plans for FY 2012 are to continue to focus on integration of behavioral health into primary care. IHS supports changing the paradigm of mental health services from being specialty and disease focused to being a part of primary care and the "Medical Home." This offers new opportunities for interventions that identify high-risk individuals before their actions or behavior become more clinically significant. IHS will continue to promote the ASBI as an integral part of a primary care based behavioral health program. IHS will provide support to YRTCs in meeting the needs of youth. There will continue to be a focus on the MSPI pilot program which provides methamphetamine and suicide prevention and intervention resources to communities in Indian Country with the greatest need for these programs. Plans also include ongoing improvements for the RPMS to support clinical best practices and disease surveillance in collaboration with federal partners.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
10. YRTC Improvement/ Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more)	FY 2010: 81% (Target Not Met)	100%	100%	0
11. Alcohol Screening (FAS Prevention): Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients. IHS-All	FY 2010: 55% (Target Met)	55%	52.6%	-2.4%

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
11. Tribally Operated Health Programs	FY 2010: 48% (Target Met)	48%	45.9%	-2.1%
Program Level Funding ($ in millions)	**$194.4**	**$194.4**	**$211.7**	**+$17.3**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

In FY 2010, the 55% target for FAS Prevention was met. In FY 2012, the target is 52.6 percent for the proportion of women screened for alcohol to prevent Fetal Alcohol Syndrome (FAS). This measure has seen significant increases in results since FY 2005, due to increased provider awareness, and an agency emphasis on behavioral health screening.

Heavy drinking during pregnancy can cause significant birth defects, including FAS. FAS is the leading known, and preventable, cause of mental retardation. 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. Continued increases in FAS screening rates will have a significant impact on AI/AN communities.

OUTPUTS

Measure	Most Recent Result FY 2009	FY 2010 Target*	FY 2012 Target*	FY 2012 +/- FY 2010
Outpatient Visits	128,164	128,200	130,300	+2,100
Inpatient Days	4,880	4,900	5,000	+100
Methamphetamine and Suicide Prevention Initiative (MSPI)				
The proportion of identified meth using patients who enter methamphetamine treatment program*	FY 2010: 1,240	1,240	TBD	TBD
Reduce the incidence of suicidal activities (ideation, attempts) in AI/AN communities through prevention, training, surveillance & intervention programs*	FY 2010: 14,242	14,242	TBD	TBD
Reduce the incidence of methamphetamine abuse in AI/AN communities through prevention, training, surveillance & intervention programs	FY 2010: 4,370	4,370	TBD	TBD
The proportion of youth (ages 6 – 21) who participate in evidence-based and/or promising practice prevention or intervention programs*	FY 2010: 42,895	42,895	TBD	TBD
Establishment of trained suicide crisis response teams**	FY 2010: 674	674	TBD	TBD
Increase Tele-behavioral health encounters***	FY 2010: 617	617	TBD	TBD
Program Level Funding ($ in millions)	**$194.4**	**$194.4**	**$211.7**	**+$17.3**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

* Proportions and incidence could not be calculated due to inconsistencies around service population estimates. Definitions have been included in progress reporting for 2011.

** Number of individuals trained has been reported instead of teams trained due to inconsistencies around definitions. Both measures will be collected in progress reporting for 2011.

*** Many programs did not have their tele-behavioral health equipment operational until the final months of the base year resulting in fewer encounters than would be expected from a full year of tele-behavioral health data reporting.

GRANT AWARDS:

(whole dollars)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	15	15	15
Average Award	$100,000	$100,000	$100,000
Range of Awards	n/a	n/a	n/a
Total Awards	$1,500,000	$1,500,000	$1,500,000

AREA ALLOCATION – Alcohol and Substance Abuse

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Aberdeen	$14,440,399	$14,440,399	$15,709,446	$1,269,047
Alaska	31,378,669	31,378,669	34,136,281	2,757,612
Albuquerque	12,562,752	12,562,752	13,666,788	1,104,036
Bemidji	10,373,267	10,373,267	11,284,888	911,621
Billings	11,436,382	11,436,382	12,441,431	1,005,049
California	11,262,979	11,262,979	12,252,789	989,810
Nashville	9,091,507	9,091,507	9,890,484	798,977
Navajo	19,507,277	19,507,277	21,221,610	1,714,333
Oklahoma	15,783,079	15,783,079	17,369,123	1,586,044
Phoenix	17,117,449	17,117,449	18,621,760	1,504,311
Portland	16,724,811	16,724,811	18,194,616	1,469,805
Tucson	3,223,549	3,223,549	3,506,840	283,291
Headquarters	21,506,880	21,506,880	23,396,942	1,890,062
Total, A&SA	**$194,409,000**	**$194,409,000**	**$211,693,000**	**+$17,284,000**

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

CONTRACT HEALTH SERVICES

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$779,347	$779,347	$948,646	+$169,299
FTE	6	6	6	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 2012 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Contract Health Services (CHS) funds are used to purchase services from the private sector in situations where (1) no IHS direct care facility exists, (2) the direct care element is incapable of providing required emergency and/or specialty care, (3) the direct care element has an overflow of medical care workload, and (4) supplementation of alternate resources is required (i.e., Medicare, private insurance) to provide comprehensive care to eligible Indian people.

The annual allocation of Contract Health Services (CHS) funds is based on each Area's established funding base for the prior year and increases for inflation, population growth, and program increases are distributed against the Area or Tribes base. New CHS funds are distributed using a formula that consists of three basic factors multiplied together; active user population, cost of purchasing health care services within a geographic area and, access to care (lack of availability of inpatient care).

The demand for CHS is high, and the CHS program uses the CHS eligibility criteria and the IHS medical priority system in order to determine priorities for purchasing services and to manage its budget within appropriations, while utilizing alternate resources to ensure IHS is the payor of last resort. Tribes manage 54 percent of the CHS budget and must adhere to the same regulations as the IHS managed CHS programs.

The rising cost of health care services, transportation costs, and the increased demand for CHS play a critical role in the number of services the program can purchase. In FY 2010 CHS denied 204,420 of services needed by eligible American Indians and Alaska Natives (AI/AN). However, Because Tribes operate more than 50 percent of the CHS budget and do not always report services it is difficult to measure all unmet need. IHS estimates that 36,204 of denials will be upheld (not within medical priority). At current funding levels, most programs are approving only medically emergent referrals (life or limb) and less urgent, routine and/or preventive care must be deferred or denied pending additional appropriations.

The CHS program also includes $58 million for the Catastrophic Health Emergency Fund (CHEF) which is centrally managed at IHS Headquarters and is available to both IHS managed and Tribally managed CHS programs. CHEF provides funding for high cost cases (after meeting the threshold) such as burn victims, motor vehicle accidents, high risk obstetrics, and cardiology. The top three diagnostic categories funded in FY 2010 were injuries, cancer, and heart disease.

In FY 2010, 1,747 high cost cases were funded from CHEF funds on a rolling basis at a total cost of $48,000,000; 865 submitted cases that were not funded at a total cost of $14,000,000. It is estimated that more cases may qualify for CHEF but were not reported due to the depletion of the CHEF before the end of FY 2010.

The CHS program maximizes its annual resources by contracting with Blue Cross/Blue Shield of New Mexico as its fiscal intermediary (FI). The FI assists the IHS by ensuring CHS payments are in accordance with its payment policy focuses on the appropriateness of care and coordinates benefits with other payers to maximize the CHS resources. All IHS managed CHS programs, some Tribally managed CHS programs and all the CHEF cases utilize the FI.

An important change in IHS' health facility construction patterns underscores the importance of CHS funding to IHS and Tribal facilities. Five hospitals have been or are planned to be replaced by ambulatory health centers with no inpatient services due to the workload is unable to support a full service hospitals and service population. These new ambulatory health centers will be required to purchase inpatient care from the private sector in order to maintain the same level of services.

Based on input that the CHS program is a top tribal priority, the IHS Director established a Tribal workgroup in FY 2010 to review and make recommendations on improving the business of the CHS program. Three work group meetings and two listening sessions were held in 2010 with recommendations on the distribution formula, how to better document the overall level of CHS need, and strategies to improve the business of CHS. IHS staff and Tribes will work together to implement the recommendations to improve CHS business practices over the next few years.

The CHS program is involved in Case Management and best practice activities to ensure AI/AN patients receive quality patient care when referred to private providers and that all third party payers are identified prior to utilizing CHS funds. These activities directly relate to the Agency's priority to improve the quality and access to care and improve how the Agency does business.

FUNDING HISTORY

Fiscal Year	CHS	CHEF	TOTAL
2007	$525,099,000	$18,000,000	$543,099,000
2008	$552,755,366	$26,578,800	$579,334,000
2009 Omnibus	$603,477,366	$31,000,000	$634,477,000
2010 Enacted	$731,347,000	$48,000,000	$779,347,000
2011 Continuing Resolution	$731,347,000	$48,000,000	$779,347,000

BUDGET REQUEST
The FY 2012 budget request for Contract Health Services is $948,646,000, an increase of $169,299,000 over the FY 2010 Enacted level of $779,347,000. The increases will provide:

Current Services +$79,664,000

Federal and tribal pay costs are under the pay freeze enacted by Congress.

Inflation +$56,758,000 will fund inflationary cost increases.

Population Growth +$22,906,000 will fund increased services need from the growing AI/AN population.

Program Increase +$89,635,000

CHS +$79,635,000: This increase is estimated to purchase the following additional services over the FY 2010 levels:

- 5,732 Inpatient admissions
- 218,070 Outpatient visits, and
- 7,930 One-way patient travel trips

The purchase of these additional services addresses medically necessary care and relates directly to the Agency's third priority to improve quality and access to care while improving customer service for patients and providers.

These services are critical and will provide needed care to thousands of patients who would otherwise not have access to care. These increases will improve the quality of care for AI/AN patients who require a higher level of care than what is available from a direct service facility. It will provide for needed specialty and secondary care including primary care in those areas with limited direct care services.

CHEF +$10,000,000: This increase will fund an additional 400 high cost cases from the CHEF.

The CHEF increase will increase access and improve patient care, and lessen the burden of high costs cases, particularly for those smaller IHS and Tribally managed CHS programs with limited budgets.

The FY 2012 budget request includes $37,418,000 for current services and $46,000,000 for program increases in FY 2011. The current services funds are necessary costs to sustain the CHS program and services such as inpatient and outpatient care that cannot be provided in IHS and Tribal facilities. The CHS program purchases services that include but are not limited to care for cardiac events, life threatening traumatic injuries, and obstetric care.

The additional $46,000,000 will enable the program to increase the CHEF by $5,000,000 and provide additional CHS services over the FY 2010 level.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Average Days between Service End and Purchase Order (PO) Issued	82.1 days FY 2010 (Target Not Met)	78 days	74 days	-4 days
Program Level Funding ($ in millions)	**$634.5**	**$779.3**	**$948.6**	**+$169.3**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	FY 2010 Most Recent Results	FY 2012 Target	FY 2012 +/-FY2010
Inpatient Admissions	41,720	47,452	+5,732
Ambulatory: Out Patient Visits	1,587,114	1,805,184	+218,070
Patient Travel: One Way Trips	57,715	65,645	+7,930
Program Level Funding ($ in millions)	**$779.3**	**$948.6**	**+$169.3**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**

AREA ALLOCATION * – Contract Health Services

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Aberdeen	$78,908,161	$78,908,161	$96,049,528	$17,141,367
Alaska	75,781,210	75,781,210	92,243,303	16,462,093
Albuquerque	37,181,683	37,181,683	45,258,729	8,077,046
Bemidji	52,364,546	52,364,546	63,739,794	11,375,248
Billings	56,767,563	56,767,563	69,099,286	12,331,723
California	40,773,077	40,773,077	49,630,288	8,857,211
Nashville	30,155,332	30,155,332	36,706,031	6,550,699
Navajo	84,986,329	84,986,329	103,448,067	18,461,738
Oklahoma	95,265,179	95,265,179	115,959,811	20,694,632
Phoenix	63,049,120	63,049,120	76,745,398	13,696,278
Portland	83,216,850	83,216,850	101,294,201	18,077,351
Tucson	16,986,338	16,986,338	20,676,312	3,689,974
CHEF	48,000,000	48,000,000	58,427,129	10,427,129
Headquarters	15,911,612	15,911,612	19,368,121	3,456,509
Total, CHS	**$779,347,000**	**$779,347,000**	**$948,646,000**	**+$169,299,000**

* The allocation of the FY 2012 CHS funds to Areas will be determined by the funding base, inflation, population growth, with new CHS program increases distributed using a formula that includes active user population, cost of purchasing health care services within a geographic area and, access to care (lack of availability of inpatient care).

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

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$144,315	$144,315	$156,613	+$12,298
FTE	286	286	291	+5

SUMMARY OF THE BUDGET REQUEST

The FY 2012 budget request for Preventive Health is $156,613,000, an increase of $12,298,000 over the FY 2010 Enacted level. This increase will fund population growth, inflation and staffing for two newly constructed facilities.

- $70.6 million for **Public Health Nursing**, an increase of $6.5 million for Commissioned Officers' pay costs, inflation, population growth, and staffing new facilities to support prevention-focused health interventions for individuals, families, and community groups as well as improving health status by early detection through screening and disease management. The Public Health Nursing's health promotion and disease prevention focus is accomplished through primary, secondary, and tertiary prevention focused health interventions towards individuals, families, and community groups as well as improving health status by early detection through screening and disease management. Primary prevention targets healthy populations and activities are aimed at preventing the onset of disease in high risk populations through education, health awareness, and risk reduction. Secondary prevention detects and treats problems in the early stages of illness or disease. These interventions target disease before complications arise and before signs or symptoms appear. Secondary prevention targets populations with common risk factors. Tertiary prevention reduces further complications from a disease or illness and restores the individual to their optimum level of health. Tertiary prevention interventions occur after a disease or illness has developed.
- $18.2 million for **Health Education**, an increase of $1.5 million for Commissioned Officers' pay costs, inflation, population growth, and staffing new facilities to support the provision of community health, school health, worksite health promotion, and patient education. The Health Education program standardizes, coordinates and integrates education issues within the IHS including health literacy for clients, professional education and training, as well as educational materials for staff, patients, families and communities.
- $65.7 million for **Community Health Representatives** (CHRs), an increase of $4.1 million for Commissioned Officers' pay costs, inflation, and population growth, to help bridge the gap between AI/AN individuals and health care resources through outreach by specially trained indigenous community members. CHRs integrate basic medical knowledge about health promotion/disease prevention and local community knowledge.
- $2.1 million for **Immunization AK**, an increase of $130,000 for inflation and population growth, to continue the provision of vaccines for preventable diseases, immunization

consultation/education, research, and liver disease treatment and management through direct patient care, surveillance, and education. The Hepatitis B and Haemophilus Immunization Programs (Alaska) budget supports these priorities through direct patient care, surveillance and educating AI/AN patients.

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

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

PUBLIC HEALTH NURSING

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$64,071	$64,071	$70,613	+$6,542
FTE	254	254	257	+3

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 2012 Authorization ..... Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

The Public Health Nursing program provides quality, culturally sensitive health promotion and disease prevention nursing services through primary, secondary and tertiary prevention services to individuals, families, and community groups.

- *Primary prevention interventions* include health education 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. Other interventions include chronic disease care, self-management education, medication management, and care coordination.

Public Health Nurses played a critical role in the H1N1 influenza pandemic in FY2009-FY2010. The PHN expertise in communicable disease assessment, outreach, investigation, surveillance and monitoring interventions helped to manage the H1N1 influenza pandemic and prevent disease spread in communities. The Public Health Nurses contributed to the agency's primary prevention efforts in immunizing for influenza and H1N1 by providing community influenza/H1N1 immunization clinics and immunizations to the home bound.

PHN home visiting nursing services include services for:

- Maternal and pediatric population, 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;
- Communicable disease investigation and treatment.

The Public Health Nursing program awarded 15 grants and program awards in FY 2008 with continuation funding through FY 2011. PHN grants and competitive program awards provide funding to increase local public health nursing prevention services through public health nursing case management services for high risk and vulnerable patients and families. This request includes funding for grants and program awards to be awarded in FY 2012.

Data quality improvement has been a priority for the program. A data improvement project continues to evaluate data and provide training to standardize documentation. The PHN Data Mart captures data related to clinical and quality improvement activities. The PHN program uses Data Mart reports to determine demands for PHN services as well as to provide accountability and transparency in alignment with the Agency's priorities.

The PHN program contributes toward 10 agency performance measures; six are highlighted in the corresponding output table: tobacco screening, domestic violence screening, depression screening, Pap smear follow-up, adult influenza vaccinations, and adult pneumococcal vaccinations. The FY 2010 target for the public health nursing measure was 430,000 encounters. The final result of 454,679 encounters exceeded the target by 24,679 encounters, a 5.7 percentage increase. The data quality improvement project begun in 2009 is the basis for the increased FY 2010 performance and it is an ongoing project.

FUNDING HISTORY

Fiscal Year	Amount
2007	$52,445,000
2008	$55,939,000
2009 Omnibus	$59,885,000
2010 Enacted	$64,071,000
2011 Continuing Resolution	$64,071,000

BUDGET REQUEST

The FY 2012 budget request for Public Health Nursing of $70,613,000 is an increase of $6,542,000 over the FY 2010 Enacted level of $64,071,000.

Current Services +$6,542,000

Pay Costs +$114,000 will fund pay raises for Commissioned Officers employed by the agency. Federal and Tribal pay are otherwise subject to the pay freeze enacted by Congress.

Inflation +$1,793,000 will fund inflationary costs.

Population Growth +$1,839,000 will fund costs related to anticipated population growth.

Staffing/Operating Cost Requirements for New/Expanded Facilities +$2,796,000 will fund the PHN workforce necessary to staff new facilities.

Staff for New Facility	Amount	FTE/Tribal Positions
Absentee Shawnee Health Center (JV), Little Axe, OK	$453,000	4
Elbowoods Health Center, New Town, ND	$230,000	2
Carl Albert Hospital, Replacement (JV), Ada, OK	$303,000	3
Lake County Tribal Health Center (JV), Lakeport , CA	$235,000	2
Cherokee Nation Health Center (JV), Vinita, OK	$442,000	4
Cheyenne River Health Center, Eagle Butte, SD	$1,133,000	10*
Grand Total:	$2,796,000	25

* Federal FTE

OUTCOMES

Measure	Most Recent Result	FY 2010	FY 2012 Target	FY 2012 +/- FY 2010
23: **Public Health Nursing:** Total number of public health activities captured by the PHN data system; emphasis on primary, secondary and tertiary prevention activities to individuals, families and community groups.	FY 2010: 454,679 (Target Exceeded)	435,000	424,203	-10,797
Program Level Funding ($ in millions)	**$64.1**	**$64.1**	**$70.6**	**+$6.5**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
PHN Vacancy Rates	(FY2010) 19%	18	17	-1
Contributes to the following performance measures:				
Tobacco Screening	5,653	5,653	5,709	+565
Domestic Violence Screening	6,467	6,467	7,113	+646
Depression Screening	13,042	13,042	14,346	+1,304
Pap smear or Follow-up	2,220	2,220	2,442	+222
Adult Influenza Vaccine	103,513	103,513	113,864	+10,351
Adult Pneumococcal Vaccine	7,792	7,792	8,571	+779
Program Level Funding ($ in millions)	**$64.1**	**$64.1**	**$70.6**	**+$6.5**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

GRANTS AWARDS

(whole dollars)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	15	15	15
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

AREA ALLOCATION – Public Health Nursing

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Aberdeen	$7,876,223	$7,876,223	$9,699,717	$1,823,494
Alaska	3,887,377	3,887,377	4,114,658	227,281
Albuquerque	3,481,136	3,481,136	3,684,665	203,529
Bemidji	2,225,763	2,225,763	2,355,895	130,132
Billings	4,292,215	4,292,215	4,543,165	250,950
California	623,097	623,097	894,527	271,430
Nashville	1,086,913	1,086,913	1,150,461	63,548
Navajo	13,613,049	13,613,049	14,408,955	795,906
Oklahoma	11,078,750	11,078,750	12,924,485	1,845,735
Phoenix	7,215,550	7,215,550	7,637,417	421,867
Portland	3,013,168	3,013,168	3,189,337	176,169
Tucson	1,038,816	1,038,816	1,099,552	60,736
Headquarters	4,638,943	4,638,943	4,910,165	271,222
Total, PHN	**$64,071,000**	**$64,071,000**	**$70,613,000**	**+$6,542,000**

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

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$16,682	$16,682	$18,190	+$1,508
FTE	26	26	28	+2

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 2012 Authorization ..... Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Service (IHS) Health Education program has been in existence since 1955. The program continues to focus on the importance of educating its American Indian/Alaska Native (AI/AN) clients in a manner that empowers them to make better choices in their lifestyles and how they utilize health services. Leadership is provided by the single Lead Consultant at IHS Headquarters to the 23 IHS fulltime field positions located throughout the IHS. Program dollars support approximately 75 tribal Health Education staff.

The Health Educators program staff partner with other IHS disciplines and programs to ensure that the education of IHS clients continues to occur even at sites without a full-time health educator; they provide leadership and guidance on educational issues provided by all disciplines and programs. All encounters are documented and coded in the Resource and Patient Management System (RPMS). Health Education provides leadership in the integration of Healthy People 2020 goals, goals that integrate health literacy, patient-provider communications and electronic health information opportunities to our clients. Health education provided within IHS strives for the inclusion of health education, health literacy, and the development and management of multimedia educational materials which includes written and electronic resources.

The IHS can demonstrate a steady increase in the health and patient education encounters that are being provided to AI/AN clients by all providers within the IHS and by IHS' Tribal partners. This model concept demonstrates not only the collaboration between the IHS Health Education program and all IHS health disciplines and programs but also demonstrates an IHS-wide focus and commitment to education. As the Health Education Output Table demonstrates, IHS has maintained a steady increase in the number of AI/AN clients that have participated in an educational encounter. The number of visits in which education was provided has moved from approximately 777,000 visits with education provided in FY 2004 to 2,603,500, at the end of FY 2010, which represents a three-fold increase in health education services over this period.

This increase demonstrates the IHS commitment to improve health education access, increase health literacy, increase patient-provider communications, and ultimately to achieve better health outcomes.

The Health Education program maintains data tracking of two key program objectives – tobacco cessation and cardiovascular disease (CVD) assessment. During the most recently completed national performance data collection period, the Health Education program contributed to increased performance of the proportion of tobacco-using patients that receive tobacco cessation intervention from the 12 percent FY 2006 baseline to 24 percent in FY 2009 and increased the proportion of at-risk patients who have a comprehensive assessment for all CVD-related risk factors to 32 percent in FY 2009 from a baseline of 12 percent in FY 2006.

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

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

The Health Education Program has identified the following areas of emphasis for 2012:

- Continue and strengthen the development of standardized, nationwide patient and health education programs through the integration of the IHS Patient Education Protocols into all IHS software packages including the Patient Care Component (PCC), Patient Care Component+ (PCC+) and the electronic health record, with the continued provision of ongoing training to IHS and Tribal staff on the documentation and coding of patient and health education. This effort assists IHS to meet Healthy People objectives to improve consumer access to health information and to improve health communications to our clients.
- Increase a concentrated focus on the area of Healthy People: Health Communications:
  - Increase the proportion of AI/ANs with access to health information;
  - Improve the health literacy of AI/ANs with inadequate or marginal literacy skills;
  - Increase the health information contained on www.ihs.gov ensuring that information disclosed is quality-assured and culturally appropriate for AI/AN clients;
  - Improve patient-provider communication skills.

FUNDING HISTORY

Fiscal Year	Amount
2007	$14,287,000
2008	$14,991,000
2009 Omnibus	$15,723,000
2010 Enacted	$16,682,000
2011 Continuing Resolution	$16,682,000

BUDGET REQUEST

The FY 2012 budget request for Health Education is $18,190,000, an increase of $1,508,000 over the FY 2010 Enacted level of $16,682,000.

Current Services +$1,508,000

Pay Costs +$3,000 will fund pay raises for Commissioned Officers employed by the agency. Federal and Tribal pay are otherwise subject to the pay freeze enacted by Congress.

Inflation +$593,000 will fund inflationary costs.

Population Growth +$477,000 will fund costs related to anticipated population growth.

Staffing/Operating Cost Requirements for New/Expanded Facilities +$435,000 will fund the Health Education workforce necessary to staff new facilities.

Staff for New Facility	Amount	FTE/Tribal Positions
Carl Albert Hospital Replacement (JV), Ada, OK	$106,000	1
Elbowoods Health Center, New Town, ND	$86,000	1
Cherokee Nation Health Center (JV), Vinita, OK	$66,000	1
Cheyenne River Health Center, Eagle Butte, SD	$177,000	2*
Grand Total:	**$435,000**	**5**

* Federal FTE

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
32: **Tobacco Cessation Intervention:** Proportion of tobacco-using patients that receive tobacco cessation intervention. IHS-All	FY 2010: 25% (Target Not Met but Improved)	27%	24.3%	-2.7%
32: Tribally Operated Health Programs	FY 2010: 23% (Target Exceeded)	22%	22.2%	+0.2%
30: **CVD Comprehensive Assessment**: Proportion of Ischemic Heart Disease patients who have a comprehensive assessment for all CVD-related risk factors. IHS-All	FY 2010: 35% (Target Exceeded)	33%	33.8%	+0.8%
30: Tribally Operated Health Programs	FY 2010: 30% (Target Exceeded)	29%	29.0%	0
Program Level Funding ($ in millions)	**$16.7**	**$16.7**	**$18.2**	**+$1.5**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

OUTPUTS

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Number of Visits with Health/Patient Education	FY 2010 2,603,500	2,424,200	2,459,000	+34,800
Program Level Funding ($ in millions)	**$16.7**	**$16.7**	**$18.2**	**+$1.5**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

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

AREA ALLOCATION – Health Education

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Aberdeen	$1,712,781	$1,712,781	$2,085,948	$373,167
Alaska	1,910,679	1,910,679	2,033,575	122,896
Albuquerque	1,228,231	1,228,231	1,307,232	79,001
Bemidji	636,437	636,437	677,373	40,936
Billings	1,233,927	1,233,927	1,313,294	79,367
California	258,764	258,764	275,408	16,644
Nashville	519,828	519,828	553,264	33,436
Navajo	2,356,156	2,356,156	2,507,706	151,550
Oklahoma	2,582,781	2,582,781	2,920,908	338,127
Phoenix	1,830,808	1,830,808	1,948,567	117,759
Portland	955,527	955,527	1,016,987	61,460
Tucson	223,289	223,289	237,651	14,362
Headquarters	1,232,792	1,232,792	1,312,086	79,294
Total, HEALTH ED	**$16,682,000**	**$16,682,000**	**$18,190,000**	**+$1,508,000**

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

COMMUNITY HEALTH REPRESENTATIVES

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$61,628	$61,628	$65,746	+$4,118
FTE	6	6	6	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 2012 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Community Health Representative (CHRs) are one of critical attributes that make the Indian Health System special by linking the health programs to the American Indian and Alaska Native patients and communities. This is accomplished under the concept of utilizing indigenous community members as health paraprofessionals to expand health services and initiate community change. CHRs are authorized by Congress to provide health care, health promotion and disease prevention services to Indian communities and Tribal members (Indian Health Care Improvement Act [IHCIA] as amended, Public Law 111-148, dated March 23, 2010). The IHCIA also mandated the Secretary to provide a quality training program, including continuing education needs for CHRs.

The six FTE positions reflect CHR personnel within three federally-administered CHR Programs which were previously operated by Tribes. Funds are distributed through Area allocations to the Tribes who employ approximately 1,600 CHRs.

Training is a key tool to provide laypersons with the comprehensive health education, skills and competencies needed to perform the wide variety of culturally sensitive job responsibilities the various Tribes assign to their CHRs. Training affords CHRs the skills needed to provide 16 categories of services that make a difference in their patients' lives and which contribute to Agency performance measures. CHRs provide a critical link in the continuity of care.

Program accomplishments during FY 2010 include:

1. 637 CHRs trained in RPMS CHR PCC; 64 CHRs trained in Basic and Refresher courses
2. Enhanced collaboration with various disciplines and offices within and outside IHS to avoid waste and duplication and improve access to existing resources, including among many: a) the Improving Patient Care Initiative which focuses on patient-centered care in a medical home model and incorporates community based programs and services; b) sample training curricula from federal and non-governmental resources; and c) partnerships with the American Cancer Society and the American Association of Diabetes Educators
3. Progress in updating Chapter 16, Community Health Representatives in the Indian Health Manual

4. Enhancements to the IHS Resource Patient and Management System (RPMS) CHR Patient Care Component (PCC) data application

For FY 2010, data from 47 percent of reporting CHR Programs on types of services provided by CHRs showed that direct *Patient Care* (taking vital signs, providing foot care, providing emotional support, providing personal care like bathing, shampooing hair, etc.) led at nearly 23 percent; *Case Finding/Screening* was nearly 14 percent; *Transportation* was 12 percent; *Monitoring Patients* was over 12 percent; *Case Management* was over 12 percent; *Health Education* was over 11 percent; and *Other Patient Services* was over 6 percent.

FUNDING HISTORY

Fiscal Year	Amount
2007	$54,891,000
2008	$54,925,000
2009 Omnibus	$57,796,000
2010 Enacted	$61,628,000
2011 Continuing Resolution	$61,628,000

BUDGET REQUEST

The FY 2012 budget request for Community Health Representatives is $65,746,000, an increase of $4,118,000 over the FY 2010 Enacted level of $61,628,000. The increase will provide:

Current Services +$4,118,000

Pay Costs +$2,000 to cover Commissioned Officers' pay costs. Federal and tribal pay costs are included in the pay freeze enacted by Congress.

Inflation +$2,360,000 to cover the cost of providing health care services

Population Growth +$1,756,000 to cover the cost of providing health care services to the projected increase in population.

Current services are necessary costs to sustain valuable programs and maintain improvements made in performance measures regarding chronic disease services and CHR health promotion/disease prevention efforts.

The total funding for Community Health Representatives will provide:

- $63,773,620 (approximately 97 percent of total funding) for Self-Determination contracts and compacts with Tribes for direct health care, health promotion and disease prevention services as identified in Tribal funding agreements and scopes of work to 1.9 million AI/AN population throughout 12 Areas in homes and other community-based settings.
- $1,972,380 (approximately 3 percent of total funding) is under direct Federal administration for training, information technology costs, special projects and national education meeting(s); and is subject to Tribal shares of which 59.9 percent was paid to Tribes in FY 2010. Federally retained funds will support the following plans in FY 2012, but are not limited to:
  - Training CHRs nationally on the CHR PCC data application;
  - Providing CHR Basic and Refresher training and paying registration, travel and per diem for CHRs from Tribes leaving shares for training;

- Providing administrative, logistical, training, web management, listserv and other program assistance;
- Funding the FY 2012 CHR National Education Conference (NEC), held biannually;
- Refining CHR curriculum for cost-effective provision of training through online training modules and in person;
- Continuing health information technology development and data support, specifically to (a) include limited patient education protocols and codes, (b) require notation of referrals made to and from CHRs to help track access issues and the potential impact of CHR activities, and (c) integrate continuous quality improvement efforts into data collection and data integrity;
- Enhancement of the national CHR web-based tracking system to improve data reporting to/by the national level;
- Continuing efforts to provide CHR education on the Improving Patient Care Initiative and Model for Improvement, and assessment and dissemination of information related to CHR involvement and integration into the patient's health care team and medical home.

OUTPUTS TABLE

Measure	Most Recent Result	FY 2010 Target	FY 2011 Target	FY 2011 +/- FY 2010
Patient Services in Hours directed to Chronic Diseases (1), (2), (3)	FY 2010: 193,706	151,700	151,700	0
# of contacts (3), (4)	FY 2010: 1,839,111	1,302,500*	1,321,500	+19,000
# of CHRs trained in basic, refresher, and first responder training	FY 2010: 64[7]	70	267	+67
Number of CHRs trained on CHR PCC	FY 2010: 637	640[6]	363[5]	-277
Program Level Funding ($ in millions)	**$61.6**	**$61.6**	**$65.7**	**+$4.1**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

[1, 3]126 of 290, about 47 percent, CHR Programs assigned Program Codes reported in RPMS CHR PCC, the only way IHS Headquarters can track CHR data (42 percent reported in 2009; 55 percent in 2008; 33 percent in 2007). 193,706 service hours were extrapolated from 47 percent reporting.
[2]The Program Performance target above represents an effort by the IHS national CHR Program to obtain specific service hours provided in the categories of diabetes, heart, hypertension, nutrition, cancer, other chronic, dialysis, obesity, depression, renal failure, and liver disease related to IHS GPRA indicators and drawn from the CHR PCC software application.
[3]Training conducted on CHR PCC suggests that CHRs routinely under-report the services they provide. Typically they report 2-3 services, but when queried further they identify 5-7 additional services that regularly are unreported (checking homes for hazards as part of injury prevention efforts, providing homemaker services, providing health information on/checking medications, coordinating appointments, interpreting/translating, health education).
[4]Patient contacts are the number of services multiplied by number served
[5] Estimate based only on CHRs trained in regional training throughout the year – no national education conference in FY 2011
[6]Estimate based on inclusion of CHR participants at tentatively scheduled FY 2010 National CHR Education meeting which will be added to the number of CHRs trained throughout the year
[7]Actual number trained was less than target due to unanticipated termination of interagency training agreement
*Revised from previously published estimates due to improved data system capacity

With the proposed funding increase for FY 2012, the CHR program will strive to reach the level of services proposed in FY 2012 and continue to work toward addressing the following challenges:

1. Currently, RPMS CHR PCC is the only data system by which IHS can furnish data for budget purposes or program management. With Tribes having the option of another data source, data validation coordination will be essential.
2. Improvements to connectability for remote sites.
3. Ensuring necessary federal security requirements for Tribal members to request access to RPMS.

GRANTS AWARDS

No grant awards were made in FY 2010 and FY 2011; none are anticipated for FY 2012.

AREA ALLOCATION – Community Health Representatives

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Aberdeen	$7,317,328	$7,317,328	$7,806,274	$488,946
Alaska	4,451,073	4,451,073	4,748,495	297,422
Albuquerque	3,533,937	3,533,937	3,770,076	236,139
Bemidji	4,857,278	4,857,278	5,181,843	324,565
Billings	4,494,912	4,494,912	4,795,263	300,351
California	2,021,598	2,021,598	2,156,682	135,084
Nashville	3,493,976	3,493,976	3,727,444	233,468
Navajo	6,952,078	6,952,078	7,416,618	464,540
Oklahoma	9,036,457	9,036,457	9,640,276	603,819
Phoenix	6,307,907	6,307,907	6,729,403	421,496
Portland	4,726,213	4,726,213	5,042,020	315,807
Tucson	1,985,177	1,985,177	2,117,827	132,650
Headquarters	2,450,066	2,450,066	2,613,780	163,714
Total, CHR	**$61,628,000**	**$61,628,000**	**$65,746,000**	**+$4,118,000**

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 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$1,934	$1,934	$2,064	+$130
FTE	0	0	0	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 2011 Authorization.....Permanent

Allocation Method ..... 100 percent Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Hepatitis B Program

The Hepatitis B Program was initiated in 1983 because of the need to prevent and monitor hepatitis B infection among a large population of Alaska Natives with or susceptible to the disease. It continues to provide this service in addition to evaluation of vaccine effectiveness and the medical management of persons with hepatitis and liver disease. Hepatitis and other liver disease continues to be a health disparity in American Indian and Alaska Natives people (AI/AN). To address this disparity, the Program provides regular medical monitoring and clinical care follow-up of chronic liver disease patients, consultation on immunization and hepatitis issues, follow-up of persons with autoimmune and non-alcoholic fatty liver disease, and follow-up of large cohorts of persons vaccinated with hepatitis A and B vaccine to determine duration of immunity and if booster doses will be needed in the future. The Program uses computer-based applications that integrate laboratory and other clinical data into a series of reports that allows program clinicians to follow a large number of patients with chronic hepatitis and other liver disease. The Program follows patients statewide with chronic hepatitis B with the goal of reducing the lifetime risk of death from liver cancer or cirrhosis from 25 percent to <10 percent by early detection and removal of hepatocellular cancer and treatment with antiviral medications.

In 2010, 63 percent of AI/AN with chronic hepatitis B or C infection (63 percent and 72 percent, respectively) were screened for liver cancer and for liver aminotransferase levels to detect liver inflammation and potential treatment candidates at least once during the year. There were 109 new cases of chronic hepatitis C infection identified in 2010. A future challenge will be to determine good candidates for antiviral therapy, especially with the advent of several new potent and more effective antiviral agents. Within the next 5 to 10 years, an estimated 25–33 percent of patients will need therapy for Hepatitis C.

Immunization (Hib) Program

The Immunization (Haemophilus Influenza; Hib) Program started in 1989 with a targeted Haemophilus influenzae type b prevention project in the Yukon Kuskokwim Delta and now maintains high vaccine

coverage by providing resources, training and coordination to Tribal facilities throughout Alaska. The Program conducts activities through e-mail, phone consultation, onsite training, teleconferences, web-based trainings, written guidelines, presentations, and site visits. Regular meetings are held with regional Immunization Coordinators, Clinical Directors, Community Health Aide Program (CHAP), 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. 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 among all ages. In 2010, the Program accomplished the following: Immunization Coverage, 19-35 month olds–exceeded GPRA objectives of 80 percent for child vaccine coverage with 4:3:1:3:3:1 series (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1Var) in 2009 and 2010; Pneumococcal vaccine coverage in elders > 65 years greatly exceeded the 2010 GPRA objective of 83 percent; Published an article in VACCINE showing vaccine led to 99.9 percent decrease in Hepatitis A disease in Alaska Natives; Greater than 95 percent decrease in Hib and vaccine-type pneumococcal meningitis among Alaska Native children; Rapid increase in HPV vaccine coverage in Alaska Native girls; International collaboration to study interventions for chronic lung disease in indigenous children; Recently published articles on RSV, empyema, otitis media & respiratory viruses in Alaska Native children; and, coordinated distribution, education, and implementation of H1N1 vaccination in Tribal facilities.

FUNDING HISTORY

Fiscal Year	Amount
2007	$1,681,000
2008	$1,733,000
2009 Omnibus	$1,823,000
2010 Enacted	$1,934,000
2011 Continuing Resolution	$1,934,000

BUDGET REQUEST

The FY 2012 budget request is $2,064,000, an increase of $130,000 over the FY 2010 Enacted level of $1,934,000.

Current Services +$130,000

Inflation + $75,000 will fund inflationary costs.

Population Growth + $55,000 will fund costs related to anticipated population growth.

Current services are necessary costs to sustain valuable programs and maintain improvements made in performance measures in recent years. Activities associated with this funding include the provision of training of Tribal immunization coordinators statewide in RPMS and consultation in the migration to Electronic Health Records, 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 conducts 2.5 days of outpatient clinics at the Alaska Native Medical Center (ANMC) and travels to regional health centers to conduct outpatient clinics. The Program anticipates expanding outpatient clinics at ANMC by 1 day (3.5 days total) to focus on the increasing cases of chronic hepatitis

C. These patients require intensive workup and those who are on treatment require case management to ensure compliance and healthy outcomes. As many of the patients that are monitored and their primary care provider resides outside of Anchorage, in FY 2012 the Program anticipates having in-place a venue for the education/training of providers utilizing the established statewide Tribal Health System tele-health system (video-conferencing). The goal will be to provide relevant clinical information to assist in the care and management of hepatitis and liver disease patients. The Program maintains and works to grow partnerships with Tribes throughout the Alaska Tribal Health System (ATHS). Annual field clinics are conducted at 13 sites 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. The Program strives to achieve quality of and access to care by recruiting and retaining the highest level of clinical and support staff. To increase access to care, the Program is always on the lookout for new cases though the utilization of regular electronic health care records reviews and a statewide referral system. The Program strives to make all work accountable, transparent, fair and inclusive through systematic reporting of upcoming clinical screenings to ATHS clinics and the notification of screening and subsequent report of results to the provider and patients. The Program ensures accountability by using customer satisfaction surveys and maintains flexibility in scheduling to accommodate programmatic and customer needs that might arise.

Immunization (Hib) Program

The budget request will be used for program staff travel to National Immunization Conference and limited printing 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. The Program supports the HHS Strategic Plan: 1) Preventing disease through immunization; 2) Improving maternal and infant health; and 3) Planning and preparing for public health emergencies by providing an infrastructure to maintain high immunization coverage for basic vaccines and have a rapid response to emergencies such as pandemic Flu. Outputs during FY2012 will include: 1) the activities listed above under Program Description, 2) technical support to Tribal agencies developing Electronic Health Records (EHR), 3) networking with other departments and agencies for Emergency Preparedness. New strategies include: 1) collaboration with other agencies such as CDC in developing media materials 2) network with IHS and other agencies to provide technical assistance regarding EHRs 3) obtain grant funding and technical assistance to support uncovered program activities such as emergency preparedness. The future challenge of the diversity of EHRs employed by Tribal agencies that may result in a temporary loss or delay of Area-wide reporting of immunization coverage, will continue to be addressed through coordinated technology efforts by IHS and Tribes.

Outputs

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Hepatitis Program (Targeted/Known Cases = T and Screened = S)				
Sum of Hepatitis Patients Targeted for Screening	2938	2872	3268	+396
Chronic Hepatitis B Patients Screened/Targeted	T=1123 S=712	T=1138 S=750	T=1103 S=735	T=-35* S=-15
Chronic Hepatitis C Patients Screened/Targeted	T=1357 S=983	T=1314 S=788	T=1507 S=1083	T=+193 S=+295
Other Liver Disease Patients Screened/Targeted**	T=458 S=375	T=420 S=300	T=658 S=526	T=+238 S=+226
Hepatitis A/B vaccinations***	5000	5000	5000	0
Immunization Program				
2011 Objective: Combined (4:3:1:3:3:1:4) Immunization Rates for AI/AN Children Aged 19-35 Months	81%	86%	88%	+2%
2011 Objective: Influenza vaccination rates among adult patients aged >65 years	49%	59%	60%	+1%
2011 Objective: Pneumococcal vaccination rates among adult patients aged 65 years and older	89%	88%	90%	+2%
3-27 month old Alaska Native immunization reported:	5,200	5,200	5,200	0
19-35 month olds Immunization reported:	3,570	3,100	3,700	+600
11-17 year old Immunization reported:	11,670	12,000	12,000	0
65+ year old Immunization reported:	6,540	8,400	6,800	-1,600
Program Level Funding ($ in millions)	**$1.9**	**$1.9**	**$2.1**	**+$0.1**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

* Decline in hepatitis B cases due to an aging cohort and their deaths; discovery of new cases is rare given hepatitis B vaccinations.

** Other liver disease includes autoimmune hepatitis, primary biliary cirrhosis, nonalcoholic fatty liver disease.

*** Includes vaccination of patients at high risk (e.g., injection drug users, other liver disease, and hepatitis C and/or HIV infection) and scheduled/routine vaccination of infants, children and adults (number based on births, incidence of hepatitis and estimations).

All data reported is that which is available to the Alaska Native Tribal Health Consortium.

GRANTS AWARDS -- The program does not award any grants.

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

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$43,139	$43,139	$46,745	+$3,606
FTE	8	8	8	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 2012 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Urban Indian Health Program (UIHP) was established in 1976 to provide affordable and accessible health care for the underserved urban American Indian/Alaska Native (AI/AN) population. The Indian Health Service (IHS) provides funding through limited, competing contracts and grants with 34 urban Indian 501(c)(3) non-profit organizations to provide health care in 41 sites throughout the U.S. Urban Indian Health Organizations (UIHO) define their scopes of work and services based upon the documented unmet needs of the urban AI/AN community they serve. Each UIHO is governed by a Board of Directors of whom at least 51 percent are AI/AN.

UIHOs provide primary medical care and public health case management wrap-around services for approximately 46,000 urban AI/ANs who do not have access to the resources offered through IHS and tribally operated health care facilities. Urban Indian primary care clinics and case management programs provide high quality, culturally accessible, affordable, and accountable health services. The services include ambulatory health care, health assessment, health promotion, disease education, child abuse prevention, immunizations, and behavioral health services. The UIHOs fulfill IHS data reporting requirements including the IHS Government Performance and Results Act (GPRA) report and the Diabetes Non-Clinical Audit report. Eight programs participate in the IHS Improving Patient Care program.

The UIHOs report on the amounts and purposes for which IHCIA, as amended (2010), funding is used, including: a) the number of eligible urban AI/ANs for whom services are provided, and b) the number and type of services provided to urban AI/ANs. Information contained in the 2008 Uniform Data System (UDS) report indicated that the UIHO served a population that was 55 percent AI/AN. The UIHOs have policies requiring supporting documentation of the eligibility of a particular individual included in their Title V reports.

There are 21 full ambulatory facilities. A full ambulatory UIHO provides direct medical care to the population served for 40 or more hours per week. The range of services varies greatly among the programs that are defined as full ambulatory. Some full ambulatory programs have two or more full

time medical doctors, full time pharmacist, provide lab and radiology services, and have on-site dental providers. At the opposite end of the spectrum, some full ambulatory programs have a full time medical provider, but do not offer dental, pharmacy, lab or radiology services.

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

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

As of May 2010, two programs have implemented IHS Resource and Patient Management System (RPMS)/Electronic Health Record (EHR); four have fully implemented IHS RPMS and are working on transitioning to RPMS/EHR; twenty programs are working to implement RPMS, and six programs have non-RPMS electronic systems.

The 2010 national measure reporting cycle (July 1, 2009 – June 30, 2010) was successful for the UIHOs. Areas of greatest accomplishment included: (1) 100 percent of the UIHO reported on 34 of the 34 performance measures, and (2) 11 UIHO reported through CRS; 13 reported using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records). The goal is to transition to 100 percent electronic reporting for the UIHO using RPMS, and once the data is stabilized, advocate for inclusion in the IHS national clinical performance measure reporting.

Program challenges include increasing the number of RPMS/EHR programs, providing training and technical assistance to increase third party billing revenue, hiring providers for 24/7 coverage to meet FQHC designation, increasing the number of Joint Commission or Accreditation Association for Ambulatory Health Care, Inc. accredited programs, and increasing quality of and access to preventative health services. Tribal leadership consistently demonstrates its support for funding urban Indian health programs to serve their members who reside away from their communities. These programs often provide the only affordable, culturally competent healthcare services available in these urban areas.

FUNDING HISTORY

Fiscal Year	Amount
2007	$33,755,000
2008	$34,547,000
2009 Omnibus	$36,189,000
2010 Enacted	$43,139,000
2011 Continuing Resolution	$43,139,000

BUDGET REQUEST
The FY 2012 budget request for the Urban Indian Health Programs is $46,745,000; an increase of $3,606,000 over the FY 2010 Enacted level of $43,139,000. Of the total funding, 95 percent will fund direct health care services for 49,146 urban AI/ANs and 5 percent will fund program administration.

The program funding and accomplishments will strengthen and enhance implementation of the DHHS Strategic Plan for Fiscal Years 2010-2015, Goal 1: Transform Health Care by:

- Working with urban Indians to provide outreach, information and assistance to assure that urban AI/ANs are enrolled and able to use the benefits available under the IHCIA.
- Improving third party billing operations, implementing payment reforms and increasing quality improvement efforts.
- Increasing the number of urban medical homes for urban AI/AN patients.
- Emphasizing preventive health services including evaluation, dissemination and promotion of effective clinical preventive services.
- Implementing and utilizing tele-medicine.
- Expanding access to quality culturally competent care for urban AI/AN through close collaboration with the Department of Health and Human Services (HHS) Operating Divisions to implement the IHCIA.
- Increasing the number of health care providers to provide health services for urban AI/AN.
- Increasing technical assistance for implementing RPMS/EHR in 4 additional programs.

Current Services +$2,606,000

Pay Costs +$22,000 will fund pay increase for Commissioned Officers. Federal and tribal pay costs are included in the pay freeze enacted by Congress.

Inflation +$1,420,000 will fund inflationary costs.

Population Growth +$1,164,000 will fund costs related to anticipated population growth.

Current services are necessary costs to sustain valuable programs and maintain improvements made in performance measures in recent years. UIHOs provide primary health care and public health case management wrap-around services. The culturally competent accessible health services include health promotion, disease education, immunizations, behavioral health services and outreach and referral services.

Activities designed to increase the quality of and access to care for the urban AI/ANs include providing third party billing training and technical assistance, increasing the number of programs using RPMS/EHR, and increasing the number of accredited programs.

Program Increase +$1,000,000

The $1,000,000 program increase will be used for competitive grants to assist urban Indian clinics in improving third party collections. The grants will be used for training, on-site technical assistance, and off-site technical assistance via conference calls and webinars. Additional program support will increase revenue and services for the AI/AN populations served.

Outcome

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
UIHP-E: Cost per service user in dollars per year. *(Efficiency)*	FY 2008: $995 Target Not Met	Discontinue	Discontinue	N/A
UIHP-1: Percent decrease in years of potential life lost. (Outcome 1)	FY 2003: 51.7 (Baseline)	N/A	N/A	N/A
UIHP-2: Percent of AI/AN patients with diagnosed diabetes served by urban health programs that achieve ideal blood sugar control. (Outcome)	FY 2010: 37% (Target Met)	Baseline	34.9%	N/A
UIHP-3: Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher (Outcome 2)	FY 2010: 18% (Target Met)	Baseline	N/A	N/A
UIHP-6: Increase the number of diabetic AI/ANs that achieve ideal blood pressure control (Outcome 3)	FY 2008: 28% (Baseline)	28%	26.4%	-1.6%
UIHP-7: Number of AI/ANs served at Urban Indian Clinics. (Outcome)	FY 2008: 45,853 (Baseline)	47,611	49,146	+1,535
Program Level Funding ($ in millions)	**$43.1**	**$45.5**	**$46.7**	**+$3.6**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

1 Long-term measure, baseline for 2003 to be reported in 2009 after which a target will be set for 2009
2 Long-term measure, reportable in 2010 and 2013.

Output

Measure	FY 2008 Results*	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Medical Encounters	233,519	233,600	235,000	+ 1,400
Ancillary Encounters	193,468	193,500	195,200	+ 1,700
Dental Encounters	53,496	53,500	55,500	+ 2,000
Health Education Encounters	45,386	45,400	47,500	+2 ,100
Nutrition Encounters	85,267	85,300	88,500	+ 3,200
Behavioral Health Encounters	151,531	151,500	156,500	+5,000
Other Encounters	167,588	167,500	170,000	+2,500
Total Encounters	930,255	930,300	948,200	+17,900
Program Level Funding ($ in millions)	$43.1	$45.5	$46.7	+$3.6
ARRA Level Funding ($ in millions)	$0	$0	$0	$0

*FY 2009 results will be available February 2011.

GRANTS AWARDS

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	33	34	34
Average Award	$227,856	$227,856	$227,856
Range of Awards	$122,832 - $626,765	$122,832 - $626,765	$122,832 - $626,765

Grant Awards – Funding for the Urban Indian health programs for FY 2010 came from the FY 2010 appropriations for both the grants and contracts awarded to the programs.

AREA ALLOCATION – Urban Health

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Aberdeen	$1,525,737	$1,525,737	$1,653,274	$127,537

AREA ALLOCATION – Urban Health

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Alaska	0	0	0	0
Albuquerque	2,429,023	2,429,023	2,632,066	203,043
Bemidji	4,426,208	4,426,208	4,796,196	369,988
Billings	2,271,337	2,271,337	2,461,199	189,862
California	6,505,587	6,505,587	7,049,391	543,804
Nashville	920,238	920,238	997,161	76,923
Navajo	718,309	718,309	778,353	60,044
Oklahoma	2,056,349	2,056,349	2,228,240	171,891
Phoenix	2,480,141	2,480,141	2,687,457	207,316
Portland	5,540,627	5,540,627	6,003,769	463,142
Tucson	516,010	516,010	559,143	43,133
Headquarters	13,749,434	13,749,434	14,898,753	1,149,319
Total, URBAN	**$43,139,000**	**$43,139,000**	**$46,745,000**	**+$3,606,000**

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

INDIAN HEALTH PROFESSIONS

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$40,743	$40,743	$42,016	+$1,273
FTE	29	29	29	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 2012 Authorization ..... Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Care Improvement Act (IHCIA) P.L. 94-437 as amended, authorizes the Indian Health Service (IHS) Indian Health Professions (IHP) to manage the Scholarship Program, Loan Repayment Program, health professions training related grants, and recruitment and retention activities for IHS. The IHS made their first Scholarship Program awards in 1978 when Congress appropriated funds for the IHP program.

The IHP program has seen much success throughout the years including but not limited to the following:

- enabling American Indians and Alaska Natives (AI/AN) to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs;
- serving as a catalyst to the development of Indian communities by providing educational opportunities and enabling AI/AN health care professionals to further Indian self-determination in the delivery of health care;
- developing and maintaining American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field; and
- assisting Indian health programs to recruit and retain qualified health professionals.

Sections 103 and 104 (Scholarship Program) – Section 103, the Preparatory and Pre-Graduate Scholarship Programs, prepares students to enter a health profession training program. Graduate students and junior-level and senior-level students have priority for Section 103 funding unless otherwise specified. Section 104, the Health Professions Scholarship Program, provides financial support for AI/AN students (from federally recognized Tribes only) who are enrolled in health professions or allied health professions programs. Students incur service obligations and payback requirements upon acceptance of funding from the Section 104 program.

In 2008, the IHS reviewed service obligations owed and the years of service provided by the scholar. The results showed that on average scholars received 2.21 years of Health Professions

(Section 104) scholarship funding and they served an average of 6.13 years of full-time clinical service in their health profession at an Indian health program. On average, scholars served 3.92 years beyond their service obligation.

The following disciplines were awarded during FY 2010 for the 2010-11 school year:

Section 103 Preparatory - 22 students				
Pre-Pharmacy	9		Pre- Medical Technology	1
Pre-Nursing	7		Pre-Occupational Therapy	1
Pre- Clinical Psychology	1		Pre- Social Work	2
Pre- Physical Therapy	1			
Section 103 Pre-Graduate - 27 students				
Pre-Medicine	13		Pre-Optometry	3
Pre-Dentistry	10		Pre-Podiatry	1
Section 104 Professional - 223 students				
Physician (DO and MD)	54		Dental Hygienist	1
Nurse (ADN, BS and MS)	53		Dietitian	3
Pharmacist	38		Occupational Therapist	2
Dentist	19		Chemical Abuse Counseling	1
Physical Therapist	14		Health Care Administration	0
Physician Assistant	9		Health Education	0
Clinical Psychologist	10		Health Records	2
Optometrist			Nurse Anesthetist	1
Nurse Practitioner	4		Podiatrist	0
X-Ray Technology	2		Respiratory Therapist	1
Engineer	2		Sanitarian	1
Medical Technology	0		Women's Health Nursing	2
Social Work	4			

Loan Repayment Program (Section 108) – The IHS Loan Repayment Program (LRP) is an invaluable tool in recruitment and retention by offering health care professionals the opportunity to ease qualified health professions related student loan debts and help Indian health programs meet the staffing needs of high priority professions and sites. 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 $4,000 per year to offset tax liability. Loan repayment recipients with more than $40,000 in loan debt can extend their initial two year contract on an annual basis and receive up to an additional $20,000 per year, plus up to $4,000 for taxes, until their original loan debt is paid.

In 2008, the IHS reviewed service obligations owed and the years of service provided by the loan repayment recipients. The results of the study showed that the LRP recipient service obligation period average was 2.65 years. The average retention period for loan repayment recipients was 7.44 years. LRP recipients, on average, served 4.79 years beyond their service obligation.

In FY 2010, the IHS LRP made loan repayment awards to the following disciplines:

Awards by Profession	Total Awards	New Awards	Contract Extensions	Matched Not Awarded
Nurses	125	116	9	105
Dental*	110	48	62	4
Pharmacists	97	41	56	52
Physicians	92	29	63	5
PA/APN	52	34	18	30
Behavioral Health	35	24	11	4
Optometrists	31	14	17	2
Podiatrists	12	0	12	0
Rehabilitative Services	15	8	7	3
Other Professions **	30	24	6	27
TOTAL	**599**	**338**	**261**	**232**

***** Includes Dentists and Dental Hygienists

** Other Professions	Total Awards	Matched Not Awarded
X-Ray Technician	9	7
Dietician	6	9
Medical Technician	3	1
Engineer	7	9
Sanitarian	4	1
Respiratory Therapist	0	0
Chiropractor	1	0
TOTAL	**30**	**27**

By Pay System	Awards
Tribal Employees	281
Civil Service	200
Commissioned Corps	115
Urban Health Employees	3
Total	**599**

Grant Programs - The IHP administers three grant programs which provide health professions training funding to colleges and universities: the Indians Into Nursing (Section 112); Indians Into Medicine (Section 114); and Indians Into Psychology (Section 217).

FUNDING HISTORY

Fiscal Year	Amount
2007	$31,375,000
2008	$36,291,000
2009 Recovery Act	$0
2009 Omnibus	$37,500,000
2010 Enacted	$40,743,000
2011 Continuing Resolution	$40,743,000

BUDGET REQUEST

The FY 2012 budget request for Indian Health Professions of $42,016,000 is an increase of $1,273,000 over the FY 2010 Enacted level of $40,743,000.

Current Services +$1,273,000

Federal Pay Costs +$4,000 to cover federal Commissioned Officer pay costs. Federal and tribal pay costs are subject to the pay freeze enacted by Congress.

Inflation +$1,269,000 to fund inflationary costs.

Current services are necessary cost increases to sustain valuable programs. The increase will be utilized to partially offset the 7.7 percent increase in tuition costs sustained by the programs. The table below specifies the expected outcomes of the budget request by section.

Section	Title	FY 2010	FY 2012 Request	FY 2012 +/- FY 2010	Expected Outcome
103	Health Professions Preparatory and Pre-Graduate Scholarships	$3,905,096	$3,183,444	-$721,652	25 continuing and 42 new student agreements
104	Health Professions Scholarship	$10,628,886	$12,802,769	+$2,173,883	158 continuing and 76 new student contracts
105	Extern Program	$1,181,932	$1,181,932	$0	135 temporary clinical assignments
108	Loan Repayment Program	$21,338,884	$21,159,653,,	-$179,231	248 contract extensions and 318 new contracts.
112	Quentin N. Burdick American Indians Into Nursing Program	$1,768,497	$1,768,497	$0	5 grants
114	Indians into Medicine (INMED) Program	$1,162,319	$1,162,319	$0	3 grants
217	American Indians Into Psychology Program	$757,386	$757,386	$0	3 grants
	TOTAL	**$40,743,000**	**$42,016,000**	**+$1,273,000**	

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
42: Scholarships: Proportion of Health Professionals Scholarship recipients placed in Indian health settings within 90 days of graduation.	FY 2010: 56% (Target Not Met)	75%	75%	0%
Program Level Funding ($ in millions)	$40.7	$40.7	$42.0	+$1.3
ARRA Level Funding ($ in millions)	$0	$0	$0	$0

The performance goal refers to placement of scholars within 90 days of completion of their health professions degree or training. The IHP works with scholars, discipline chiefs and sites to assist in the placement of available scholarship recipients in Indian health facilities, i.e., hospitals and clinics. The current estimate for time required to hire a healthcare professional into IHS is approximately 140 days from the time the request is placed into the Office of Personnel Management (OPM) Capital HR program to entry on duty. Placement of scholars within 90 days is affected strongly by internal IHS human resource capacity, OPM requirements, and licensure requirements that are beyond the scholarship program's capacity to alter. The FY 2012 target should remain the same as 2010 and be evaluated for its relevance for FY 2013. IHS hiring reforms and improvements in tracking scholarship placements in FY 2011 should contribute to improved performance on this measure.

OUTPUTS

Measure	Most Recent 2010	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Number of Scholarship Awards – Total				
Section 103	30	30	30	0
Section 103P	38	33	37	+4
Section 104	252	285	234	-50
Number of Externs (Section 105)	146	135	135	0
Number of Loan Repayments Awarded – Total (Section 108)b/				
New Awards (2 Year Awards)	338	176	311	+135
Contract Extensions (1 Year Awards)	261	430	249	-181
Continuation Awards (Funded in Previous Fiscal Year)	422	196	277	+31
Number of Grants Awarded – Total (see Below)	10	10	11	+1
Program Level Funding ($ in millions)	**$40.7**	**$40.7**	**$42.0**	**+$1.3**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

a/ Loan repayment figures do not show data from non-IHP funding ($4,981,727 in H&C funding - 97 new two year awards anticipated in FY 2012).

GRANTS AWARDS

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Indians into Nursing (Section 112)			
Number of Awards	5	5	5
Range of Awards	$300,000-$350,000	$300,000-$350,000	$300,000-$350,000
Indians Into Medicine(Section 114)			
Number of Awards	3	3	3
Range of Awards	$170,000-$728,250	$170,000-$728,250	$170,000-$728,250
Indians Into Psychology (Section 217)			
Number of Awards	3	3	3
Range of Awards	$252,462	$252,462	$252,462

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

TRIBAL MANAGEMENT GRANT PROGRAM

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$2,586	$2,586	$2,762	+$176
FTE	0	0	0	0

Authorizing Legislation.....25 U.S.C. 450, Self-Determination and Education Assistance Act, as amended 2010

FY 2012 Authorization ..... Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Tribal Management Grant (TMG) Program was created in 1976 under Sections 103(b)(2) and 103(e) of Public Law (P.L.) 93-638, Indian Self-Determination and Education Assistance Act, as amended. It was established to assist Tribes and/or Tribal organizations (T/TO) to assume all or part of existing Indian Health Service (IHS) programs, services, functions and activities (PFSA) and further develop and improve their health program management capability. The TMG Program provides 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 infrastructure systems to manage or organize PSFA.

All federally-recognized Indian Tribes and Tribally-sanctioned Tribal organizations are eligible to apply for a TMG. The TMG Program has established three funding priorities. The first priority is for any Tribe that has received Federal recognition or restoration within the last five years. The TMG Program recognizes that newly recognized or restored Tribes need assistance implementing or developing management and infrastructure systems for their organization. The second funding priority focuses on T/TO that are addressing audit material weaknesses. The TMG Program recognizes the importance of addressing audit weaknesses in order to strengthen infrastructure and provide additional or improved services. The third funding priority includes all other projects and T/TO. Most applicants submit projects under this funding priority to perform feasibility studies, implement planning or evaluation projects, or improve their management capabilities.

The TMG funds are distributed primarily for direct grant awards with approximately 3 percent of the funds used for overall administration of the program. The TMG Programs offers four project types with three different award amounts and project periods:

1. Planning and Evaluation projects are funded up to $50,000 with project periods not to exceed 12 months. The planning project allows T/TO to establish goals and performance measures for current health programs or to design their health program and management system.

An evaluation study determines the effectiveness and efficiency of a program or if new components will assist the T/TO improve its health care delivery system.

2. Feasibility studies are funded 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.
3. 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 programs, functions, services, and activities (PFSA), such as health records systems or billing and accounting systems.
4. TMG administrative funds are used to provide program requirements training, grant writing workshops and general technical assistance. These efforts assist T/TO in developing proposals that fully address the TMG project cycle and are responsive to the program announcement. Past performance has demonstrated that T/TO who participate in TMG training and technical assistance sessions score higher in the objective review than those with no grant training.

FUNDING HISTORY

Fiscal Year	Amount
2007	$2,438,000
2008	$2,490,000
2009 Omnibus	$2,586,000
2010 Enacted	$2,586,000
2011 Continuing Resolution	$2,586,000

BUDGET REQUEST

The FY 2012 budget request for Tribal Management Grants of $2,762,000 is an increase of $176,000 over the FY 2010 Enacted level of $2,586,000.

Current Services +$176,000

Inflation + $176,000 will fund inflationary costs

In FY 2012, the budget will fund multi-year continuation grants and 1-2 additional new grants depending on the type of project awarded.

OUTPUTS TABLES

Measure	FY 2010	FY 2010 Target	FY 2012 Target	FY 2012+/- FY 2010
Feasibility Studies	2	0	1	+1
Planning Grants	1	1	1	0
Evaluation Studies	0	0	1	+1
Health Management Structure*	24	24	24	0
Program Level Funding ($ in millions)	**$2.6**	**$2.6**	**$2.8**	**+$.2**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

* Health Management Structure includes both new and continuation awards

GRANTS AWARDS TABLES

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards [1]	27	26	27
Average Award	$90,074	$95,615	$95,185
Range of Awards	$20,792 - $150,000	$12,819 - $49,843	$50,000 - $100,000

AREA ALLOCATION – Tribal Management

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Headquarters	2,586,000	2,586,000	2,762,000	176,000
Total, TM	**$2,586,000**	**$2,586,000**	**$2,762,000**	**$176,000**

Note: Funds are not allocated on a recurring basis to Areas but awarded on a competitive basis to Tribes and Tribal organizations.

[1] Includes partial awards

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

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$68,720	$68,720	$73,636	+$4,916
FTE	331	336	348	+17

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 2012 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

The Headquarters operations are set forth by statute and administrative requirements by the Department of Health and Human Services (DHHS), the Administration, Congress, and field operations in 12 Area Offices and 163 Service Units. The IHS Headquarters provides general program direction and oversight for IHS Areas and 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 health programs (I/T/U); maintains national statistics and public health surveillance; identifies trends; and projects future needs. The IHS Headquarters actively works with the DHHS to formulate and implement national health care priorities, goals, and objectives for AI/ANs. The IHS Headquarters works with the DHHS to formulate a budget and necessary legislation. In addition, it responds to congressional inquiries and interacts with other governmental entities to enhance and support health care services for AI/ANs.

The 12 Area Offices distribute resources, monitor and evaluate the full range of comprehensive health care and community oriented public health programs, and provide technical support to local Service Units and I/T/U staff. They ensure the delivery of quality health care through the 163 Service Units and participate in the development and demonstration of alternative means and techniques of health services management and delivery programs to promote the optimal provision of health services to Indian people through the Indian health system.

The Direct Operations budget supports the leadership and overall management of the IHS to ensure effective support for the IHS mission. This includes oversight of financial, employee, facilities, information and support resources and systems. Even with approximately half of the IHS budget

managed by Tribes, the IHS continues to function as a large comprehensive, primary care system that benefits from many efficiencies through common administrative systems and consistent business practices. The Direct Operations budget provides critical support in the overall administration of the health programs and services throughout the IHS and its funding is allocated to IHS Headquarters, 12 Area Offices, and Tribal shares.

Leadership and direction is focused on the Agency's four priorities: to renew and strengthen the partnership with Tribes and improve the tribal consultation process; to reform the IHS; to improve the quality and access to care for patients who are served by the IHS; and to be as transparent, accountable, fair, and inclusive as possible in the work performed. One example of the most recent accomplishments related to the Agency priority to renew and strengthen its partnership with tribes is that, through December 31, 2010, the Agency had implemented six recommendations from tribes to improve the tribal consultation process. They were: 1) forming the Director's Tribal Advisory Workgroup on Consultation; 2) developing an electronic mail (e-mail) address to encourage feedback via e-mail in addition to submitting a letter (consultation@ihs.gov); 3) developing a Tribal Consultation website (under the Director's Blog); 4) posting all letters to Tribal Leaders on the Director's Blog and electronically mailing them via list serves; 5) conducting listening sessions in IHS Areas and meeting individually with tribes; and 6) hosting listening sessions and meetings at National conferences (such as the National Congress of American Indians annual convention and the National Indian Health Board consumer conference). The IHS has also begun comprehensive improvements and reforms in management and administration of key Agency functions, including financial management, property management, performance management, and hiring reforms, including improved suitability determinations for new hires and ongoing oversight and improvements in healthcare provider credentialing and facility accreditation.

Direction also includes specific focus on the Secretary's Key Initiatives and the HHS Strategic Plan for Fiscal Years 2010-2015. In addition, the Agency will be guided by the Department's strategic initiatives and the priorities of the Secretary. The Direct Operations budget also supports leadership and oversight for the accomplishment of the performance measures that are included in the IHS FY 2011 Annual Performance Plan. The measures address many of the administrative aspects of providing health care to the AI/AN population and other Departmental goals of achieving equivalent and improved health status for all Americans.

Priorities for performance improvements in Direct Operations include responsiveness to key stakeholders (the Administration, the Congress, and Tribal partners) in a transparent and timely manner in achieving administrative requirements, demonstrating administrative improvements and ongoing accountability to key stakeholders for new permanent authorities of the Indian Health Care Improvement Act, and timely response to congressional requests related to the new reauthorized Act.

FUNDING HISTORY

Fiscal Year	Amount
2007	$63,631,000
2008	$63,624,000
2009 Omnibus	$65,345,000
2010 Enacted	$68,720,000
2011 Continuing Resolution	$68,720,000

BUDGET REQUEST

The FY 2012 budget request for Direct Operations of $73,636,000 is an increase of $4,916,000 over the FY 2010 Enacted level of $68,720,000.

Current Services +$1,512,000

Federal Pay Costs +$174,000 to cover federal Commissioned Officer pay costs. Federal pay costs are subject to the pay freeze enacted by Congress.

Inflation + $1,338,000 will fund inflationary costs.

Program Increase +$3,404,000

Program expansion will fund: (a) continuing investments to improve the IHS' capacity for providing oversight and accountability in key administrative areas such as property, financial, and human resources management; (b) addressing unfunded mandates for national initiatives associated with privacy requirements, facilities, and personnel security; and (c) for improving responsiveness to external authorities such as OMB and Congress, including but not limited to the implementation and continuing accountability for new permanent authorities of the reauthorization of the Indian Health Care Improvement Act. Recent congressional oversight as well as reports issued by the General Accountability Office and the Office of Inspector General demonstrate the importance of making improvements in these areas.

The distribution of Direct Operations funds includes Headquarters operations, 12 Area Offices operations, and Tribal shares as indicated by the table below:

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Headquarters (56.5%)	$38,826,000	$38,826,000	$41,604,340
Title I Contracts (non-add)	*2,062,075*	*2,062,075*	*2,209,589*
Title V Compacts (non-add)	*5,820,999*	*5,810,999*	*6,237,414*
Area Offices (12) (43.5%)	*29,893,200*	29,893,200	32,031,660
Title I Contracts (non-add)	*875,253*	*875,253*	*937,866*
Title V Compacts (non-add)	*8,896,612*	*8,896,612*	*9,533,046*
BA	**$68,720,000**	**$68,720,000**	**$73,636,000**

AREA ALLOCATION – Direct Operations

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Aberdeen	$2,565,707	$2,565,707	$2,749,249	$183,542
Alaska	4,948,824	4,948,824	5,302,846	354,022
Albuquerque	1,370,762	1,370,762	1,468,822	98,060
Bemidji	1,470,519	1,470,519	1,575,715	105,196
Billings	2,349,873	2,349,873	2,517,975	168,102
California	1,552,092	1,552,092	1,663,123	111,031
Nashville	1,788,947	1,788,947	1,916,922	127,975
Navajo	3,222,435	3,222,435	3,452,957	230,522
Oklahoma	3,756,706	3,756,706	4,025,448	268,742
Phoenix	3,212,022	3,212,022	3,441,799	229,777

AREA ALLOCATION – Direct Operations

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Portland	2,707,310	2,707,310	2,900,982	193,672
Tucson	714,790	714,790	765,924	51,134
Headquarters	39,060,013	39,060,013	41,854,236	2,794,223
Total, DIR OPS	**$68,720,000**	**$68,720,000**	**$73,636,000**	**+$4,916,000**

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

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$6,066	$6,066	$6,329	+$263
FTE	12	12	12	0

Authorizing Legislation..... Title V of the Indian Self-Determination and Education Assistance Act, as amended 25. U.S.C. 458aaa, 42 C.F.R. Part 137

FY 2012 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

In FY 1992, the IHS was instructed by Congress to initiate planning activities with Tribal governments with approved Department of Interior self-governance compacts for the development of a Self-Governance Demonstration Project (SGDP) as authorized by P.L. 100-472, the Indian Self-Determination Act Amendments of 1988. The Indian Health Care Amendments of 1992, P.L. 102-573, extended authority to fund the Tribal SGDP in IHS and established the Office of Tribal Self-Governance (OTSG). Through enactment of P.L. 106-260, the Tribal Self-Government Amendments of 2000, permanent authority for the Tribal Self-Governance Program was given to the IHS under Title V, Tribal Self-Governance, 25 U.S.C. §§ 458aaa-458aaa18. The Final Rule implementing Title V was promulgated on May 17, 2002, 42 C.F.R. § 137.

The OTSG is responsible for a wide range of agency functions that are critical to the IHS' relationship with American Indian and Alaska Native nations, Tribal organizations and other American Indian/Alaska Native groups. The budget supports OTSG activities to comply with the President's Memorandum for the Heads of Executive Departments and Agencies of November 5, 2009, on Tribal consultation; renews and strengthens our partnership with Tribes; in the context of national health reform, brings reform to IHS; improves the quality of and access to care for American Indian and Alaska Native individuals; and is accountable, transparent, fair, and inclusive.

Since 1993, the 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]. As of January 2011, the IHS negotiated a total of 78 self-governance compacts and 100 funding agreements with Indian Tribal governments and Tribal organizations. In FY 2011, the Tribes involved in Self-Governance represent 59 percent of the 565 federally-recognized Indian Tribes in the United States or 37 percent of the total Indian health system user population. In FY 2012,

[1] The Self-Governance budget line only accounts for Title V ISDEAA compacts and funding agreements.

approximately $1.5 billion, or one-third, of the total IHS budget appropriation, will be transferred to Tribes to support 108 ISDEAA Title V compacts and 129 funding agreements[2].

The Self-Governance budget supports activities, including but not limited to, nation-to-nation negotiations of Self-Governance compacts and funding agreements; oversight of the IHS Director's Agency Lead Negotiators (ALN); technical assistance on Tribal consultation activities; analysis of Indian Health Care Improvement Act new authorities; and, funding to support the activities of the IHS Director's Tribal Self-Governance Advisory Committee (TSGAC).

The Self-Governance budget strengthens and renews partnerships with Tribes 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 applications for Self-Governance Planning and Negotiation Cooperative Agreements;
- Provides resource and technical assistance to Tribes and Tribal organizations for the implementation of Tribal Self-Governance;
- Provides Tribal Self-Governance Trainings to Tribes, Tribal organizations and Tribal groups;
- Arranges national Tribal Self-Governance meetings, including an annual conference in partnership with the Department of the Interior, to promote the participation by all American Indian and Alaska Native Tribes in IHS Tribal Self-Governance activities and program direction;

[2] Tribes who exercise Self-Governance authority under Title V of the ISDEAA must meet statutory requirements, including (a) successfully completes the planning phase; (b) has requested participation in self-governance by resolution or other official action by the governing body of each Indian tribe to be served; and (c) has demonstrated, for 3 fiscal years, financial stability and financial management capability (25 U.S.C. 458aaa–2; 42 C.F.R. Part 137, Subpart C).

For FY 2011, the IHS estimated an additional 19 Tribes entering into Title V ISDEAA compacts and Funding Agreements. This estimate meets the statutory limits for participation (25 U.S.C. 458aaa–2, 42 C.F.R. § 137.15). The projected budget estimates were based on the FY 2010 IHS Contract Support Costs Shortfall Report and other IHS methodologies to estimate a budget need. In addition, the IHS provides Negotiation Cooperative Agreements where the criteria for funding mirror the statutory requirements. Approximately, 8 negotiation cooperative agreements are available each fiscal year. For this pool, an average estimate of $5 million per Tribe is used to project estimates for Tribes entering into a Title V ISDEAA compact and Funding Agreement.

For FY 2012, the IHS estimates an additional 12 Tribes entering into Title V ISDEAA compacts and Funding Agreements. Projection for FY 12: 108 compacts and 129 funding agreements. Although some of these tribes may not currently meet all statutory criteria, these tribes continue to express interest in SG by applying for a self-governance planning or negotiation cooperative agreements; attending the annual self-governance conference; requesting self-governance training from the OTSG and the IHS Area/HQ staff; or participating in SG in the Department of Interior.

- Develops, publishes, and presents information related to the IHS Tribal Self-Governance activities to Tribes, Tribal organizations, state and local governmental agencies and other interested parties;
- Coordinates Self-Governance Tribal Delegation Meetings for HHS, IHS Headquarters and Area Senior officials.

The Self-Governance budget supports health innovation and reform activities with Tribes:

- Oversees the negotiations of Tribal Self-Governance compacts and funding agreements with participating Tribes;
- Negotiates new authorities available to Tribes under the Indian Health Care Improvement Act;
- Provides support of projects that improve tribally-operated health programs GPRA reporting and facility accreditation.

The Self-Governance budget improves quality of and access to care:

- Provides support of projects that assist Tribally-operated health programs to enhance information technology infrastructure to prepare for Meaningful Use and other federal Agency reporting standards;
- Provides support for negotiation for Title V construction project agreements to assist Tribes to expand and to modernize health care facilities;
- Collaborates in crosscutting issues and processes including, but not limited to budget formulation; resolution of audit findings; Self-Determination issues; Tribal shares methodologies; and emergency preparedness, response and security.

The Self-Governance budget makes all work transparent, fair and inclusive:

- Maintains, troubleshoots, and updates a Title V database containing amendments and payments to tribes that provides 24/7 access to IHS staff and Tribes. This database also meets all Federal Funding Accountability and Transparency Act requirements and reports all Title V compact and funding agreement amounts to the HHS Tracking Accountability in Government Grants System;
- Coordinates and reports Agency Tribal Consultation activities with Tribes, HHS, and other federal agencies in accordance with law, executive orders and policy;
- Publishes and disseminates Self-Governance information nationally to Tribes and Tribal organizations

FUNDING HISTORY

Fiscal Year	Amount
2007	$5,763,000
2008	$5,836,000
2009 Omnibus	$6,004,000
2010 Enacted	$6,066,000
2011 Continuing Resolution	$6,066,000

BUDGET REQUEST

The FY 2012 budget request for Self-Governance of $6,329,000 is an increase of $263,000 over the FY 2010 Enacted level of $6,066,000.

Current Services +$263,000

Inflation + $263,000 will fund inflationary costs.

Current services are necessary costs to sustain valuable programs and maintain improvements made in Tribally-operated Health Programs performance measures in recent years. Additionally, this funding will support further implementation of the IHS Tribal Self-Governance Program to federally recognized Indian Tribes and Tribal organizations under Title V of the ISDEAA; increase funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to enter into the IHS Tribal Self-Governance Program; continue to fund performance projects; and, fund Tribal shares needs in IHS Areas and Headquarters for any Indian Tribe(s) that have decided to participate in self-governance.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
TOHP-1: Percentage of TOHP clinical user population included in GPRA data.	FY 2010: 74% (Target Not Met but Improved)	78%	74%	-4.0%
TOHP-E: Tribally Operated Health Programs: Hospital admissions per 100,000 diabetics per year for long-term complications of diabetes.	FY 2009: 92.8 (Target Exceeded)	135.7	N/A	N/A
TOHP-SP: Implement recommendations from Tribes annually to improve the Tribal consultation process.	N/A	N/A	Implement at least 3 recommendations annually	N/A
Program Level Funding ($ in millions)	**$6.0**	**$6.0**	**$6.3**	**+$0.3**

OUTPUTS

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Increase Program Training Projects	6	6	6	0
Develop Tribal Health Information Technology Infrastructure Sites/Projects	7 (Target Not Met)	10	10	0
Develop & support IHS Chronic Care initiatives at Tribal site: Screening Projects	1 (Target Not Met)	3	3	0
Third Party Infrastructure Demonstration Project with a Tribe.	New Output Measure	1	1	1
Program Level Funding ($ in millions)	**$6.0**	**$6.0**	**$6.3**	**+$0.3**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

AREA ALLOCATION – Self Governance

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Headquarters	6,066,000	6,066,000	6,329,000	263,000
Total, SELF-GOV	**$6,066,000**	**$6,066,000**	**$6,329,000**	**$263,000**

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CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$398,490	$398,490	$461,837	+$63,347
FTE	0	0	0	+7

Authorizing Legislation25 U.S.C. §§ 450 et seq., Indian Self-Determination and Education Assistance Act; P.L. 93-638, as amended 2010

FY 2012 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The 1975 Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, gave Indian Tribes the authority to contract with the Federal government to operation programs serving their Tribal members and other eligible persons and to receive not less than the amount of program funding that the Secretary would have otherwise provided for the direct operation of the program. The Act was further amended; the 1988 amendments identified Contract Support Costs (CSC) and provided that CSC be added to the program amount. CSC are defined as reasonable costs for activities that Tribes and Tribal organizations must carry out but that the Secretary either did not carry out in her direct operation or the program or provided from resources other than those under contract.

Elements of CSC include:

- Pre-award costs (e.g., consultant and proposal planning services)
- Start-up costs (e.g., purchase of administrative computer hardware and software)
- Direct CSC (e.g., unemployment taxes on direct program salaries)
- Indirect CSC (e.g., pooled costs)

All Federally recognized Tribes and Tribal organizations are eligible to contract or compact health programs through Title I and Title V of the ISDEAA. In FY 2011, approximately $2.3 billion of the IHS appropriations will be under Tribal Health Administration. Many Tribes have identified CSC as a top budget priority.

The IHS CSC policy was established in 1992 to govern the administration and allocation of CSC, and was developed through extensive consultation and participation of Tribes. The IHS continuously reviews the soundness of its CSC allocation policies to assure that CSC provided to Tribes is reasonable and does not duplicate other funding provided by IHS' self-determination agreements with Tribes. The most recent CSC Policy revision in 2007 was established as a permanent Chapter within the IHS Manual (Part 6, Chapter 3, TN-2007-05). Allocations for new and expanded CSC are made at the average level

of CSC funding paid to all existing P.L. 93-638 awards. The IHS Policy conforms to applicable OMB Circular A-87 and A-122 cost principles. Tribes receive special technical assistance for calculating CSC, and each Tribal request that is submitted for CSC is reviewed for consistency and to ensure it does not duplicate other funding. This ongoing review of CSC allocation policies and technical assistance addresses IHS Priority 3: To improve the Quality of and Access to Care. Further, the IHS has issued additional guidance concerning any new or expanded contracts or compacts entered into since FY 2007 (in response to the March 2005 Supreme Court decision in *Cherokee Nation v. Leavitt*[1]). This guidance requires that Tribes and the IHS reach agreement concerning both the unavailability of Indian Self-Determination (ISD)/CSC funding for new and expanded contracts and compacts and the obligation of the IHS to fund CSC pursuant to the appropriations "Cap" on CSC. If there is not agreement on the part of the Tribe, then the new or expanded program request will likely be declined (in whole or in part), consistent with the *Southern Ute Indian Tribe v. Leavitt*[2]. These principles need to be adhered to in instances where CSC funding may not be available in order for the IHS to enter into new contracts or compacts under the Indian Self-Determination and Education Assistance Act. If the Tribe and the IHS could not reach agreement, the proposal to contract for the new and expanded programs, services, functions, and activities (PFSA), or a portion of the proposal, would be declined.

The FY 2010 CSC funding increase of $116,092,000 was allocated using the final 2010 CSC Shortfall Report to address CSC shortfall associated with ongoing contracts and compacts. The 2010 funding increased the percent of CSC "level of need funded" (LNF) from 67.48 percent to approximately 78.49 percent. The LNF represents that portion of the total Tribal CSC requirements that the IHS is able to pay in any given fiscal year. The goal is to increase the percentage of LNF.

In FY 2011 Congressional Justification, the IHS Tribal CSC workgroup proposed to provide an update to the 1999 GAO report on CSC need, resources, and deficiencies within the coming year. At this time the Agency does not have sufficient resources to provide the proposed update.

FUNDING HISTORY

Fiscal Year	Amount
2007	$269,730,000
2008	$267,398,000
2009 Omnibus	$282,398,000
2010 Enacted	$398,490,000
2011 Continuing Resolution	$398,490,000

[1] In *Cherokee Nation of Oklahoma et. Al. v. Leavitt, Secretary of Health and Human Services, et. Al.*, the Supreme Court ruled that the IHS had received an unrestricted appropriation sufficient to provide plaintiff Tribes full funding of the contract support cost funding promised in their ISDEAA contracts with the Federal Government in fiscal years 1995, 1996, and 1997.

[2] In Southern Ute Indian Tribe v. Leavitt, the District Court for the District of New Mexico ruled that, If IHS awards a contract when no CSC funding is available from the capped appropriation for CSC, the annual funding agreement requires the parties to identify the terms of payment and $0 is properly identified as the amount for CSC.

BUDGET REQUEST
The FY 2012 budget request for Contract Support Costs of $461,837,000 is an increase of $63,347,000 over the FY 2010 Enacted level of $398,490,000.

Current Services +$13,347,000

Inflation +$13,347,000 will fund inflationary costs.

Program Increase +$50,000,000

Contract Support Costs: +$50,000,000 will be applied against projected CSC shortfalls of $171 million (FY 2012) associated with ongoing 329 contracts and compacts. After applying the FY 2012 funding allocation for CSC, the IHS projects that the FY 2012 CSC shortfall will be approximately $153 million. The projected CSC Level of Need Funded after applying the increase will be 75 percent, a 3.49 percent decrease from FY2010 funding.

Unfunded CSC associated with program increases and new staffing continues to be the greatest factor contributing to increased CSC shortfalls in recent years. The CSC need associated with program increases included in the FY 2012 budget and the CSC need associated with new or expanded programs assumed by Tribes and Tribal Organizations in FY 2012 is projected to be approximately $34 million. Therefore, the projected CSC LNF is not expected to change much between FY 2011 and 2012.

The budget represents the amount of CSC funding that will be allocated among the contracting/compacting Tribes. Although the budget request represents an increase in CSC funding, the LNF may not increase. The LNF decreases when the overall CSC need rises more quickly than the funding for CSC. IHS addresses the difference between CSC funding and CSC need in the shortfall report, which is required by Congress to inform them of the difference between the funding amounts and the actual CSC needs of tribes. 25 U.S.C. §450j-l(c).

Current Services include funding to support non-medical inflationary costs associated with the annual increased cost of providing health care under ISDEAA contracts and compacts in FY 2012. The program increase will be applied against existing CSC shortfalls associated with ongoing 329 contracts and compacts. The proposed increase will make significant progress in addressing the CSC needs of Tribally operated programs to improve quality of care for AI/ANs. The IHS projects that 280 of the total 329 Tribes and Tribal Organizations with P.L. 93-638 contracts and compacts will have CSC shortfalls at the end of FY 2011. The total CSC shortfall associated with those 280 contracts and compacts is projected to be approximately $120.6 million at the end of FY 2011.

The IHS Manual, Part 6, “Services to Tribal Governments and Tribal Organizations,” Chapter 3, “Contract Support Costs,” Section 6-3.3C, specifies how the CSC funds will be distributed. Fifty percent of the FY 2012 increase for CSC will be allocated to those Tribes with the greatest unfunded CSC level of need in such a way as to raise the minimum CSC level of need funded to the highest possible level – a bottom up approach. The remaining 50 percent of the FY 2012 CSC increase will then be allocated to all Tribes who have a CSC shortfall, in proportion to their overall share of the CSC.

OUTPUTS

Measure	Most Recent FY 2010	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
The total direct program contracted or compacted by Tribes[3].	$1,778.9	$1,747.9	$2,364.9	+$617
Program Level Funding ($ in millions)	**$398.5**	**$398.5**	**$461.8**	**+$63.3**

AREA ALLOCATION (Proposed) – CSC

Discretionary SERVICES	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2011
Aberdeen	$14,130,342	$14,130,342	$16,376,609	$2,246,267
Alaska	127,384,044	127,384,044	147,633,980	20,249,936
Albuquerque	12,043,441	12,043,441	13,957,958	1,914,517
Bemidji	24,056,526	24,056,526	27,880,734	3,824,208
Billings	10,002,706	10,002,706	11,592,812	1,590,106
California	37,277,108	37,277,108	43,202,960	5,925,852
Nashville	17,251,984	17,251,984	19,994,491	2,742,507
Navajo	34,562,131	34,562,131	40,056,390	5,494,259
Oklahoma	62,937,628	62,937,628	72,942,672	10,005,044
Phoenix	16,543,866	16,543,866	19,173,805	2,629,939
Portland	40,215,522	40,215,522	46,608,487	6,392,965
Tucson	2,084,702	2,084,702	2,416,102	331,400
Headquarters	0	0	0	0
Total, CSC	**$398,490,000**	**$398,490,000**	**$461,837,000**	**+$63,347,000**

[3] The total number of Tribes/Tribal Organizations contracting or compacting is 329.

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PUBLIC AND PRIVATE COLLECTIONS

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Medicare:	$133,114,000	$130,804,000	$130,804,000	-$2,310,000
Federal	6,986,000	6,986,000	6,986,000	0
Tribal [1]	52,648,000	57,244,000	57,244,000	+ 4,596,000
Tribal [2]	192,748,000	195,034,000	195,034,000	+ 2,286,000
Subtotal:				
Medicaid:	487,263,000	485,275,000	485,275,000	-1,988,000
Federal	22,217,000	22,217,000	22,217,000	0
Tribal [1]	107,759,000	124,203,000	124,203,000	+16,444,000
Tribal [2]	617,239,000	631,695,000	631,695,000	+14,456,000
Subtotal:				
Medicare/Medicaid Total:	809,987,000	826,729,000	826,729,000	+16,742,000
Private Insurance	81,006,000	81,006,000	81,006,000	+0
TOTAL:	**$890,993,000**	**$907,735,000**	**$907,735,000**	**+$16,742,000**
FTE	6,471	6,471	6,471	0

[1] Represents CMS Tribal collection estimates.

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

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Public and private collections are a significant part of the IHS and Tribal budgets, and provide increased access to quality health care services for American Indian and Alaska Natives (AI/AN). Third party revenue represents up to 50 percent of operating budgets at many facilities. IHS has had legislative authority to bill Medicare and Medicaid (M&M) since 1976. The collection of third party revenue is essential to maintaining facility accreditation and standards of health care through the Joint Commission on Accreditation of Healthcare Organizations, the Accreditation Association for Ambulatory Health Care. The funds are also used to maintain the certification required by the Centers for Medicare and Medicaid Services (CMS) for participation in the Medicare and Medicaid programs.

Medicare/Medicaid (M&M) -- The FY 2011 and FY 2012 estimates are based primarily on the FY 2010 actual collections and the estimated full year FY 2011 impact of the CY 2010 Medicare and Medicaid rate changes.

The CY 2010 rate increase is expected to increase FY 2011 Medicare collections by $2,286,000 and Medicaid collections by $14,456,000. In addition, estimates reflect increased Tribal assumptions of major health care programs that will impact federal collections. IHS will continue to place a high priority on finalizing CY 2011 rates and the development of FY 2010 Medicare cost reports to set future rates.

During FY 2011 and FY 2012, IHS will continue to place a priority on development of a third party interface with the new Unified Financial Management System. The IHS will continue to strengthen business office policies and management practices, including internal controls, patient benefits coordination, provider documentation training, certified procedural coding training and electronic claims processing. Priority efforts include the continued development of modifications to third party billing and accounts receivable software to improve effectiveness and to ensure system integration with its business processes and compliance with M&M regulations. These improvements will be coordinated with concurrent improvements in Contract Health Services business practices related to alternative resources.

IHS will continue to work with the CMS and the State Medicaid agencies to improve each program's capability to identify patients who are eligible to enroll in M&M and CHIP programs and in the implementation of provisions in ARRA, CHIPRA and the IHCIA. IHS works with the 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 accelerate the enrollment of Medicaid eligible AI/AN patients.

The IHS places the highest priority on meeting all accreditation standards for its healthcare facilities. The use of the M&M reimbursements will continue to be used to support and maintain facility accreditation and improve the delivery and access to health care for AI/AN people.

Private Insurance Collection -- The FY 2011 and FY 2012 private insurance budget estimates assume the continuation of the FY 2010 level. During FY 2011 and FY 2012, IHS will continue to work to enhance each health facility's capability to identify patients who have private insurance coverage, improve claims processing, including a more robust program to monitor and follow up on outstanding bills. This initiative will maintain current collections efforts notwithstanding various reports that the downturn in the economy has affected private insurance coverage for AI/ANs.

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

Outpatient Prospective Payment System If Funds are not made available in FY 2011 IHS will not be able to continue activities aimed at conducting a feasibility study which incorporates a proposed project plan component. If funds are made available in FY 2012 IHS will continue the feasibility study. The focus of the study will include, but not be limited to, an evaluation of the RPMS clinical system billing linkages, evaluation of the capacity of the IHS Practice Management Software (PMS), and identification of software changes and/or projected costs to purchase and implement new PMS software IHS-wide. Other key areas to be evaluated include:1) business process changes in Clinical departments, Medical records and business office staffing impacts, 2) Medicare outpatient revenue impacts and cost benefits, 3) necessary clinical and business office staff training, 4) system maintenance and development required by new systems, and 5) equipment and related infrastructure facility requirements.

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

Type of Obligation	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Personnel Benefits & Compensation	$400,530,000	$407,139,000	$408,779,000
Travel & Transportation	3,917,000	3,777,000	3,756,000
Non-Patient Transportation	2,864,000	2,762,000	2,746,000
Comm./Util./Rent	8,639,000	8,342,000	8,295,000
Printing & Reproduction	193,000	185,000	185,000
Other Contractual Services	158,104,000	152,458,000	151,572,000
Supplies	90,938,000	87,590,000	87,114,000
Equipment	10,140,000	9,754,000	9,701,000
Land & Structures	13,676,000	13,223,000	13,140,000
Grants	12,331,000	11,807,000	11,749,000
Insurance / Indemnities	51,000	48,000	48,000
Interest/Dividends	0,000	0,000	0,000
Subtotal	$701,383,000	$697,085,000	$697,085,000
Tribal Collections (est)	$189,610,000	$210,650,000	$210,650,000
Total Collections	**$890,993,000**	**$907,735,000**	**$907,735,000**

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SPECIAL DIABETES PROGRAM FOR INDIANS

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$150,000	$150,000	$150,000	$0
FTE	0	0	0	0

Authorizing Legislation.....111 Stat. 574, 1997 Balanced Budget Act
(P.L. 105-33), Consolidated Appropriation Act 2001 and amendment to Section 330C (c)(2)(c) Public Health Service Act through Senate Bill 2499 (passed the Senate 12/18/07) to extend funding through FY 2009, the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) Title III Special Diabetes Program for Indians to extend funding through FY 2011, and the H.R. 4994 Medicare and Medicaid Extenders Act of 2010 to extend SDPI funding through FY 2013.

FY 2012 Authorization.....Program authorized thru FY 2013

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

In 1997, Congress established the Special Diabetes Program for Indians (SDPI) to curb the diabetes epidemic and its impact on American Indians and Alaska Natives (AI/AN). The SDPI, now in its 13th year, is a $150 million per year grant program that provides funding for diabetes treatment and prevention through 404 Indian Health Service (IHS), Tribal and Urban Indian health grant programs. The IHS Office of Clinical and Preventive Services, Division of Diabetes Treatment and Prevention (DDTP) provides leadership, programmatic, administrative and technical oversight to the SDPI grant program.

AI/AN communities suffer disproportionately high rates of type 2 diabetes and resultant complications. Once exclusively a disease of adults, type 2 diabetes is increasingly common among AI/AN youth, threatening the future of AI/AN communities. The DDTP promotes collaborative evidence-based and community-driven diabetes treatment and prevention strategies to over 1.9 million AI/ANs through an extensive diabetes network consisting of a national program office, Area Diabetes consultants in 12 IHS Areas, 19 Model Diabetes Programs in 23 different IHS and Tribal sites, and the 404 SDPI grant programs. The diabetes network supports the SDPI grant programs by providing comprehensive diabetes surveillance, research translation, promotion of quality assurance and improvement activities, technical support, resource and “best practices” information and develops and distributes AI/AN specific education materials and training.

As directed by Congress, the SDPI currently consists of three major components: 1) Community-Directed diabetes grant programs, 2) Diabetes and Cardiovascular Disease Prevention Initiatives (formerly the Demonstration Projects), and 3) Diabetes Data and program delivery infrastructure. Since 1998, the Community-Directed grants have designed and carried out diabetes prevention and treatment interventions tailored to the unique problems and challenges of diabetes in their individual communities. In FY 2004 the IHS, in response to Congressional direction, developed and implemented a competitive

Demonstration Project that focused on: a) primary prevention of type 2 diabetes in those adults at risk for developing diabetes, and b) reduction of cardiovascular risk in AI/AN adults diagnosed with type 2 diabetes. Sixty-six Demonstration Project grants were awarded to IHS, Tribes and Urban Indian Health Programs for 5 years to translate findings from scientific studies on diabetes and cardiovascular disease prevention into the "real world settings" of AI/AN communities and their health care systems. Results from these Demonstration Projects are impressive, both at the programmatic and individual client levels. The final analysis and subsequent major reports of findings will be available in the 2011 SDPI Report to Congress. As a result of a new competitive grant application process in 2010, there are currently 68 Diabetes Prevention and Healthy Heart Initiatives sites that will continue to implement these prevention activities and that will begin the work of disseminating the lessons learned and resources developed during the demonstration project period. SDPI funds also support the IHS Diabetes Data infrastructure through the development and implementation of the IHS Electronic Health Record and the IHS Diabetes Management System (a software program that is part of the RPMS system) in all 12 IHS Areas and as a result, the Indian health system has been better able to identify and track AI/ANs with diabetes and improve clinical care and services. These improvements more accurately reflect the accomplishments of the program, improve program stewardship and accountability, and facilitate program management. Technical assistance, provider networks, clinical monitoring and grant evaluation activities at the Headquarters and Area office levels have also been strengthened.

The entities eligible to receive the SDPI grants include IHS programs, Tribes and Tribal organizations, and Urban Indian Health organizations. The IHS distributed this funding to the SDPI grant programs according to legislative intent through a process that included formal tribal consultation, development of a formula for distribution of the funds to eligible entities and a formal grant process. All SDPI grant programs applied for FY 2010 funding utilizing a competitive grant application process.

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. The 19 IHS Diabetes Best Practice Models, updated to include enhanced accountability measures and strengthened outcome measures, where applicable, have been used by SDPI applicants to identify strengths in diabetes resources and services in their communities, find gaps in diabetes services or programs, establish program priorities, locate best practice models that could be applied within their own communities, and to begin a work plan to develop their own local best practice models. The Tribal Leaders Diabetes Committee (TLDC) established in 1998, continues to meet several times each year at the direction of the IHS Director to review information on the SDPI progress and provide recommendations on diabetes-related issues pertinent to AI/ANs. The IHS has also developed and built upon collaborations and partnerships with federal and private organizations. The IHS DDTP has mobilized an extensive network to undertake one of the most strategic and concerted diabetes treatment and prevention efforts to date and have demonstrated the ability to design, manage and measure a complex, long-term project to address this chronic condition.

Significant challenges do remain such as: significant numbers of vacancies for professional health care positions in rural areas, adequate space to set-up programs and conduct program activities, access to clinical services in rural areas, and additional needs for training and technical assistance.

FUNDING HISTORY

Fiscal Year	Amount
2007	$150,000,000
2008	$150,000,000

2009 Omnibus	$150,000,000
2010	$150,000,000
2011 Continuing Resolution	$150,000,000

BUDGET REQUEST

The FY 2012 budget for Special Diabetes Program for Indians is $150,000,000, consistent with the level in the recent extension through 2013. While the exact distribution of funding in FY 2012 is to be determined pending tribal consultation, the distribution of funding has remained the same since 2004 after tribal consultation and is illustrated below:

SPECIAL DIABETES PROGRAM FOR INDIANS – TOTAL YEARLY COSTS 2004-2011

CATEGORY	Percentage of the total	(Dollars in Millions)
Original Diabetes Grants – now called Community-directed Diabetes Programs (302 Tribal and IHS grants in FY 2010) (including sub-grants = 329)	69.9%	$104.8
Administration of Community-directed SDPI grants (Includes administrative funds to IHS Areas, Tribal Leaders Diabetes Committee, Div of Diabetes, Grants Operations, evaluation support contracts, etc.)	2.7%	4.1
Urban Indian Health Program community-directed diabetes programs (34 grants) ($7.4M allocated to 34 grants; remaining amount redistributed within existing grants)	5 %	7.5
Demonstration Projects – now called Diabetes Prevention & Healthy Heart Initiatives since 2010 (68 grants)	15.5%	23.2
Administration of Demonstration Project Diabetes Grants (Includes administrative funds 1) to support the demonstration project coordinating center; 2) to support the limited dissemination activities; 3) to HQ; 4) to support contracts, etc.)	2.8%	4.1
Funds to strengthen the Data Infrastructure of IHS	3.4%	5.2
Native Diabetes Wellness Center (CDC)	0.7%	1.0
TOTAL:	**100%**	**$150.0**

The following tables show the accomplishments in terms of outputs and outcomes as well as the estimated change in performance. While several targets were not met, most measures showed improvement in FY 2010. Modifications to program activities, including increased accountability and evaluation, will be implemented in FY 2011-2013 and will contribute to improved performance on outcome measures in subsequent years.

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Diabetes: A1c Measured[1]: Proportion of patients who have had an A1c test. IHS-All	FY 2010: 82%	N/A	N/A	N/A
Tribally Operated Health Programs	FY 2010: 82%	N/A	N/A	N/A
1: **Diabetes: Poor Glycemic Control**: Proportion of patients with diagnosed diabetes that have poor glycemic control (A1C > 9.5). IHS-All[2,3]	FY 2010: 20/18% (Target Not Met)	16.0%	18.9%	+2.9%
1: Tribally Operated Health Programs	FY 2010: 15% (Target Not Met)	13.0%	15.8%	+2.8%
2: **Diabetes: Ideal Glycemic Control**: Proportion of patients with diagnosed diabetes	FY 2010: 36/32% (Target Not Met but	33.0%	31.0%	-2.0%

with ideal glycemic control (A1c <7.0) IHS-All[3]	Improved)			
2: Tribally Operated Health Programs	FY 2010: 35% (Target Not Met but Improved)	36.0%	33.9%	-2.1%
3: **Diabetes: Blood Pressure Control**: Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<130/80). IHS-All[3]	FY 2010: 39/38% (Target Not Met but Improved)	40.0%	36.8%	-3.2%
3: Tribally Operated Health Programs	FY 2010: 37% (Target Not Met but Improved)	39.0%	35.9%	-3.1%
4: **Diabetes: Dyslipidemia Assessment:** Proportion of patients with diagnosed diabetes assessed for Dyslipidemia (LDL cholesterol). IHS-All[3]	FY 2010: 76/67% (Target Not Met but Improved)	69.0%	64.9%	-4.1%
4: Tribally Operated Health Programs	FY 2010: 67% (Target Not Met but Improved)	68.0%	64.9%	-3.1%
Program Level Funding ($ in millions)	**$150.0**	**$150.0**	**$150.0**	**$0**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

[1]There is no measure or goal; this information is provided for context.
[2]ForPoor Glycemic Control, a reduction in the rate represents improvement.
[3]First figure in results column is Diabetes audit data for which data is not currently available; second is from the Clinical Reporting System.

OUTPUTS

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Proportion of SDPI yearly grantee assessments completed[1]	94%	90	92	+2
Proportion of SDPI grantees using at least one of the 19 Diabetes Best Practices[2]	82%	100	100	0
Proportion of patients with diagnosed diabetes assessed for DM education# provided [3](yearly audit).	62%	61	64	+3
Program Level Funding ($ in millions)	**$150.0**	**$150.0**	**$150.0**	**$0**
ARRA Level Funding ($ in millions)	**$0**	**$0**	**$0**	**$0**

[1] Newly developed target for FY 2010. Target should show steady progress until 100 percent is reached.
[2] This is a new measure for 2008. Baseline will be established. This assessment will evaluate use of its current 19 formal IHS Diabetes Best Practices. Other programs choose to implement different Diabetes Best Practices. IHS intends to add these additional Best Practices to its formal list of Diabetes Best Practices over time.
[3] Many new programs participated in the audit assessment in 2006 so the expected target was lowered in 2006.

GRANTS

SDPI Community-Directed Grant Programs by State and FY 2010 Annual Funding Amounts in Notices of Award

State	State Name	Total Number of SDPI Grant Programs	Financial Assistance Award FY 2010
AK	Alaska	25	$8,999,946
AL	Alabama	1	199,088
AZ	Arizona	30	26,355,244
CA	California	40	8,319,826
CO	Colorado	3	728,212

SDPI Community-Directed Grant Programs by State and FY 2010 Annual Funding Amounts in Notices of Award			
State	**State Name**	**Total Number of SDPI Grant Programs**	**Financial Assistance Award FY 2010**
CT	Connecticut	3	308,315
FL	Florida	2	482,822
IA	Iowa	1	254,197
ID	Idaho	4	760,150
IL	Illinois	1	226,282
KS	Kansas	7	695,810
LA	Louisiana	4	311,243
ME	Maine	5	437,505
MA	Massachusetts	1	$317,358
MI	Michigan	13	2,128,707
MN	Minnesota	13	3,345,382
MS	Mississippi	1	1,014,657
MT	Montana	16	5,512,348
NC	North Carolina	1	1,192,543
ND	North Dakota	7	2,643,997
NE	Nebraska	5	1,590,573
NM	New Mexico	31	6,938,491
NV	Nevada	19	3,260,719
NY	New York	4	1,199,897
OK	Oklahoma	33	17,592,178
OR	Oregon	14	1,799,861
RI	Rhode Island	1	96,912
SC	South Carolina	1	134,905
SD	South Dakota	14	5,439,117
TN	Tennessee	2	79,915
TX	Texas	4	588,651
UT	Utah	6	1,449,293
WA	Washington	35	4,019,223
WI	Wisconsin	13	3,200,243
WY	Wyoming	3	747,878
	TOTAL	**363 (includes IHS, Tribal & Urban grants and sub-grantees)**	**$112,191,488**

SDPI Grant DP and HH Initiative Grants by State and FY 2010 Annual Funding in Notices of Award			
	State	**Total Number of SDPI DP and HH Initiatives**	**Total FY 2010 Financial Assistance Award**
AK	Alaska	5	$1,694,200
AZ	Arizona	6	2,163,900
CA	California	11	3,388,500
ID	Idaho	1	324,300
KS	Kansas	1	397,000

SDPI Grant DP and HH Initiative Grants by State and FY 2010 Annual Funding in Notices of Award			
	State	**Total Number of SDPI DP and HH Initiatives**	**Total FY 2010 Financial Assistance Award**
MI	Michigan	2	648,600
MN	Minnesota	4	1,297,200
MS	Mississippi	1	397,000
MT	Montana	2	648,600
NC	North Carolina	1	324,300
NE	Nebraska	2	648,600
NM	New Mexico	5	1,766,900
NY	New York	1	324,300
OK	Oklahoma	8	2,957,900
OR	Oregon	2	794,000
SD	South Dakota	8	2,667,100
UT	Utah	1	397,000
WA	Washington	5	1,694,200
WI	Wisconsin	2	648,600
	Total	**68**	**$23,182,200**

SDPI Funding Amounts Overall by Area and Urban and SDPI Program				
Area Name	**Community-Directed**	**DP Initiative**	**HH Initiative**	
Aberdeen	$9,432,052	$2,018,500	$1,297,200	
Alaska	$8,999,946	$1,369,900	$324,300	
Albuquerque	$7,319,223	$397,000	$1,369,900	
Bemidji	$7,834,950	$1,621,500	$972,900	
Billings	$5,231,685	$324,300	$324,300	
California	$6,350,378	$2,018,600	$1,369,900	
Nashville	$5,461,968	$397,000	$648,600	
Navajo	$14,056,955	$721,300	$324,300	
Oklahoma	$18,112,325	$1,912,300	$1,442,600	
Phoenix	$13,674,138	$397,000	$1,118,300	
Portland	$5,783,584	$1,766,900	$1,045,600	
Tucson	$2,539,246	$0	$0	
Urban	$7,395,038			**Grand Total**
Total	**$112,191,488**	**$12,944,300**	**$10,237,900**	**$135,373,688**

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

FACILITIES

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$394,757	$394,757	$457,669	+$62,912
M&I	*$53,915*	*$53,915*	*$57,078*	*+$3,163*
Sanitation	*$95,857*	*$95,857*	*$79,710*	*-$16,147*
HCFC	*$29,234*	*$29,234*	*$85,184*	*+$55,950*
FEHS	*$193,087*	*$193,087*	*$210,992*	*+$17,905*
Equipment	*$22,664*	*$22,664*	*$24,705*	*+$2,041*
Quarters	*$6,288*	*$6,288*	*$7,500*	*+$1,212*
FTE	1,218	1,236	1,246	+28

SUMMARY OF THE BUDGET REQUEST

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

BUDGET AUTHORITY

The FY 2012 budget request is $457,669,000, an increase of $62,912,000 over the FY 2010 Enacted level of $394,757,000. This increase represents:

Maintenance & Improvement +$3,163,000 – The condition of facilities is measured through an IHS database, the Backlog of Essential Maintenance, Alterations, and Repair (BEMAR). 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 care through larger M&I projects to reduce the BEMAR, currently reported at over $472 Million;
- Ensuring that health care facilities meet building codes and standards;
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., sustainability, energy conservation, seismic, environmental, handicapped accessibility, and security.

Sanitation Facilities Construction -$16,147,000 – Provides for essential water supply, sewage disposal, and solid waste disposal facilities:

- Projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the BIA-Home Improvement Program (HIP), Tribes, individual homeowners, or other nonprofit organizations;

- Projects to serve existing housing.
- Special projects (studies, training, or other needs related to sanitation facilities construction), and emergency projects.

Health Care Facilities Construction +$55,950,000 – The request will fund the following:

- Barrow Hospital, Barrow, Alaska, which will be completed;
- Kayenta Health Center, Kayenta, Arizona, to continue construction;
- San Carlos Health Center, San Carlos, Arizona, to continue construction;
- Southern California YRTC design and site grading; and
- Assess the feasibility of acquiring facilities through modular construction.

Facilities and Environmental Health Support +$17,905,000 – Provides for:

- Personnel who provide facilities and environmental health services throughout the Indian Health Service and operating costs associated with provision of those services and activities.

Equipment +$2,041,000 – Provides for:

- Routine replacement medical equipment to over 1,600 Federally and Tribally-operated health care facilities allocated on workload using a standard formula;
- New medical equipment in tribally-constructed health care facilities;
- TRANSAM, a program under which IHS acquires and distributes surplus Department of Defense medical equipment and ambulance programs.

COLLECTIONS

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

Quarters +$1,212,000 – Collected to be used for:

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

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

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$53,915	$53,915	$57,078	+$3,163
FTE	0	0	0	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

FY 2012 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Maintenance and Improvement (M&I) funds are the primary source of funding to maintain, repair, and improve existing IHS facilities and Tribal health care facilities which are used to deliver and support healthcare services. M&I funding goes to federal, government-owned buildings and Tribally-owned space where healthcare 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 necessary to deliver health care in direct support of the IHS' mission and goal.

Maintaining reliable and efficient buildings is increasingly challenging as existing facilities age and additional space is added into the real property inventory. The Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) is a measure of the condition of facilities and establishes priorities for larger M&I projects. Adequate M&I funding is essential to correct the deficiencies and keep the BEMAR to an acceptable level.

The physical condition of IHS-owned and many Tribally-owned facilities is evaluated through annual general surveys conducted by local facility personnel and IHS Area Office engineers. In addition, comprehensive facility condition surveys are conducted every five years by a team of engineers and architects or other specialists. These surveys, together with routine observations by facilities personnel, identify deficiencies that are included in the BEMAR database. The current BEMAR for all IHS and reporting Tribal facilities as of October 1, 2010 is $472,921,000.

M&I Funds Allocation Method

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

- **Routine Maintenance Funds** - These funds support activities that are generally classified as those needed for maintenance and minor repair to upkeep the facility in its current condition. Funding allocation is formula based. The Building Research Board of the National Academy of Sciences (NAS) (*Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings, 1990*) has determined that approximately two to four percent of current replacement value of supported buildings is required to maintain (i.e., 'sustain') facilities in their current condition.
- **M&I Project Funds –** These funds are used for major projects to reduce the BEMAR and make improvements necessary to support healthcare delivery. Funding allocation is formula based.
- **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 facilities on a national basis.
- **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 the Indian Health Service.

FUNDING HISTORY

Fiscal Year	Amount
2007	$54,688,000
2008	$52,889,000
2009 Recovery Act	$100,000,000
2009 Omnibus	$53,915,000
2010 Enacted	$53,915,000
2011 Continuing Resolution	$53,915,000

BUDGET REQUEST

The FY 2012 budget request for Maintenance and Improvement of $57,078,000 is an increase of $3,163,000 over the FY 2010 Enacted level of $53,915,000.

Current Services +$3,163,000

Inflation +$1,632,000 will fund inflationary costs.

Population Growth +$1,531,000 will fund costs related to anticipated population growth.

Current services increases are necessary costs to sustain the program by adjusting for inflation and population growth. Funding for Maintenance and Improvement is mainly being used for routine maintenance and for addressing mandated requirements, including environmental compliance and demolition of excess property, and any remaining funds are available to fund the major repair projects

and renovations necessary to ensure that aged facilities are in a condition to provide effective and efficient health services.

This level of funding will allow the IHS to maintain the condition of the IHS real property portfolio at approximately the existing level.

The requested funding for M&I provide:

- Approximately $53.2 million to sustain the condition of Federal and tribal health care facilities buildings.
- Approximately $0.4 million will be allocated to the IHS Area Offices and Tribes for projects to reduce the BEMAR deficiencies that will improve healthcare facilities' Condition Index (CI) and for improvements that support the IHS mission in meeting changing healthcare delivery needs.
- $3 million will be allocated for environmental compliance projects and $500,000 for demolition projects.

OUTCOMES and OUTPUTS -- Program has no outputs or outcomes.

GRANTS AWARDS -- The program has no grants awards.

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

SANITATION FACILITIES CONSTRUCTION

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$95,857	$95,857	$79,710	-$16,147
FTE	192	177	177	-15

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

FY 2012 Authorization.....Permanent

Allocation Method ..... Needs-based priority system for construction project allocation to
P.L. 86-121Memorandum of Agreements, P.L. 93-638 Self-Determination Contracts and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Sanitation Facilities Construction (SFC) is an integral component of the IHS disease prevention activities. The Indian Health Service (IHS) has carried out the program since 1959 using funds appropriated for SFC to provide potable water and waste disposal facilities for AI/AN people. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other environmentally-related diseases have been dramatically reduced by about 80 percent since 1973. IHS physicians and health professionals credit many of these health status improvements to IHS's provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations. It is important to note that 12 percent or over 46,000 American Indian and Alaska Native homes are without access to safe water or adequate wastewater disposal facilities and are still at an extremely high risk for gastrointestinal disease and respiratory disease at rates similar to third world countries. 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 in the home as part of a comprehensive public health program.

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

SFC projects can be managed by the IHS directly (Direct Service) or they can be managed 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 are to be served by the facilities. Projects start with a Tribal Project Proposal and are funded and

implemented through execution of an agreement between the Tribe and IHS. In these agreements the Tribes also agree to assume ownership responsibilities, including operation and maintenance. The overall SFC goals, eligibility criteria, and project funding priorities remain the same, regardless of the delivery methods chosen by a Tribe. More than 70 percent of all SFC is performed by Indian tribes/firms.

The Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L.94-437) directs the IHS to identify the universe of sanitation facilities needs for existing Indian homes by documenting deficiencies and then proposing projects to address those needs. Types of projects range from those providing new and existing homes their first services such as water wells and onsite wastewater systems or by connections to community water and wastewater facilities. The universe of need also includes projects to upgrade existing water supply and waste disposal facilities and projects to improve sanitation facilities operation and maintenance capabilities in Indian country. As of November, 2010, the list of all documented projects to correct documented sanitation project deficiencies totaled almost $3.0 billion with those projects considered economically and technically feasible totaling almost $1.45 billion. Typically, projects with exceptionally high capital costs are considered economically infeasible if their cost per home exceeds an established allowable unit cost per home for a particular geographical area. Technical feasibility relates to operability and sustainability of the proposed system. As of the end of FY 2010, there were about 230,000 or approximately 60 percent of AI/AN homes in need of sanitation facilities, including 9 percent or nearly 34,000 AI/AN homes without potable water. Maximum health benefits will be realized by addressing existing sanitation needs identified in the backlog and by providing sanitation facilities for new homes when they are constructed.

In 2010 the IHS provided service to 18,639 AI/AN homes. Projects that provide sanitation facilities to homes are selected for funding in priority order each year from the Sanitation Deficiency System (SDS) inventory of all needs in Indian Country. The SDS is an inventory of the sanitation deficiencies of American Indian and Alaska Native communities; those sanitation deficiencies include needed water, sewer, and solid waste facilities for existing American Indian and Alaska Native homes. Project selection is driven by objective evaluation criteria that include health impact, existing deficiency level, adequacy of previous service, capital cost, local tribal priority, operations and maintenance capacity of 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. In most years, the SFC program has exceeded all national performance measures, IHS, Departmental and program assessment performance measures.

An efficiency measure based on the average project duration is used in evaluating SFC expertise in advancing project discipline. The goal for Sanitation Facilities Construction projects completed during Calendar 2011 and the years thereafter is that the average project duration from the execution of the Project Memorandum of Agreement (MOA) to the Construction Completion date as tracked by the Sanitation Facilities Project Data System shall be 4 years or less. Project duration is the average length of time to complete project construction from the time the project is funded and is a measure of actual performance since the project schedule is under a project manager's control. This time length had been slowly increasing from 2.5 years in 1993 to over 4 years at the end of 2007. Several factors have contributed to this growth in project duration including increased administrative requirements, more involved environmental reviews, increased complexity of designs and decreases in staff resources. Reductions in the length of time a project takes to complete will yield cost savings in both construction inflation costs and project related staffing costs. In 2007, the average length of time to complete a

project increased to 4.1 years but with the implementation of a robust project management program the time to complete projects has been reduced to 3.7 years. This decrease has been a true program success in that it occurred at a time when construction budgets increased by 80 percent due to the American Recovery and Reinvestment act.

FUNDING HISTORY

Fiscal Year	Amount
2007	$94,253,000
2008	$94,253,000
2009 Recovery Act	$68,000,000
2009 Omnibus	$95,857,000
2010 Enacted	$95,857,000
2011 Continuing Resolution	$95,857,000

BUDGET REQUEST

The FY 2012 budget request for Sanitation Facilities Construction of $79,710,000 is a decrease of $16,147,000 over the FY 2010 Enacted level of $95,857,000.

Current Services +$3,472,000

Inflation +$764,000 will fund inflationary costs.

Population Growth +$2,708,000 will fund costs related to anticipated population growth.

Program Decrease -$19,619,000

Current services increases are necessary costs to sustain the program by adjusting for inflation and population growth. These funds ensure that planned sanitation facilities are constructed as proposed and scheduled.

The budget request for Sanitation Facilities Construction supports essential sanitation facilities including water supply, sewage, and solid waste disposal facilities to American Indian/Alaska Native (AI/AN) homes and communities. The SFC Program is a preventive health program that yields positive benefits in excess of the program costs.

This level of funding will be allocated as follows, with projects budgeted to include full costs for pre-planning, design, construction costs, and associated overhead:

1. Up to $48,000,000 of the total FY 2012 SFC appropriation will be reserved to serve new and like-new homes. Some of these funds may also be used for sanitation facilities for the individual homes of the disabled or sick with a physician referral indicating an immediate medical need for adequate sanitation facilities in their home. As needed, amounts to serve new and like-new homes will be established by Headquarters after reviewing Area requests. Priority will be given to projects intended to provide sanitation facilities for the first time to homes in categories B, C, and D (new homes and homes receiving major renovation bringing the homes up to like new condition) under the BIA Housing Improvement Program (HIP). (NOTE: Homes in BIA/HIP Category A are considered existing homes. Category A homes needing service will be included in the SDS.)

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

2. Up to $48,000,000 of the SFC appropriation in FY 2012 will be distributed to the Areas for prioritized projects to serve existing homes, based on a formula that considers, among other factors, the cost of facilities to serve existing homes that: (a) have not received sanitation facilities for the first time; or (b) are served by substandard sanitation facilities (water and/or sewer). Another distribution formula element is a weight factor that favors Areas with larger numbers of American Indian and Alaska Native (AI/AN) homes without water supply or sewer facilities, or without both.
3. Up to $5,000,000 will be used for projects to clean up and replace open dumps on Indian lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994.
4. Up to $2,000,000 will be reserved at IHS Headquarters. Of this amount, $1,000,000 will be used for special projects and for distribution to all Areas as needed to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situations that require immediate attention to minimize potential threats to public health. Emergency and special funds remaining at the end of the fiscal year may be distributed to the Areas to address the Sanitation Deficiency System (SDS) priority list of needs. The remaining $1,000,000 is for funding special projects to do several things. Up to $500,000 will be used in 3 Areas a year to collect homeowner data and other demographic information to strengthen verification mechanisms within the SFC Community Deficiency Profiles (CDP) in SDS in an effort to increase transparency, accuracy, and accountability of the CDP data. This data initiative began in 2010 and will be funded over 4 years to collect this data in all 12 IHS Areas. An amount up to $500,000 will be used for improving data collection systems, providing technical assistance and training for users, as well as for covering the costs of a national automated computer aided drafting contract and to fund an Alaska Native and American Indian Water Resource Center. The Water Resource Center will develop teaching materials and techniques for homeowners and communities to improve usage and support in a way that promotes health. The need is for a five-year funding stream at $250,000 annually, in partnership with the Alaska Native Tribal Health Consortium to develop a teaching system that can be used IHS wide.

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

OUTCOMES

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
(35) SFC-1: Sanitation Improvement: Number of new or like-new and existing AI/AN homes provided with sanitation facilities.	FY 2010: 18,639 (Target not met)	21,811	15,500	-6,311
(35A) SFC-2: Percent of existing homes served by the program at Deficiency Level 4 or above as defined by 25 USC 1632.	FY 2009: 38.6% (Target Exceeded)	37%	Discontinued	N/A
SFC-E: Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. *(Efficiency)*	FY 2009: 3.7 years (Target Exceeded)	4.0 years	4.0 years	0

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
SFC-3: Percentage of AI/AN homes with sanitation facilities[1]	FY 2009: 91%	90%	90%	N/A
Program Level Funding ($ in millions)	**FY2009: $95.9**	**$95.9**	**$79.7**	**-$16.2**

Outputs - program has no outputs.

Grants Awards - program has no grant awards.

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

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$29,234	$29,234	$85,184	+$55,950
FTE	0	0	0	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

FY 2012 Authorization.....Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS Health Care Facilities Construction (HCFC) funds provide optimum availability of functional, modern IHS and tribally operated health care facilities and, where no suitable housing alternative is available, staff housing. The IHS is authorized to construct health care facilities and staff quarters; renovate/construct substance abuse regional treatment centers for youth; support tribal construction of facilities under the Joint Venture Construction Program; provide construction funding for Tribal small ambulatory care facilities projects; and provide funding to replace or provide new and replacement dental units.

The construction and modernization of IHS infrastructure through the health care facilities construction program is essential to ensure the IHS commitment to the Health and Human Service Strategic goal to transform health care. The health care facilities constructed by the IHS ensure access to quality, culturally competent care for one of the poorest and most vulnerable populations in the United States, American Indians and Alaska Natives. The focus of the IHS health service programs provided in these facilities is on prevention and the delivery of comprehensive primary care in a community setting. The comprehensive nature and effectiveness of the services provided in these facilities, as well as the emphasis on prevention, combine to reduce the overall cost of health care services delivery.

Health care facilities construction is funded based on a national list of priorities for construction projects. During FY 1990, in consultation with the Tribes, the IHS revised its Health Facilities Construction Priority System (HFCPS) methodology. The HFCPS ranks proposals using factors reflecting the total amount of space needed; age and condition of the existing facility, if any; degree of isolation of the population to be served in the proposed facility; and availability of alternate health care resources. The health facilities projects remaining on the HFCPS, including those partially funded, total approximately $2.5 billion.

The Joint Venture Construction Program (JVCP) allows IHS to enter into agreements with tribes that construct their own health facilities. The JVCP is strongly supported by tribes based upon

the 55 positive responses to the FY 2009 congressionally directed solicitation for the JVCP FY 2010-FY 2012 cycle. In the Conference Report 111-316, the Conferees were 'concerned about the persistent backlog of IHS health facilities construction projects serving AI/ANs. The Conferees believe that the joint venture program provides a cost-effective means to address this backlog'. Between FY 2001 and FY 2009, 11 joint venture project agreements signed by IHS and Tribes were initiated and eight have been completed. The IHS will complete the FY 2010-FY 2012 cycle in accordance with the following statement from Congress that encouraged 'the Service to move forward with the process in an expeditious manner'. The FY 2012 applicants will be notified in the next few months to initiate planning for these selected JV health facilities construction projects funded by Tribes. Through this competitive process, applicants can and do fund equipment for the projects. Upon completion by the respective Tribe, IHS will request Congressional appropriations for staffing and operations.

FUNDING HISTORY

Fiscal Year	Amount
2007	$25,664,000
2008	$36,584,000
2009 Recovery Act	$227,000,000
2009 Omnibus	$40,000,000
2010 Enacted	$29,234,000
2011 Continuing Resolution	$29,234,000

BUDGET REQUEST

The FY 2012 budget request for Health Care Facilities Construction of $85,184,000 is an increase of $55,950,000 over the FY 2010 Enacted level of $29,234,000.

Current Services +$992,000

Inflation +992,000 will fund inflationary costs

Program Increase +$54,958,000

The FY2012 request will be allocated for the following purposes:

Barrow Hospital, Barrow, AK: $62,184,000 *COMPLETE CONSTRUCTION*

The replacement hospital will provide space to support a modem and adequately staffed health care delivery program, which will improve access to quality, culturally competent care for American Indians and Alaska Natives who are among the most vulnerable populations in the United States. This facility is needed to maintain and promote the health status and overall quality of life for the residents of the Barrow Service Area. The IHS health care services for this region are currently provided in the Samuel Simmonds Memorial Hospital, which is operated by the Arctic Slope Native Association, Ltd., under a Public Law (P.L.) 93-638 compact, with support services being provided by the Ukpeagvik Inupiat Corporation, under a P.L. 93-638 contract. The IHS also contracts with the North Slope Borough to provide community based services. The health care programs and services provided at this facility include inpatient acute care nursing and labor and delivery (8 beds); endoscopy and outpatient surgery; ambulatory care; emergency and urgent care; ancillary for diagnostic imaging and laboratory; dental; optometry; audiology; physical therapy; community health, including public health nursing, nutrition; health education, alcoholism, and community health representative program; environmental health; and mental health and social services. The proposed 9,326 gross square meters (GSM) replacement hospital

will serve a projected user population of 6,142, generating approximately 27,000 primary care provider visits and 40,000 outpatient visits annually. The IHS planned facility includes only IHS supported health care programs.

Kayenta Health Center, Kayenta, AZ: $10,000,000 *COMPLETE CLOSE-IN*

The proposed new Kayenta replacement health center will provide space to support a modern and adequately staffed health care delivery program that will improve access to quality, culturally competent care for American Indians and Alaska Natives who are among the most vulnerable populations in the United States. This facility will ensure availability to the medical services needed to maintain and promote the health status and overall quality of life for the residents of the service area. The health care programs and services provided at this facility include a level III emergency and urgent care unit with the support of the Tribal emergency medical services (EMS); a 10-bed short stay nursing unit that provides sub-acute care; a three-bed low-risk birthing center, which will allow this health center to function as an IHS alternative rural hospital. Additionally, this health center will have comprehensive ambulatory care, ancillary services, preventive community health services, behavioral health services, service unit administration, and facility support services. The proposed 16,638 gross square meters (GSM) new health center has been planned for a projected user population of 19,253, generating approximately 54,000 primary care provider visits and 107,000 outpatient visits annually. The existing facility will be disposed of in accordance with established regulations and procedures after the replacement health center is operational.

San Carlos Health Center, San Carlos, AZ: $10,000,000 *COMPLETE CLOSE-IN*

The existing hospital at San Carlos will be replaced with a modern 16,721 gross square meters (GSM) health center that will have alternative rural hospital capabilities. The replacement facility will be a modern, technologically advanced facility with the required staff to provide improved access to quality, culturally competent care for American Indians and Alaska Natives who are among the most vulnerable populations in the United States. This facility will provide an expanded level of health care services specifically designed to meet the health care needs of the San Carlos Service Unit's projected user population of 12,985, generating approximately 50,000 primary care provider visits and 128,000 outpatient visits annually (projections to 2015 based on actual FY 2008 population figures). The health care programs and services provided include eight low risk nursing care beds and two birthing beds for a total of 10 beds. New services provided by the facility will be a two-bed low risk birthing unit, physical therapy, telemedicine, podiatry, Ultra-sound, ambulatory procedures, CT, and mammography. The project will also include the construction of 43 new staff housing units.

S. California YRTC, Hemet, CA: $2,000,000 *INITIATE DESIGN/SITE GRADING*

The YRTC in southern California will provide services for American Indian/Alaskan Native youth, ages 12 to 17 who have a substance abuse disorder as primary diagnosis. Approximately 8,000 AI/AN youth, per year in California require residential substance abuse treatment. The 3,950 square meter facility will concurrently provide care for maximum of 32 youth. The facility’s program plan, procedures, and staffing will be developed to comply with California’s requirements “Community Treatment Facilities.”

Based upon the “Significant Items For Inclusion In The FY2008 Congressional Justification,” pages CJ64-66, the Senate Report 109-275, indicated ‘The Committee expects the Service to move forward with these two acquisitions (northern and southern California youth regional treatment centers) as it was

directed to do in the joint explanatory statement of the committee of conference accompanying House Report 108-792.' IHS provided the following confirming response 'IHS will advance the purchase as expeditiously as possible once the sites are selected.' The receipt of the $2,000,000 requested for the southern California YRTC will authorize the IHS to proceed with design and grading on the selected site.

A summary of funding appropriated/requested through FY 2012 for the priority construction projects listed above is shown in the following table:

Priority Project Funding Status
(Dollars in Thousands)

FACILITY	Prior to FY 11	FY 11 CR	FY 12 Est.	Total Cost (Feb 2010)	
Barrow, AK, Hosp	$68,858	$12,416	$62,184	$160,276	**
Kayenta, AZ HC	$25,318	*	$10,000	$150,000	
San Carlos, AZ	$29,604	*	$10,000	$116,000	
S. California YRTC	$1,300	-	$2,000	$20,300	

*Final distribution pending outcome of FY 2011 appropriation.

**Cost, which is an increase to actual Feb 2010 estimate, is based upon partial funding in FY 2011 that is less than the President's Request

Assess Feasibility of Modular Construction: $1,000,000 COMPLETE FEASIBILITY REPORT

This request includes $1,000,000 to address the Indian Health Care Improvement Act requirement to assess the feasibility of acquiring facilities through modular construction.

OUTCOMES

Measure	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
36 Health Care Facility Construction: Number of health care facilities construction projects completed.	FY 2010: 1[1] (Target Met)	1[2]	1[3]	0
HCFC-E **Health Care Facilities Construction:** Percent of health care facilities construction projects completed on time.	FY 2010: 100% (Target Met)	100%	100%	0
Program Level Funding ($ in millions)	**FY 2010 $29.2**	**$29.2**	**$85.9**	**+$55.9**
ARRA Level Funding ($ in millions)	**$88.5**	**$0**	**$0**	**$0**

[1] Ft. Belknap Quarters
[2]Wagner Quarters
[3]Eagle Butte

Measure	Most Recent Result[1] All FY 2010	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
HCFC-1: Diabetes: Ideal Glycemic Control: Proportion of patients with diagnosed diabetes with ideal glycemic control.	N/A	N/A	Discontinue	N/A
	47/45 (Target Met)	47	Discontinue	N/A
	31/256	28	Discontinue	N/A

Measure	Most Recent Result[1] All FY 2010	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
	(Target Exceeded)			
	42/42 (Target Exceeded)	38	Discontinue	N/A
	24/67 (Target Not Met)	26	Discontinue	N/A
	32/48 (Target Not Met but Improved)	33	Discontinue	N/A
	N/A	Exempt	Discontinue	N/A
	30/45 (Target Met)	30	Discontinue	N/A
	38/27 (Target Exceeded\)	30	Discontinue	N/A
HCFC-2: Pap Smear Rates: Proportion of eligible women who have had a Pap screen within the previous three years.	N/A	N/A	Discontinue	N/A
	46/23 (Target Exceeded)	39	Discontinue	N/A
	47/267 (Target Met)	47	Discontinue	N/A
	58/7 (Target Not Met)	64	Discontinue	N/A
	57/22 (Target Not Met)	62	Discontinue	N/A
	73/19 (Target Not Met)	81	Discontinue	N/A
	N/A	Exempt	Discontinue	N/A
	49/14 (Target Not Met)	54	Discontinue	N/A
	60/14 (Target Exceeded)	53	Discontinue	N/A
HCFC-3: Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years.	N/A	N/A	Discontinue	N/A
	68/41 (Target Exceeded)	37	Discontinue	N/A
	33/288 (Target Not Met)	37	Discontinue	N/A
	70/28 (Target Not Met)	72	Discontinue	N/A
	40/47 (Target Not Met)	43	Discontinue	N/A
	58/34 (Target Not Met)	76	Discontinue	N/A
	N/A	Exempt	Discontinue	N/A
	49/27 (Target Not Met)	53	Discontinue	N/A
	47/41 (Target Not Met)	54	Discontinue	N/A
HCFC-4: Alcohol Screening (FAS Prevention): Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients.	N/A	N/A	Discontinue	N/A
	73/3 (Target Exceeded)	69	Discontinue	N/A
	66/231	71	Discontinue	N/A

Measure	Most Recent Result[1] All FY 2010	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
	(Target Not Met)			
	66/6 (Target Not Met)	76	Discontinue	N/A
	68/17 (Target Exceeded)	57	Discontinue	N/A
	80/12 (Target Not Met but Improved)	82	Discontinue	N/A
	N/A	Exempt	Discontinue	N/A
	64/14 (Target Exceeded)	63	Discontinue	N/A
	71/5 (Target Exceeded)	69	Discontinue	N/A
HCFC-5: Combined* immunization rates for AI/AN children patients aged 19-35 months[2]: Immunization rates for AI/AN children patients aged 19-35 months.	N/A	N/A	Discontinue	N/A
	85 (Target Not Met)	92	Discontinue	N/A
	81 (Target Not Met)	89	Discontinue	N/A
	92 (Target Not Met)	93	Discontinue	N/A
	78 (Target Exceeded)	72	Discontinue	N/A
	95 (Target Exceeded)	86	Discontinue	N/A
	N/A	Exempt	Discontinue	N/A
	88 (Target Not Met)	96	Discontinue	N/A
	100 (Target Exceeded)	96	Discontinue	N/A
HCFC-6: Influenza vaccination rates among adult patients aged 65 years and older.	N/A	N/A	Discontinue	N/A
	70/34 (Target Exceeded)	69	Discontinue	N/A
	53/250 (Target Not Met)	61	Discontinue	N/A
	86/2 (Target Not Met)	98	Discontinue	N/A
	63/34 (Target Not Met)	70	Discontinue	N/A
	87/36 (Target Not Met)	96	Discontinue	N/A
	N/A	Exempt	Discontinue	N/A
	75/28 (Target Exceeded)	66	Discontinue	N/A
	61/36 (Target Exceeded)	53	Discontinue	N/A
HCFC-7: Pneumococcal vaccination rates among adult patients aged 65 years and older.	N/A	N/A	Discontinue	N/A
	90/34 (Target Met)	90	Discontinue	N/A
	83/250 (Target Not Met)	89	Discontinue	N/A

Measure	Most Recent Result[1] All FY 2010	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
	94/2 (Target Not Met)	99	Discontinue	N/A
	86/34 (Target Not Met)	87	Discontinue	N/A
	95/36 (Target Not Met)	98	Discontinue	N/A
	N/A	Exempt	Discontinue	N/A
	84/28 (Target Not Met)	85	Discontinue	N/A
	90/36 (Target Exceeded)	87	Discontinue	N/A
HCFC-8: Tobacco Cessation Intervention[2,3]: Proportion of tobacco-using patients that receive tobacco cessation intervention.	N/A	N/A	Discontinue	N/A
	47 (Target Exceeded)	40	Discontinue	N/A
	22 (Target Not Met)	29	Discontinue	N/A
	50 (Target Exceeded)	38	Discontinue	N/A
	16 (Target Exceeded)	7	Discontinue	N/A
	44 (Target Exceeded)	29	Discontinue	N/A
	N/A	Exempt	Discontinue	N/A
	45 (Target Not Met)	53	Discontinue	N/A
	46 (Target Exceeded)	38	Discontinue	N/A
HCFC-9: Percent reduction of the YPLL rate within 7 years of opening the new facility. *(Outcome)*	N/A (Fac A) (Jan 2014)	-10% (Facility A) (2014)	N/A	N/A
HCFC-10: Percent increase in the proportion of diagnosed diabetics demonstrating ideal blood sugar control within 7 years of opening the new facility *(Outcome)*	683% (Target Exceeded)	+10%	Discontinue	N/A
HCFC-11: Access to Care**:** Increasing Access to Care at completed, congressionally appropriated, priority Health Care Facilities	N/A	N/A	N/A	N/A

Measures are reported by facility in ascending order (i.e. Facility A, B, C, D, E, F).
[1]First figure in results column is performance measure results; second is relative percent increase in access from baseline.
[2]Rate changes prior to 2006 are not comparable due to CRS logic changes; increase in access rates could not be calculated.
[3]In FY 2005, this measure tracked the proportion of patients ages 5 and above who are screened for tobacco use. Prior to 2004, measure was Support local level initiatives directed at reducing tobacco usage.

OUTPUTS -- Program has no outputs.

GRANTS AWARDS -- Program has no grants awards.

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

(Dollars in Thousands)

	FY 2010 Enacted		FY 2011 CR		FY 2012 Request		FY 2012 +/- FY 2010	
	FTE	Funds	FTE	Funds	FTE	Funds	FTE	Funds
BA	1,026	$193,087	1,059	$193,087	1,069	$210,992	+43	+$17,905
FS	562	*$107,518*	583	*$107,518*	591	*$119,428*	*+29*	*$11,910*
EHS	387	*$69,196*	397	*$69,196*	399	*$74,286*	*+12*	*$5,090*
OEHE	77	*$16,373*	79	*$16,373*	79	*$17,278*	*+2*	*$905*

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 2012 Authorization.....Permanent

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

SUMMARY OF PROGRAMS

Facilities and Environmental Health Support programs provide an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs both directly and indirectly support all of the IHS facilities performance measures and improved access to quality health services. The Facilities Appropriated programs are managed to ensure accountability and transparency at IHS Headquarters and Area Offices by the Office of Environmental Health and Engineering (OEHE). At the Service Unit and field levels, OEHE staff work directly with tribes and individuals to promote and provide access to improvements in public health through surveillance, education, intervention activities, construction of sanitation facilities and health care facilities.

This activity has three sub-activities to align program and functions and is summarized below:

1. Facilities Support (FS) provides funding for staff, 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 facilities projects.
2. Environmental Health Support (EHS) provides funding for management activities and for engineers, environmental health officers, environmental health technicians, engineering aides, injury prevention specialists, and institutional environmental health officers.
3. Office of Environmental Health and Engineering Support (OEHE) provides funding for headquarters management activities and for real property asset management across the IHS facilities and environmental health programs, including technical services and support for capital investments, budget formulation, and long range planning, national policy development and implementation and liaison with the Department of Health and Human Services (HHS), Congress, Tribes, and other Federal agencies.

In addition to staffing costs, funding under this activity includes utilities and certain non-medical supplies and personal property, and biomedical equipment repair.

FUNDING HISTORY

Fiscal Year	Amount
2007	$165,272,000
2008	$169,638,000
2009 Omnibus	$178,329,000
2010 Enacted	$193,087,000
2011 Continuing Resolution	$193,087,000

BUDGET REQUEST

The FY 2012 budget request for Facilities and Environmental Health Support of $210,992,000 is an increase of $17,905,000 over the FY 2010 Enacted level of $193,087,000.

Current Services +$17,905,000

Pay Costs +$835,000 will fund pay increases for Commissioned Officers ($130,000 for FS; $580,000 for EHS; $125,000). Federal and tribal pay costs are under the pay freeze enacted by Congress.

Inflation +$4,515,000 will fund inflationary costs: ($2,522,000 for FS; $1,709,000 for EHS; and $284,000 for OEHE).

Population Growth +$5,523,000 will fund costs related to anticipated population growth: ($2,982,000, for FS; $2,044,000 for EHS and $497,000 for OEHE.)

Staffing/Operating Costs Requirements for New/Expanded Facilities +$7,032,000 will fund increases in workforce necessary to staff six newly constructed facilities: ($6,275,000 for FS and $757,000 for EHS).

Staff for New Facility	Amount	FTE/Tribal Positions	
		Facilities Support	Environmental Health Support
Carl Albert Hospital Replacement (JV), Ada, OK	$678,000	3	
Lake County Tribal Health Center (JV), Lakeport, CA	305,000	2	
Elbowoods Health Center, New Town, ND	1,021,000	3	3
Cheyenne River Health Center, Eagle Butte, SD	3,487,000	24*	3
Absentee Shawnee Health Center (JV), Little Ax, OK	755,000	4	
Cherokee Nation Health Center (JV), Vinita, OK	786,000	5	
Grand Total:	$7,032,000	41	6

* Federal FTE

Current services are necessary costs to sustain valuable programs and maintain improvements made in performance measures in recent years. Facilities and Environmental Health Support Account provides staff and operating funds for HQ, Area, and Service Unit administration and for operational supplies and non-medical equipment. Some utility costs are also paid from this account.

- The Facilities Support provides staff and operating funds for Area Office and Service Unit administration and for operational supplies and non-medical equipment. Some utility costs are also paid from this account.
- Current services are necessary costs to sustain the Sanitation Facilities and Environmental Health Service programs and maintain improvements made in performance measures in recent years. These programs provide direct public health in sanitation, injury prevention, and institutional environmental health. These disease prevention programs reduce the number of times people access direct health care services by providing prevention education programs and sanitation facilities.
- OEHE collects and reports facility data for the IHS to HHS. This information is consolidated at the HHS level for all Operating Divisions of HHS and reported to the Office of Management and Budget. OEHE continues to coordinate the requirements of HHS and the mission of the IHS Targets and measurements are documented in the HHS Real Property Asset Management Plan.

1) FACILITIES SUPPORT

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Facilities Support 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 by (1) renewing and strengthening our partnership with tribes, (2) improving the quality of and access to care, and (3) to make all our work accountable, transparent, fair and inclusive.

The IHS owns approximately 932,000 square meters of facilities (buildings and structures) and 737 hectares of Federal and trust land. The nature of space varies from sophisticated medical centers to residential units and utility plants. Facilities range in age from less than one year to more than 156 years with an average age greater than 31 years. A professional and fully-staffed workforce is essential to ensure effective and efficient operations. Typical staff functions funded may include: (1) 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; (2) specialized clinical engineers and technicians that maintain and service medical equipment; (3) realty staff that manages the real property requirements and quarters; and (4) facilities planning and construction-monitoring components that assist in the planning and construction projects.

In addition, this sub-activity provides funding for related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities-related personal property, and biomedical equipment repair and maintenance. IHS reduced the energy related utility consumption for IHS managed facilities from 2,190,000 British Thermal Units per Square Meter (BTU/SM) in 2003 to 1,929,000 BTU/SM in 2010 which is a 10.2 percent reduction. These efforts help stem the growth in utility costs. During the period FY 2003 through FY 2010, total utility costs have increased 37 percent from $15.5 million to $21.1 million and total utility costs per Gross Square Meters (GSM) increased 49 percent from $25/GSM to $38/GSM. The IHS continues to aggressively investigate options to reduce energy costs.

2) ENVIRONMENTAL HEALTH SUPPORT

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Environmental Health Support Account 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. American Indians and Alaska Natives face hazards in their environment that contribute to their health status, including: communities in remote/isolated locations; severe climatic conditions; limited availability of safe housing; lack of safe water supply; and lack of public health and safety legislation.

There are two programs funded by the Environmental Health Support Account. The **Sanitation Facilities Construction Program** (SFC) staff manages and provides professional engineering services to construct over 400 sanitation projects annually at a total cost of over $190 million. The annual project funding the program manages includes contributions from Tribes, States, and other Federal agencies. These services include management of staff, pre-planning, consultation with Tribes, coordination with other Federal, State, and local governmental entities, identifying supplemental funding outside of IHS, developing local policies and guidelines with Tribal consultation, developing agreements with Tribes and others for each project, providing project design, project construction, assuring environmental and historical preservation procedures are followed, and assisting Tribes where the Tribes provide construction management. Consistent with the 1994 Congressional set aside for "…tribal training on the operation and maintenance of sanitation facilities," $1 million of these support funds are used for technical assistance, training, and guidance to Indian families and communities regarding the operation and maintenance of essential water supply and sewage disposal facilities. In accordance with the Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L. 94-437, the staff annually updates its inventory of sanitation facilities deficiencies for existing Indian occupied homes. 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 (P.L. 103-399). Both of these inventories are widely used by other governmental agencies in their evaluation and funding of sanitation projects.

The **Environmental Health Services Program (EHS)** includes the specialty areas of injury prevention and institutional environmental health. The EHS 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 in tribal communities; identifying environmental hazards in community facilities such as food service establishments, Head Start centers, community water supply systems, and health care facilities; and providing training, technical assistance, and project funding, primarily through competitive cooperative agreements, to develop the capacity of tribal communities to address their environmental health issues. The IHS Injury Prevention Program has been instrumental in reducing the injury mortality rate of AI/AN by 58 percent since it moved from an "education only" focus to a public health approach in the 1970's. Treatment of injuries cost an estimated $350,000,000 per year in direct health care costs to IHS, Tribes, and contract care facilities. The Injury Prevention Program has developed effective strategies and initiatives to reduce the devastating burden of injuries experienced by AI/AN. The **IHS Institutional Environmental Health Program (IEH)** identifies environmental hazards and risk factors in the built environment and proposes control measures to prevent adverse health effects in health care and other community facilities and to support health care accreditation. Maintaining accreditation ensures that IHS continues to have access

to third party funding. The IHS IEH Program developed and maintains an incident reporting system (WebCident) to prepare required Occupational Safety and Health Administration logs, identify and document hazardous conditions, and develop targeted prevention strategies.

Tribal Health Programs: Area, District and Service Unit environmental health personnel work with Tribes/Tribal organizations to encourage maximum participation in planning health services delivery programs. They provide training and technical assistance to the Tribal officials who carry out administrative/management responsibilities associated with operation of federally supported programs.

OUTCOMES TABLE -- Environmental Health Support

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
27: Injury Intervention: Occupant protection restraint use (Outcome)	11 of 12 Areas completed surveys (Target Met)	New surveys based on FY 2009 Intervention	Discontinued	N/A
34: Environmental Surveillance: Identification and control of environmental health risk factors (Outcome)	12 of 12 Areas performed new surveys (Target Exceeded)	11 of 12 Areas will perform new surveys based on FY 2009 Interventions	Discontinued	N/A

OUTPUT TABLE

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 + / -FY 2010
Injury Intervention: Occupant Protection Use	FY2010:11 of 12 Areas completed surveys (Target Met)	New surveys based on FY 2009 Intervention	TBD	N/A
Environmental Surveillance: Identification and control of environmental health risk factors	FY2010; 12 of 12 Areas performed new surveys (Target Exceeded)	11 of 12 Areas will perform new surveys based on FY 2009 Interventions	TBD	N/A

GRANT AWARDS

In 2010, the Injury Prevention Program awarded $2.4 Million in cooperative agreements to 33 Tribal programs to create Tribal Injury Prevention Programs where there were none or to continue those that were previously funded. Seven Tribal programs were awarded $70,000 to implement proven or promising motor vehicle or elder fall injury interventions.

3) OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Office of Environmental Health and Engineering Support activity provides funds for management activities, personnel, contracts, contractors, and operating costs for the Office of Environmental Health and Engineering (OEHE) Headquarters. Personnel have management responsibility for IHS facilities and environmental health programs, provide direct technical services and support to Area personnel, and perform critical management functions. Management activities includes national policy development and implementation, budget formulation, project review and approval, congressional report preparation,

quality assurance (internal control reviews, Federal Managers Financial Integrity Act activities and other oversight), technical assistance (consultation and training), long range planning, meetings (with HHS, Tribes, and other Federal agencies), and recruitment and retention. Typical direct support functions performed by OEHE personnel who serve as project officers for health care facilities construction projects are: reviewing and/or writing technical justification documents, participating in design reviews and site surveys, conducting onsite inspections, and monitoring project funding status, etc. In addition, these positions support new real property asset management requirements as required by Executive Order 13327, Real Property Asset Management; and HHS Program Management objectives. These actions are to ensure management accountability and the efficient and economic use of Federal real property.

In FY 2009, OEHE Support funded personnel and developed and utilized data systems to distribute resources to Area offices for facilities and environmental health activities. Also, technical guidance, information, and training were provided throughout the IHS system in support of the Facilities Appropriation. Some of the activities and accomplishments include approval of Program Justification Documents and Program of Requirements, review and announcement of Joint Venture and Small Ambulatory projects, and awarding contracts for health care facilities construction. OEHE continued to coordinate between a centralized approach to facilities management and infrastructure outside of the IHS to the geographical challenges of the Indian Health System. Health care delivery decisions are made locally and infrastructure needs are community based to ensure the most effective use of resources to improve access to quality health care services.

OUTCOMES -- Program has no outcomes.

OUTPUTS -- Program has no outputs.

GRANT AWARDS -- Program has no grant awards.

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

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
BA	$22,664	$22,664	$24,705	+$2,041
FTE	0	0	0	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

FY 2012 Authorization..... Permanent

Allocation Method ..... Direct Federal
P.L. 93-638 Self Determination contracts and Self-Governance compacts for replacement medical formula-based equipment; equipment funds for tribally-constructed healthcare facilities are competitively allocated; TRANSAM and ambulance purchase programs are federally managed

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Equipment funds are used for maintenance, replacement, and the purchase of new medical equipment at IHS and Tribal health care facilities. It directly supports the Agency's priorities by (1) renewing and strengthening our partnership with tribes and (2) improving the quality of and access to care.

Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment to assure the best possible health outcomes. The IHS and Tribal health programs manage laboratory, x-ray, and biomedical equipment valued at approximately $320 million. With today's medical devices having an average life expectancy of approximately 6 years, medical equipment replacement is a continual process necessary to replace worn out equipment or provide equipment with newer technology that will enhance diagnosis and treatment.

Equipment Funds Allocation Method

The IHS Equipment funds are allocated in three categories: Tribally-constructed health care facilities, TRANSAM and ambulance programs, and replacement equipment:

- **Tribally-Constructed Health Care Facilities –** The IHS provides medical equipment funds to support the initial purchase of equipment for Tribally-constructed health care facilities. $5 million is set aside annually for competitive awards to Tribes and Tribal organizations that construct new or expand health care facilities space using non-IHS funding sources. On average, Tribes spend $50 to $75 million in construction projects using non-IHS funding sources to access these equipment funds. As a result, approximately 200,000 individual patients will be treated with updated medical equipment.

- **TRANSAM and Ambulance Programs –** Equipment funds are also used to acquire new and like-new excess medical equipment from the Department of Defense (DoD) or other sources through the TRANSAM program and to procure ambulances for IHS and Tribal emergency medical services programs. Currently $1 million is set aside annually for the TRANSAM and Ambulance Programs that obtains approximately $4 million in equipment for approximately 100 different tribes.
- **Replacement Equipment –** The balance of equipment funds are allocated to IHS and Tribal health care facilities to purchase new medical equipment, including replacement of existing equipment used in diagnosing and treatment of illnesses. Funding allocation is formula based.

FUNDING HISTORY

Fiscal Year	Amount
2007	$21,619,214
2008	$21,282,000
2009 Recovery Act	$20,000,000
2009 Omnibus	$22,067,000
2010 Enacted	$22,664,000
2011 Continuing Resolution	$23,711,000

BUDGET REQUEST

The FY 2012 budget request for Equipment of $24,705,000 is an increase of $2,041,000 over the FY 2010 Enacted level of $22,664,000.

Current Services +$2,041,000

Inflation + $1,393,000 will fund inflationary costs.

Population Growth + $648,000 will fund costs related to anticipated population growth.

Current services increases are necessary costs to sustain the program by adjusting for inflation and population growth.

The requested funding for Equipment provides:

- Approximately $18.7 million for routine replacement medical equipment to over 1,600 Federally and Tribally-operated health care facilities.
- Approximately $5 million for new medical equipment in Tribally-constructed health care facilities.
- Approximately $1 million for the TRANSAM and ambulance programs.

OUTCOMES - Program has no outcomes.

OUTPUTS - Program has no outputs.

GRANT AWARDS - Program has no grants.

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

PERSONNEL QUARTERS/QUARTERS RETURN FUNDS

(Dollars in Thousands)

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012+/- FY 2010
BA*	$6,288	$6,288	$7,500	+1,212
FTE	27	27	27	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.

Authorizing Legislation .....Public Law 98-473, Sec. 320 as amended

FY 2012 Authorization ..... Permanent

Allocation Method Quarters Return (QR) funds are collected from tenants of quarters that are operated by direct Federal and P.L. 93-638 Self Determination contract and Self-Governance compact programs. These funds are deposited in the Quarters Return Account with the U.S. Treasury. The IHS then allocates these funds to the Area Offices for use at the locality in which they are collected.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Staff quarters' operation, maintenance, and improvement costs are funded with Quarters Return (QR) funds. QR funds are collected from tenants of quarters. These funds will be used for the operation, management, and general maintenance of quarters, including maintenance personnel services, security guard services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (stoves, water heaters, furnaces, etc.). In certain situations, M&I funds may be used, in conjunction with QR funds, to ensure adequate quarters maintenance; e.g., locations with few quarters where QR funds are not enough to pay for all required maintenance costs.

FUNDING HISTORY

Fiscal Year	Amount
2007	$6,288,000
2008	$6,288,000
2009	$6,288,000
2010 Enacted	$6,288,000
2011 Continuing Resolution	$6,288,000

BUDGET REQUEST

The FY 2012 budget estimate for Quarters is $7,500,000, which is an increase of $1,212,000 above the 2010 enacted level. This increase brings the request into alignment with the anticipated funds that will be collected from tenants. Rental rates are established in accordance with OMB Circular A-45.

OUTCOMES/OUTPUTS, GRANTS AWARDS -- Program has no Outcomes, Outputs, Grant awards tables.

FY 2012 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2011 CR	FY 2012 Estimate	FY 12 +/- FY 2011
DIRECT OBLIGATIONS			
Personnel Compensation:			
Full-Time Permanent(11.0).....	402,916	416,468	13,552
Other than Full-Time Permanent(11.3).....	24,817	25,954	1,137
Other Personnel Comp.(11.5).....	53,463	55,267	1,804
Military Personnel Comp (11.7).....	96,795	101,349	4,554
Special Personal Services Payments (11.8).....	219	222	3
Subtotal, Personnel Compensation.....	578,210	599,260	21,050
Civilian Personnel Benefits(12.1).....	132,363	135,687	3,324
Military Personnel Benefits (12.2)	42,579	45,700	3,121
Benefits to Former Personnel(13.0).....	5,787	5,817	30
Subtotal, Pay Costs.....	**758,939**	**786,464**	**27,525**
Travel(21.0).....	43,906	48,746	4,840
Transportation of Things(22.0).....	11,724	13,222	1,498
Rental Payments to GSA(23.1).....	14,539	16,526	1,987
Rental Payments to Others(23.2).....	1,703	1,937	234
Communications, Utilities and Miscellaneous Charges(23.3.....	34,184	39,126	4,942
Printing and Reproduction(24.0).....	598	666	68
Other Contractual Services:			
Advisory and Assistance Services(25.1).....	9,492	10,700	1,208
Other Services(25.2).....	185,099	218,421	33,322
Purchases from Govt. Accts.(25.3).....	67,010	76,283	9,273
Operation and Maintenance of Facilities(25.4)....	8,475	9,478	1,003
Research and Development Contracts(25.5).....	9	9	0
Medical Care(25.6).....	408,310	600,510	192,200
Operation and Maintenance of Equipment(25.7).	6,411	7,376	965
Subsistence and Support of Persons(25.8).....	68,829	67,864	(965)
Subtotal, Other Contractual Current.....	**753,635**	**990,641**	**237,006**
Supplies and Materials(26.0).....	133,561	156,227	22,666
Equipment (31.0).....	19,100	21,075	1,975
Land & Structures (32.0).....	32,129	24,249	(7,880)
Investments & Loans (33.0).....	0	0	0
Grants, Subsidies, & Contributions (41.0).....	2,247,056	2,523,509	276,453
Insurance Claims & Indemnities (42.0).....	1,214	1,331	117
Interest & Dividends (43.0).....	87	89	2
Subtotal Non-Pay Costs.....	**3,293,436**	**3,837,344**	**543,908**
Total, Direct Obligations.....	**4,052,375**	**4,623,808**	**571,433**

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

Object Class	FY 2011 CR	FY 2012 Estimate	Increase or Decrease
Personnel Compensation:			
Full-Time Permanent (11.0)	402,916	416,468	13,552
Other than Full-Time Permanent (11.3)	24,817	25,954	1,137
Other Personnel Comp. (11.5)	53,463	55,267	1,804
Military Personnel Comp. (11.7)	96,795	101,349	4,554
Special Personnel Services Payments (11.8)	219	222	3
Subtotal, Personnel Compensation	578,210	599,260	21,050
Civilian Personnel Benefits (12.1)	132,363	135,687	3,324
Millitary Personnel Benefits (12.2)	42,579	45,700	3,121
Benefits to Former Personnel (13.0)	5,787	5,817	30
Total, Pay Costs	**758,939**	**786,464**	**27,525**
Travel (21.0)	18,073	20,305	2,232
Transportation of Things (22.0)	11,724	13,222	1,498
Rental Payments to Others (23.2)	1,703	16,526	14,823
Communications, Utilities & Misc. Charges (23.3)	34,184	39,126	4,942
Printing and Reproduction (24.0)	598	666	68
Other Contractual Services:			
Advisory and Assistance Services (25.1)	9,492	10,700	1,208
Other Services (25.2)	185,099	218,421	33,322
Purchases from Govt. Accts. (25.3)	67,010	76,283	9,273
Operation and Maintenance of Facilities (25.4)	8,475	9,478	1,003
Operation and Maintenance of Equipment (25.7)	6,411	7,376	965
Subsistance and Support of Persons (25.8)	68,829	67,864	(965)
Subtotal, Other Contractual	345,316	390,122	44,806
Supplies and Materials (26.0)	133,561	156,227	22,666
Total, Non-Pay Costs	**545,159**	**636,194**	**91,035**
Total Salaries & Expenses	1,304,098	1,422,658	118,560
Direct FTE	9,501	9,626	125

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

	FY 2010 Enacted	FY 2011 CR	FY 2012 Estimate
Headquarters			
Sub-Total, Headquarters	456	475	493
Area Offices			
Aberdeen Area Office	1,933	1,952	1,966
Alaska Area Office	592	598	602
Albuquerque Area Office	1,040	1,050	1,057
Bemidji Area Office	491	496	499
Billings Area Office	928	938	944
California Area Office	93	94	94
Nashville Area Office	179	181	182
Navajo Area Office	4,724	4,771	4,804
Oklahoma City Area Office	1,628	1,644	1,655
Phoenix Area Office	2,709	2,736	2,755
Portland Area Office	567	572	576
Tucson Area Office	461	466	469
Sub-Total, Area Offices	15,345	15,497	15,604
Trust Funds (Gift)	23	23	23
TOTAL FTES	15,824	15,995	16,120

Average GS Grade

2008.....	8.2
2009.....	8.2
2010.....	8.2

INDIAN HEALTH SERVICE
DETAIL OF PERMANENT POSITIONS

(Dollars in Thousands)

	2010 Enacted	2011 CR	2012 Estimate
Total - ES's	20	18	18
Total - ES Salaries	$3,548	$3,479	$3,479
GS/GM-15	425	426	426
GS/GM-14	399	382	382
GS/GM-13	405	411	415
GS-12	910	923	932
GS-11	1,278	1,296	1,309
GS-10	555	563	568
GS-9	1,332	1,351	1,364
GS-8	306	310	313
GS-7	1,045	1,060	1,070
GS-6	1,314	1,332	1,345
GS-5	2,192	2,223	2,244
GS-4	1,210	1,227	1,239
GS-3	236	239	242
GS-2	53	54	54
GS-1	1	1	1
Subtotal	11,661	11,797	11,904
Total - GS Salaries	$468,267	$468,267	$468,267
Assistant Surgeon General CO-08	1	1	1
Assistant Surgeon General CO-07	7	7	7
Director Grade CO-06	478	484	489
Senior Grade CO-05	554	561	567
Full Grade CO-04	569	576	582
Senior Assistant Grade CO-03	408	392	395
Assistant Grade CO-02	94	104	105
Junior Grade CO-01	18	35	35
Subtotal	2,129	2,159	2,181
Total - CO Salaries	$254,000	$254,000	$257,556
Ungraded	1,346	1,346	1,346
Total - Ungraded Salaries	$35,246	$35,246	$35,246
Trust Funds (Gift)	23	23	23
Average ES level	ES-02		
Average ES salary	$177		
Average GS grade	8.2		
Average GS salary	$38,533		

Indian Health Service

Programs Proposed for Elimination

The Indian Health Service (IHS) has nine small grant programs proposed for elimination in the President's FY 2012 Budget request. The elimination of these programs allows the Agency to redirect $7 million[1] (based on FY 2011 levels) to programs that will have greater impact on improving health outcomes and more access to health care services for a larger number of American Indian and Alaska Native (AI/AN) patients.

PROGRAM (FY 2011 BA in millions)	
Health Promotion/Disease Prevention (HPDP) Grants	$1.067
Healthy Youth Lifestyles Grant (National Congress of American Indians)	$1.000
Chronic Care Grant (Institute for Healthcare Improvement)	$.835
Elder Health Long Term Care Grants	$.700
Children and Youth Grants	$.600
Women's Health Grants	$.600
Domestic Violence /Sexual Assault Grants to Urban Programs	$.524
National Indian Health Board Cooperative Agreement	$.500
National Native American EMS Association Grant	$.090
TOTAL	$5.916

PROGRAM DESCRIPTIONS

Health Promotion/Disease Prevention (HP/DP) (-$1,067,000)

In FY 2011 there are nine Tribal and two Urban Indian Health Program 3-year HP/DP cooperative agreements in their third year of funding. The IHS HP/DP competitive grant program was established in FY 2005 to develop, implement, and coordinate innovative and effective community and clinic-based intervention programs to address behavioral risk factors that contribute to obesity, cancer, and diabetes. A recent independent evaluation found that many of the grantees did not present evidence to demonstrate positive changes and outcomes.

Healthy Youth Lifestyles Grant (National Congress of American Indians) (-$1,000,000)

This grant is a limited competition cooperative agreement with the National Congress of American Indians (NCAI) to promote healthy lifestyles in youth through healthy eating behaviors and physical activity. The NCAI uses the curriculum "Together Raising Awareness for Indian Life" (TRAIL) with 35 selected Tribal Boys and Girls Clubs in Indian Country. The IHS promotes healthy lifestyles in other ways and will explore expanding the use of the TRAIL curriculum in ongoing funded programs..

Chronic Care Grant (Institute for Healthcare Improvement) (-$835,000)

To address the increasing chronic disease burden of Indian people, the IHS determined to redesign its delivery of primary care services to advance reliable and evidence-based care, to better integrate all of

[1] The proposed Grants Savings was based on approximately $7M of small grant programs that included a $2.1M estimate for Domestic Violence Prevention Initiative (DVPI) grants. However, actual funding levels for DVPI were less than anticipated. Therefore, IHS will absorb the additional $1.1M savings.

the health programs available to patients, and to put patients and families at the center of care. In order to achieve this redesign, the IHS solicited an organization with experience in health care transformation. Through a grant the IHS began working with The Institute for Healthcare Improvement for this purpose to expand its Improving Patient Care Program. The grant was funded in FY 2007 – 2009 with the budget period ending in July 2010. A contract to continue this work was implemented in FY 2011. IHS has reorganized the Improving Patient Care program during FY 2010 and is developing internal leadership capacity for the program, making the use of outside consultants no longer necessary for FY 2012.

Elder Health Long Term Care Grants (-$700,000)
In FY 2011, there are nine Tribal and one Urban Indian Health Program 2-year elder health long term care grants in their second year of funding. The purpose of this grant program is to assist Tribes, Tribal organizations, and Urban Indian Health programs in the development of long-term services and support for AI/AN people. Funding supports both planning and program implementation, with the aim of developing sustainable programs and services. The average grant award under this program is $70,000. IHS will work with other Federal programs to address this need.

Children and Youth Grants (-$600,000)
In FY 2011, there are nine Tribal and one Urban Indian Health Program five-year cooperative agreements in their third year of funding. These grantees conduct afterschool, summer camp, and seasonal programming and receive substantive assistance with evaluation. Community-based programs, defined by their cultural practices, address homework completion (use of libraries); nutrition and physical activity in small and large groups; and healthy relationships with peer-to-peer, older youth, and adult mentoring in both intensive and long-term relationships (i.e., group meetings, day/short trips, incentivized longer trips). The average grant award from this program is $60,000. IHS will work with other Federal programs to address this need and expand resources for these activities for all Tribes.

Women's Health Grants (-$600,000)
In FY 2011, there are one Urban Indian Health Program and three Tribal grantees. Through FY 2010, their focus was on the integration of behavioral health care (mental health and substance abuse service delivery) into primary care for women and girls. In FY 2011, the program is focusing on demonstrating the use of an evidence-based model of hospital-to-home care in which advance practice nurses work to ensure smooth transition from hospital to home for patients at high risk for poor post-discharge outcomes. The IHS will work on ensuring that results from FY 2011 will be useful for integration into ongoing programs.

Domestic Violence (DV)/Sexual Assault Grant to Urban Programs (-$524,000)
In FY 2011, there are eight Urban Indian Health Program three-year grants in their second year of funding. With the rate of domestic violence among Native women being reported as the highest of any ethical or racial groups in the U.S., the demand for DV prevention and sexual assault treatment services has increased. IHS will seek to identify other Federal programs and resources to address this need for Urban Indian populations.

National Indian Health Board (NIHB) Cooperative Agreement (-$500,000)
Under the cooperative agreement, the NIHB carries out health program objectives in the AI/AN community with outreach and education efforts in the interest of improving Indian health care. NIHB represents all 565 federally-recognized tribes, providing policy analysis and development, program

assessment and development, regional and national meeting coordination, consultation and health care advocacy to IHS and the Department of Health and Human Services based on tribal input through a broad based consumer network. NIHB provides planning and technical assistance to Tribes, Area Indian Health Boards, and other Tribal organizations through the cooperative agreement. In consultation with Tribes, IHS will evaluate this cooperative agreement for its effectiveness in carrying out Indian health care objectives.

National Native American EMS Association (NNSEMSA) Grant (-$90,000)

The purpose of the cooperative agreement with NNAEMSA was to improve EMS for AI/AN people by improving communications between IHS and AI/AN EMS providers; by improving communications and information among other federal agencies, professional organizations and AI/AN EMS providers; and by supporting an annual Educational Conference. In the past, NNAEMSA provided a quarterly newsletter to EMS programs and sponsored annual educational conferences that included continuing education. The grant was funded in FY 2005 – 2009 with the budget period ending in July 2010.

INDIAN HEALTH SERVICE
Summary of Reimbursements, Assessments, and Purchases
FY 2010

Jan 14, 2011 CJ

		Object Class								FY 2010	FY 2011	FY 2012
		11.1 & 12.1	21.0	22.0	23.2 & 23.3	24.0	25.3	26.0	31.0	Actual	Estimate	Estimate
Type of Funding	**Reimbursement for Services Purchased within HHS**											
SSF	Service & Supply Fund				98,330		20,823,037			20,921,367	17,761,570	18,131,000
SSF	HHS Consolidated Acquisition System (HCAS) Operations and Maintenance						3,875,268			3,875,268	3,318,000	3,384,000
SSF	Unified Financial Management System (UFMS) Operations and Maintenance						4,937,116			4,937,116	5,896,000	6,014,000
SSF	UFMS Assessment and Upgrade (Under JFA as of FY 10)						0					
	Subtotal SSF	0	0	0	98,330	0	29,635,421	0	0	29,733,751	26,975,570	27,529,000
OS TAP	Audit Resolution						19,000			19,000	60,000	63,000
OS TAP	Web Communications						1,399,000			1,399,000	2,293,000	2,293,000
OS TAP	Small Business Center						177,000			177,000	177,000	177,000
OS TAP	Tracking Accountability Government Grants System						77,000			77,000	123,000	186,000
OS TAP	Departmental Contract Information System						242,000			242,000	286,000	427,000
OS TAP	Acquisition Integration Modernization						259,000			259,000	259,000	259,000
OS TAP	High Performing Organizations and Competitive Sourcing Reporting						39,000			39,000	53,000	49,000
OS TAP	Commissioned Corps Force Management						7,898,956			7,898,956	7,935,000	8,010,000
OS TAP	Human Resource Services						2,914,000			2,914,000	2,495,000	2,506,000
OS TAP	HSPD-12						1,669,000			1,669,000	2,405,000	2,833,000
OS TAP	OGC Claims						350,000			350,000	420,000	439,000
OS TAP	EEO Investigations (new for non-psc in FY11)										302,000	304,000
OS TAP	EEO Services (new for non-psc in FY11)										5,000	5,000
OS TAP	Strategic Resourcing (new for non-psc in FY11)										65,000	65,000
	Subtotal Non-PSC	0	0	0	0	0	15,043,956	0	0	15,043,956	16,878,000	17,616,000
JFA	UFMS Assessment and Upgrade (under JFA as of FY 10)									858,000	1,543,043	2,275,238
JFA	Office of General Counsel	547,700	44,097	16		713	476,047	1,441	22,459	1,201,014	1,251,473	1,271,497
JFA	OGC Ethics Program						236,402			236,402	333,000	343,000
JFA	HSPD-12 Implementation						258,583			258,583	101,866	101,866
JFA	HCAS						0			0	0	0
JFA	HHS Enterprise						761,899			761,899	0	0
JFA *	Legislatively Mandated Initiatives and Emerging Technologies (formerly part of HHS Enterprise)										1,438,025	1,574,480
JFA	IT Access for the Disabled						43,002			43,002	0	0
JFA	Regional Health Administrators						388,899			388,899	308,010	308,010
JFA	Motor Vehicle Management Information System						8,000			8,000	8,000	8,400
JFA	Secretarial Protective Operations Staff						0			0	0	0
JFA	(Environmental) Compliance and Process Tracking System						0			0	0	0
JFA	Health Services Research Library						500,000			500,000	507,000	515,112
JFA	Office of Global Health Affairs						13,404			13,404	13,404	13,404
JFA *	CFO Financial Statement Audit						533,000			533,000	535,000	555,000
JFA *	Regions Together Initiative									0	0	0
JFA	Media Monitoring and Analysis						61,042			61,042	59,322	61,695
	Subtotal JFA Assessments	547,700	44,097	16	0	713	3,280,278	1,441	22,459	4,863,245	6,098,143	7,027,702
	Government-wide Administrative Functions											
JFA	Tri-Council (CFOC, CIOC, PEC)						59,898			59,898	60,737	61,708
JFA *	Government-wide E-Gov Initiatives (formerly part of HHS Enterprise)									0	342,023	340,134
JFA	Federal Employment Services						70,222			70,222	71,205	72,344
JFA	President's Council on Bioethics						9,227			9,227	22,800	22,800
	Subtotal, GAF	0	0	0	0	0	139,347	0	0	139,347	496,765	496,986
	Grand Total	547,700	44,097	16	98,330	713	48,099,002	1,441	22,459	49,780,299	50,448,478	52,669,688

* New

Object Class Description:
11.1 & 12.1 -- Salaries & Benefits
21.0 -- Travel
22.0 -- Transportation of Things
23.2. & 23.3-- Rental Payments, Communications, Utilities
24.0 -- Printing & Reproduction
25.3 -- Purchases of goods and servics from Govt Accounts
26.0 -- Supplies & Materials
31.0 -- Equipment

FY 2012 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

The **IHS** will use **$1,914,614.00** of its **FY 2012** budget to support Department-wide enterprise information technology and government-wide E-Government initiatives. Operating Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, **$179,106.00** is allocated to developmental government-wide E-Government initiatives for **FY 2012**. This amount supports these government-wide E-Government initiatives as follows:

FY 2012 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$30,743.00
Line of Business - Grants Management	$2,646.00
Line of Business - Financial	$18,063.00
Line of Business - Budget Formulation and Execution	$13,263.00
Disaster Assistance Improvement Plan	$14,372.00
Federal Health Architecture	$100,019.00
Line of Business - Geospatial	$0.00
FY 2012 Developmental E-Gov Initiatives Total	**$179,106.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. The Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally, NIH is an internally HHS-designated Center of Excellence. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Disaster Assistance Improvement Plan (DAIP): The DAIP, managed by Department of Homeland Security, assists agencies with active disaster assistance programs such as HHS to reduce the burden on other federal agencies which routinely provide logistical help and other critical management or organizational support during disasters.

Lines of Business-Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology (HIT) Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs.

In addition, **$161,029.00** is allocated to ongoing government-wide E-Government initiatives for **FY 2012**. This amount supports these government-wide E-Government initiatives as follows:

FY 2012 Ongoing E-Gov Initiatives*	
E-Rule Making	$12,681.00
GovBenefits	$31,867.00
Integrated Acquisition Environment	$56,242.00
Grants.gov	$60,239.00
FY 2012 Ongoing E-Gov Initiatives Total	**$161,029.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Department of Health & Human Services
Indian Health Service
Number of Service Units and Facilities
Operated by IHS and Tribes, October 1, 2010

Type of Facility	TOTAL	IHS Total	TRIBAL Total	Title I [a]	Title V [b]	Other [c]
Service Units	**163**	61	102			
Hospitals	**45**	28	17	3	14	0
Ambulatory	**597**	**91**	506	187	313	6
Health Centers	293	58	235	116	119	0
School Health Centers	15	2	13	11	2	0
Health Stations	123	31	92	52	40	0
Alaska Village Clinics	166	0	166	8	152	6

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

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

[c] Operated by a local government, not a tribe, for some Alaska Native villages through a standard procurement contract

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2009 Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	27,214	23,145	50,359
Aberdeen	3,556		3,556
Alaska		11,674	11,674
Albuquerque	1,436		1,436
Bemidji	409		409
Billings	1,835		1,835
California			*
Nashville		1,253	1,253
Navajo	12,693	3,265	15,958
Oklahoma	1,540	6,731	8,271
Phoenix	5,116	222	5,338
Portland			*
Tucson	629		629

* No direct inpatient facilities in FY 2009

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	4,877,082	6,901,445	11,778,527
Aberdeen	784,207	96,252	880,459
Alaska	**	1,557,191	1,557,191
Albuquerque	492,727	84,349	577,076
Bemidji	262,472	664,080	926,552
Billings	495,373	120,608	615,981
California	**	505,158	505,158
Nashville	10,128	457,106	467,234
Navajo	1,109,611	442,024	1,551,635
Oklahoma	515,161	1,968,943	2,484,104
Phoenix	789,168	416,792	1,205,960
Portland	278,337	523,075	801,412
Tucson	139,898	65,867	205,765

** No IHS facilities in FY 2009

INDIAN HEALTH SERVICE
Immunization Expenditures

	FY 2010 Estimate	FY 2011 CR	FY 2012 Estimate	Increase or Decrease
Infants and Children	$12,903,354	$12,903,354	$13,329,165	+$425,811
Adults 65+	$1,786,625	$1,786,625	$1,845,584	+$58,959
HPV vaccine Female 19-26 years))	$9,088,511	$9,088,511	$9,388,432	+$299,921
Adult 19 – 64 years influenza			$3,210,800	$3,210,800
Monitoring	$106,914	$106,914	$110,442	+$3,528
Total:	$23,885,404	$23,885,404	$27,884,423	+$3,999,018

1/ The immunization estimates do not include the Hepatitis B and Haemophilus Immunization program (Alaska) budget line item

The Indian Health Service (IHS) patient care data system does not calculate itemized costs for the treatment of various conditions. Therefore, an indirect method was used for calculating immunization costs based on an estimated patient population and the amount of staff time for required immunizations, as well as the immunization costs not available through the Vaccines for Children program.

Immunization costs were categorized by age groups; infants and children (3 to 27 months of age), and adults ≥ 65 years of age. In addition costs for two specific vaccines – HPV and influenza - were included for two age groups, as well as an estimate of monitoring costs.

By combining these two groups, an estimate of $10,540,043 was calculated for the IHS immunization expenditures in FY 2004 with inflation costs added into the equation. Since then, costs have been iterated using inflation rates and the addition of new expenses, such as the introduction of a new vaccine:

FY 2009 Estimated Costs = FY 2008 cost times 3.8 percent
FY 2010 Estimated Costs = FY 2009 cost times 3.0 percent
FY 2011 Estimated Costs = FY 2010 CR
FY 2012 Estimated Costs = FY 2011 cost times 3.3 percent

For FY 2012, $3,210,800 was added for adult (19 – 64 year old) flu vaccination. The total cost does not include inflation, which may affect future estimated costs. The methodology was calculated based on the following assumptions:

1. 50% coverage of the 19 – 64 year old population (~ 401,349)
2. Cost of a dose of influenza vaccine at $8.00.

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

1. Individuals outside these target groups are regular recipients of immunizations (e.g., HBg and influenza immunization for health care workers and those at specific risk for other vaccine-preventable diseases), however, there is not a methodology to estimate the size of these groups.
2. There is not a methodology to estimate indirect costs or administrative overhead associated with the administration of immunizations, or operation of the immunization program.

DEPARTMENT OF HEALTH AND HUMAN SERVICE
Indian Health Service
Drug Control Budget
FY 2012

RESOURCE SUMMARY

	Budget Authority (in Millions)		
	2010 Enacted	**2011 CR**	**2012 Estimate**
Drug Resources by Function			
Prevention	18.771	18.771	19.560
Treatment	77.246	77.246	86.074
Total Drug Resources by Function	**$96.017**	**$96.017**	**$105.634**
Drug Resources by Decision Unit			
Alcohol and Substance Abuse	91.661	91.661	101.278
Urban Indian Health Program	4.356	4.356	4.356
Total Drug Resources by Decision Unit	**$96.017**	**$96.017**	**$105.634**

Drug Resources Personnel Summary			
Total FTEs (direct only)	171	171	177
Drug Resources as a Percent of Budget			
Agency Budget	$ 5,099.656	$ 5,116.398	$5,689.043
Drug Resources Percentage	1.88%	1.88%	1.86%

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. IHS supports substance abuse treatment and prevention services as part of this mission.

METHODOLOGY

The Indian Health Service (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

In FY 2012, IHS requests $105.6 million for its drug control activities. This is $9.6 million above the FY 2010 Enacted Level.

Alcohol and Substance Abuse
Total FY 2012 Request: $211.7million
The FY 2012 request includes an increase in current services to continue to support the Alcohol and Substance Abuse Program. The program will continue to support methamphetamine and suicide prevention and substance abuse treatment initiatives.

FY 2012 Program Changes

In FY 2012, IHS will continue to serve American Indian and Alaska Natives impacted by methamphetamine abuse through its Youth Regional Treatment Centers and other federal and Tribally-operated substance abuse treatment and prevention programs. In addition to those direct services, IHS, through the Methamphetamine and Suicide Prevention Initiative (MSPI), also provides Area allocation funding for pilot projects and federal grant awards to 111 Area Tribal awardees, 12 Urban grantees, 3 Tribal Youth grantees, and one federally-operated Youth Regional Treatment Center (YRTC). The awards are to establish evidence based or practice based methamphetamine and suicide prevention and intervention pilot projects. These programs represent an innovative partnership with IHS to deliver services by and for the communities themselves, with a national support network for ongoing program development and evaluation. The award and grant recipients participate on regular initiative conference calls to share evidence based and promising practices in methamphetamine and suicide prevention programs in American Indian/Alaska Native communities, as well as develop ongoing evaluation methods for program improvement. In addition, the first annual meeting on methamphetamine and suicide interventions was held in Oklahoma City on September 1 - 2, 2010, to share evidence-based and practice-based models. A second meeting was also held in Anchorage, AK on October 5 - 6, 2010. This second meeting was scheduled at the request of the MSPI projects in Alaska to ensure greater direct participation of those programs due to the long distances involved for their travel from geographically isolated communities.

Urban Indian Health Program- Alcohol and Substance Abuse Title V Grants
Total FY 2012 Request: $46.7 million
The FY 2012 budget estimate includes funds for the Urban Indian Health Program, a portion of which is provided in the form of federal grants to 34 urban Indian 501(c)3 non-profit organizations to carry out alcohol and substance abuse prevention and treatment activities in the communities served. All urban programs have active partnerships with their local Veterans Health Administration programs and several have identified joint program alcohol and substance abuse initiatives.

The FY 2012 Budget includes funding for the Urban Indian Health Program which will be used to continue serving urban American Indians and Alaskan Natives impacted by alcohol and substance abuse through the Title V grant program, Alcohol and Substance Abuse Prevention and Treatment. Substance abuse prevention and education programs services address alcohol/drugs, suicide, self-esteem, injury control, domestic violence, and sexual abuse.

Performance

Introduction

This section on the FY 2010 performance of the drug control portion of the IHS Alcohol and Substance Abuse Program is based on agency GPRA documents. The IHS Alcohol and Substance Abuse Program undertakes anti-drug abuse activities to raise community awareness and target high-risk groups in addition to educating staff on issues and skills related to substance abuse. In 2007, IHS' Tribally-Operated Health Program (TOHPs) including its drug control activities, were assessed and received an assessment rating of "Adequate."

IHS Alcohol and Substance Abuse Program		
Selected Measures of Performance	**FY 2010 Target**	**FY 2010 Achieved**
Alcohol-use screening among appropriate female patients	55%	55%
Accreditation rate for Youth Regional Treatment Centers*	100%	81%

* In operation 18 months or more.

Discussion

The measures reported in the table indicate results from both Tribally-Operated Health Programs and Federally-Administered Health Programs. Currently, Tribally-Operated Health Programs have 17 measures, including alcohol- and health- related performance indicators. The percent of appropriate female patients screened for alcohol-use (fetal alcohol syndrome prevention) was 55% in FY 2010. As a result, the FY 2010 performance target for this measure was met. Alcohol screening improved by 3 percentage points over FY 2009 results.

The accreditation measure – 'Accreditation rate for Youth Regional Treatment Centers' – was not met in FY 2010. The FY 2010 and FY 2011 performance target will remain 100% and the agency is confident that the target will be met.

IHS also conducts the Comprehensive Update on Substance Abuse and Dependency course. This course is provided twice a year to IHS/Tribal/Urban primary care providers to enhance professional skills in addiction prevention, intervention, and treatment. The program includes a section on prevention, recognition, and treatment of opioid dependence. Safe prescribing activities have become a high priority for IHS. Activities include the development of a lending library (video and slide materials) designed to improve provider in-service capability and community presentations. Approximately 60 primary care providers receive this training each year.

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 Number (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 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 1992, the IHS has entered into agreements with Tribes and Tribal organizations to plan, conduct, and administer programs authorized under Section 102 of the Act. Today, approximately $2.5 billion of the Agency's appropriation is under Tribal health administration through Title I contracts and Title V compacts. The IHS and Tribes have entered 232 Title I contracts and Annual Funding Agreements. Under Title V, the IHS is a party to 77 compacts and 98 funding agreements; the Title V program constitutes $1.3 million or 34 percent of the IHS budget, and covers 36.8 percent of total IHS users and 58.7 percent of federally-recognized Tribes.

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 control of community services, later expanding 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 31 percent of the hospitals funded by IHS. With the increase of ambulatory medical facilities, Tribes continue to expand their provision of health care.

Self-Determination Implementation: Contract Support Cost (CSC) Funding –The 1975 Indian Self-Determination and Education Assistance Act (ISDEAA), Pub. L. 93-638, gave Indian Tribes the authority to contract with the Federal government to operate programs serving their tribal members and other eligible persons and to receive not less than the amount of program funding that the Secretary would have otherwise provided for the direct operation of the program. The Act was further amended; the 1988 amendments identified Contract Support Costs (CSC) and provided that CSC be added to the program amount. CSC are defined as reasonable costs for activities that Tribes and Tribal Organizations must carry out but that the Secretary either did not carry out in her direct operation of the program or provided from resources other than those under contract.

The demand for CSC funding has increased because of the new and expanded programs, services, functions, or activities assumed by Tribes and Tribal organizations under both Titles I and V of the ISDEAA. Tribes and Tribal organizations use this funding to increase their Tribal capacity to professionally manage ISDEAA agreements and the corresponding services in their communities.

Indian Health Service
Self Governance Funded Compacts FY 2010

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Alabama	**$4,000,000**	**$228,000**	**$125,000**	**$648,000**	**$5,001,000**
Poarch Band of Creek Indians	$4,000,000	$228,000	$125,000	$648,000	$5,001,000
Alaska	**$412,056,220**	**$37,495,000**	**$33,164,780**	**$91,748,000**	**$574,464,000**
Alaska Native Tribal Health Consortium	$106,670,000	$27,165,000	$8,826,000	$9,339,000	$152,000,000
Aleutian Pribilof Islands Association, Inc.	$3,406,000	$801,000	$340,000	$1,034,000	$5,581,000
Arctic Slope Native Association	$8,259,000	$75,000	$1,175,000	$2,618,000	$12,127,000
Bristol Bay Area Health Corporation	$22,390,000	$956,000	$1,986,000	$6,920,000	$32,252,000
Chugachmiut	$4,420,000	$105,000	$228,000	$1,583,000	$6,336,000
Copper River Native Association	$2,232,000	$33,000	$207,000	$503,000	$2,975,000
Council of Athabascan Tribal Governments	$2,022,000	$103,000	$69,000	$1,015,000	$3,209,000
Eastern Aleutian Tribes, Inc.	$3,221,000	$25,000	$149,000	$1,151,000	$4,546,000
Kenalitze Indian Tribe	$2,148,000	$6,000	$198,000	$331,000	$2,683,000
Ketchikan Indian Community	$5,460,000	$132,000	$867,000	$2,515,000	$8,974,000
Knik Traditional Council	$66,000	$1,000	$9,000	$9,000	$85,000
Kodiak Area Native Association	$7,137,000	$91,000	$383,000	$1,330,000	$8,941,000
Maniilaq Association	$27,810,000	$975,000	$2,374,000	$10,614,000	$41,773,000
Metlakatla Indian Community	$6,244,000	$956,000	$400,000	$736,000	$8,336,000
Mount Sanford Tribal Consortium	$789,000	$1,000	$69,000	$183,000	$1,042,000
Native Village of Eklutna	$184,000	$1,000	$5,000	$19,000	$209,000
Norton Sound Health Corporation	$22,698,000	$775,000	$1,697,000	$4,377,000	$29,547,000
Seldovia Village Tribe	$1,705,000	$35,000	$65,000	$490,000	$2,295,000
Southcentral Foundation	$66,793,000	$1,531,000	$4,558,000	$19,015,000	$91,897,000
SouthEast Alaska Regional Health Corporation	$38,963,220	$1,431,000	$3,006,780	$7,284,000	$50,685,000
Tanana Chiefs Conference	$32,470,000	$711,000	$1,679,000	$5,218,000	$40,078,000
Yakutat Tlingit Tribe	$319,000	$3,000	$26,000	$82,000	$430,000
Yukon-Kuskokwim Health Corporation	$46,650,000	$1,583,000	$4,848,000	$15,382,000	$68,463,000
Arizona	**$36,329,000**	**$4,712,000**	**$1,484,000**	**$3,306,000**	**$45,831,000**
Gila River Indian Community	$36,329,000	$4,712,000	$1,484,000	$3,306,000	$45,831,000
California	**$52,364,338**	**$2,652,662**	**$2,023,000**	**$15,316,000**	**$72,356,000**
Consolidated Tribal Health Project, Inc.	$3,929,000	$279,000	$86,000	$1,385,000	$5,679,000
Hoopa Valley Tribe	$5,494,000	$895,000	$221,000	$956,000	$7,566,000
Indian Health Council, Inc.	$8,334,000	$482,000	$233,000	$2,486,000	$11,535,000
Karuk Tribe of California	$2,941,000	$224,000	$80,000	$1,163,000	$4,408,000
Northern Valley Indian Health, Inc.	$2,798,338	$234,662	$56,000	$533,000	$3,622,000
Redding Rancheria	$6,398,000	$101,000	$483,000	$2,399,000	$9,381,000
Riverside-San Bernardino County Indian Health, Inc.	$20,805,000	$362,000	$731,000	$5,831,000	$27,729,000
Susanville Indian Rancheria	$1,665,000	$75,000	$133,000	$563,000	$2,436,000
Connecticut	**$2,454,000**	**$35,000**	**$0**	**$31,000**	**$2,520,000**
Mohegan Tribe of Indians of Connecticut	$2,454,000	$35,000	$0	$31,000	$2,520,000
Florida	**$7,964,000**	**$531,000**	**$215,000**	**$1,071,000**	**$9,781,000**
Seminole Tribe of Florida	$7,964,000	$531,000	$215,000	$1,071,000	$9,781,000
Kansas	**$2,484,000**	**$96,000**	**$5,000**	**$233,000**	**$2,818,000**
Prairie Band of Potawatomi Nation	$2,484,000	$96,000	$5,000	$233,000	$2,818,000
Idaho	**$15,098,000**	**$840,000**	**$1,043,000**	**$1,878,000**	**$18,859,000**
Coeur D'Alene Tribe	$5,895,000	$278,000	$621,000	$1,021,000	$7,815,000
Kootenai Tribe of Idaho	$701,000	$23,000	$58,000	$58,000	$840,000
Nez Perce Tribe	$8,502,000	$539,000	$364,000	$799,000	$10,204,000
Louisana	**$1,252,000**	**$95,000**	**$97,000**	**$119,000**	**$1,563,000**
Chitimacha Tribe of Louisana	$1,252,000	$95,000	$97,000	$119,000	$1,563,000
Maine	**$3,377,000**	**$201,000**	**$143,000**	**$703,000**	**$4,424,000**
Penobscot Indian Nation	$3,377,000	$201,000	$143,000	$703,000	$4,424,000
Massachusetts	**$723,000**	**$69,000**	**$178,000**	**$218,000**	**$1,188,000**
Wampanoag Tribe of Gay Head	$723,000	$69,000	$178,000	$218,000	$1,188,000
Michigan	**$24,746,000**	**$1,194,000**	**$1,380,000**	**$2,791,000**	**$30,111,000**
Grand Traverse Band of Ottawa and Chippewa Indians	$2,853,000	$202,000	$54,000	$450,000	$3,559,000
Keweenaw Bay Indian Community	$3,225,000	$236,000	$459,000	$565,000	$4,485,000
Little River Band of Ottawa Indians	$1,964,000	$104,000	$211,000	$350,000	$2,629,000
Sault Ste. Marie Tribe of Chippewa Indians	$16,704,000	$652,000	$656,000	$1,426,000	$19,438,000
Minnesota	**$19,772,000**	**$1,079,000**	**$2,116,000**	**$1,306,000**	**$24,273,000**
Bois Forte Band of Chippewa Indians	$2,651,000	$255,000	$65,000	$470,000	$3,441,000
Fond du Lac Band of Lake Superior Chippewa	$11,222,000	$494,000	$1,030,000	$445,000	$13,191,000
Mille Lacs Band of Ojibwe	$4,210,000	$281,000	$1,007,000	$283,000	$5,781,000
Shakopee Mdewakanton Sioux Community	$1,689,000	$49,000	$14,000	$108,000	$1,860,000
Mississippi	**$17,185,000**	**$1,093,000**	**$1,051,000**	**$1,782,000**	**$21,111,000**
Mississippi Band of Choctaw Indians	$17,185,000	$1,093,000	$1,051,000	$1,782,000	$21,111,000
Montana	**$21,877,000**	**$1,425,000**	**$1,662,000**	**$3,305,000**	**$28,269,000**
Chippewa Cree Tribe of the Rocky Boy's Reservation	$11,479,000	$820,000	$978,000	$2,098,000	$15,375,000
Confederated Salish and Kootenai Tribes of Flathead	$10,398,000	$605,000	$684,000	$1,207,000	$12,894,000

Indian Health Service
Self Governance Funded Compacts FY 2010

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Nevada	**$20,108,000**	**$989,000**	**$1,238,000**	**$3,488,000**	**$25,823,000**
Duck Valley Shoshone-Paiute Tribe	$6,768,000	$486,000	$639,000	$1,587,000	$9,480,000
Duckwater Shoshone Tribe	$1,067,000	$34,000	$166,000	$758,000	$2,025,000
Ely Shoshone Tribe	$1,271,000	$42,000	$48,000	$260,000	$1,621,000
Las Vegas Paiute Tribe	$4,052,000	$128,000	$104,000	$251,000	$4,535,000
Washoe Tribe of Nevada and California	$4,989,000	$165,000	$195,000	$301,000	$5,650,000
Yerington Paiute Tribe of Nevada	$1,961,000	$134,000	$86,000	$331,000	$2,512,000
New Mexico	**$2,317,000**	**$62,000**	**$179,000**	**$278,000**	**$2,836,000**
Pueblo of Sandia	$911,000	$59,000	$0	$0	$970,000
Taos Pueblo	$1,406,000	$3,000	$179,000	$278,000	$1,866,000
New York	**$7,911,000**	**$348,000**	**$201,000**	**$616,000**	**$9,076,000**
St. Regis Mohawk Tribe	$7,911,000	$348,000	$201,000	$616,000	$9,076,000
North Carolina	**$21,703,000**	**$1,453,000**	**$834,000**	**$3,527,000**	**$27,517,000**
Eastern Band of Cherokee Indians	$21,703,000	$1,453,000	$834,000	$3,527,000	$27,517,000
Oklahoma	**$320,352,857**	**$24,686,100**	**$20,371,043**	**$39,815,000**	**$405,225,000**
Absentee Shawnee Tribe of Oklahoma	$7,742,000	$362,000	$741,000	$995,000	$9,840,000
Cherokee Nation	$112,638,000	$7,694,000	$4,582,000	$12,381,000	$137,295,000
Chickasaw Nation	$56,432,000	$6,851,000	$7,289,000	$10,301,000	$80,873,000
Choctaw Nation of Oklahoma	$58,846,000	$6,914,000	$5,316,000	$6,834,000	$77,910,000
Citizen Potawatomi Nation	$13,763,000	$800,000	$690,000	$2,722,000	$17,975,000
Kaw Nation	$1,395,000	$82,000	$179,000	$229,000	$1,885,000
Kickapoo Tribe of Oklahoma	$7,666,000	$94,000	$123,000	$870,000	$8,753,000
Modoc Tribe of Oklahoma	$50,900	$100	$4,000	$16,000	$71,000
Muscogee (Creek) Nation	$41,466,000	$1,662,000	$1,048,000	$3,514,000	$47,690,000
Northeastern Tribal Health System	$7,121,000	$42,000	$113,000	$834,000	$8,110,000
Ponca Tribe of Oklahoma	$3,841,000	$57,000	$142,000	$393,000	$4,433,000
Sac and Fox Nation	$7,491,957	$60,000	$111,043	$442,000	$8,105,000
Wyandotte Nation	$1,900,000	$68,000	$33,000	$284,000	$2,285,000
Oregon	**$24,450,000**	**$1,066,000**	**$2,207,000**	**$7,122,000**	**$34,845,000**
Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians of Oregon	$1,644,000	$75,000	$255,000	$523,000	$2,497,000
Confederated Tribes of Grand Ronde	$6,568,000	$267,000	$461,000	$2,363,000	$9,659,000
Confederated Tribes of Siletz Indians of Oregon	$7,659,000	$202,000	$650,000	$1,809,000	$10,320,000
Confederated Tribes of the Umatilla Reservation	$6,613,000	$442,000	$639,000	$1,599,000	$9,293,000
Coquille Indian Tribe	$1,966,000	$80,000	$202,000	$828,000	$3,076,000
Washington	**$50,112,000**	**$3,300,000**	**$2,361,000**	**$10,838,000**	**$66,611,000**
Jamestown S'Klallam Indian Tribe	$925,000	$68,000	$80,000	$285,000	$1,358,000
Kalispel Tribe of Indians	$982,000	$97,000	$19,000	$59,000	$1,157,000
Lower Elwha Klallam Tribe	$1,781,000	$95,000	$95,000	$318,000	$2,289,000
Lummi Indian Nation	$8,516,000	$565,000	$225,000	$1,701,000	$11,007,000
Makah Indian Tribe	$3,690,000	$412,000	$265,000	$1,015,000	$5,382,000
Muckleshoot Indian Tribe	$6,696,000	$272,000	$167,000	$0	$7,135,000
Nisqually Indian Tribe	$2,332,000	$115,000	$101,000	$567,000	$3,115,000
Port Gamble S'Klallam Tribe	$2,442,000	$139,000	$124,000	$646,000	$3,351,000
Quinault Indian Nation	$5,471,000	$369,000	$171,000	$1,709,000	$7,720,000
Shoalwater Bay Indian Tribe	$1,833,000	$55,000	$255,000	$696,000	$2,839,000
Skokomish Indian Tribe	$2,002,000	$197,000	$102,000	$477,000	$2,778,000
Squaxin Island Indian Tribe	$2,695,000	$131,000	$180,000	$910,000	$3,916,000
Suquamish Tribe	$1,594,000	$55,000	$135,000	$514,000	$2,298,000
Swinomish Indian Tribal Community	$2,227,000	$206,000	$153,000	$756,000	$3,342,000
Tulalip Tribes of Washington	$6,926,000	$524,000	$289,000	$1,185,000	$8,924,000
Wisconsin	**$21,149,000**	**$959,000**	**$597,000**	**$1,006,000**	**$23,711,000**
Forest County Potawatomi Community	$2,229,000	$199,000	$327,000	$331,000	$3,086,000
Oneida Tribe of Indians of Wisconsin	$18,920,000	$760,000	$270,000	$675,000	$20,625,000
Grand Total	**$1,089,784,415**	**$84,608,762**	**$72,674,823**	**$191,145,000**	**$1,438,213,000**

Indian Health Service
FY 2010 Self-Governance Funding Agreements
By Area

Area	Tribal User Pop	Program Tribal Shares	Area Tribal Shares	Headqtrs Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
Alaska	117,492	424,871,000	13,855,000	10,829,000	33,163,000	91,746,000	574,464,000
Aberdeen	0	152,000	128,000	0	0	0	280,000
Albuquerque	888	1,345,000	943,000	91000	179000	278000	2,836,000
Bemidji	27,506	64,006,000	2,965,000	1,926,000	4,094,000	5,104,000	78,095,000
Billings	15,096	20,783,000	1,893,000	967,000	1,641,000	2,985,000	28,269,000
California	26,617	49,774,000	3,208,000	2,034,000	2,022,000	15,318,000	72,356,000
Nashville	38,310	62,475,000	6,005,000	2,143,000	2,843,000	8,715,000	82,181,000
Oklahoma	237,023	324,844,000	10,758,000	12,016,000	20,377,000	40,048,000	408,043,000
Phoenix	21,120	58,318,000	1,708,000	2,110,000	2,723,000	6,795,000	71,654,000
Portland	40,383	85,785,000	5,930,000	3,296,000	5,558,000	19,746,000	120,315,000
Total, IHS	524,435	1,092,353,000	47,393,000	35,412,000	72,600,000	190,735,000	1,438,493,000