DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year

2 0 0 9

Indian Health Service

Justification of Estimates for Appropriations Committees

Introduction

The Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS') performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through HHS agencies' FY 2009 Congressional Justifications and Online Performance Appendices, the Agency Financial Report and the HHS Performance Highlights. These documents can be found at: http://www.hhs.gov/budget/docbudget.htm and http://www.hhs.gov/afr/.

The Performance Highlights briefly summarizes key past and planned performance and financial information. The Agency Financial Report provides fiscal and high-level performance results. The FY 2009 Department's Congressional Justifications fully integrate HHS' FY 2007 Annual Performance Report and FY 2009 Annual Performance Plan into its various volumes. The Congressional Justifications are supplemented by the Online Performance Appendices. Where the Justifications focus on key performance measures and summarize program results, the Appendices provide performance information that is more detailed for all HHS measures.

This Indian Health Service Congressional Justification and Online Performance Appendix can be found at http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/bf_cong_justifications.asp.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

I present the Indian Health Service (IHS) fiscal year (FY) 2009 Congressional Justification. This budget request provides our most fully integrated and transparent performance budget to date and supports the President's Management Agenda (PMA) and priorities and the Department of Health and Human Services' FY 2007 through 2012 Strategic Plan. Consistent with the Government Performance and Results Act of 1993, this justification includes the FY 2009 Annual Performance Plan and the FY 2007 Annual Performance Report.

Performance measurement and reporting continues as a mainstay of IHS performance management, including the quarterly review of critical health care data. These data are utilized to enhance the integration of a performance management culture across the Indian health care system. This improved monitoring capacity coupled with an increased awareness and commitment to the IHS mission across the Indian health system are our greatest assets.

For FY 2009, the IHS provides a comprehensive set of performance measures that reflect essential health services with evidence-based linkages to improved health outcomes.
The ongoing 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 elements of the Departmental and IHS Strategic Plans:

HHS Strategic Objectives:

- 1.2 Increase health care service availability and accessibility.
- 1.3 Improve health care quality, safety, cost, and value.
- 1.4 Recruit, develop, and retain a competent health care workforce.
- 2.1 Prevent the spread of infectious diseases.
- 2.2 Protect the public against injuries and environmental threats.
- 2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors, and recovery.
- 2.4 Prepare for and respond to natural and manmade disasters.

IHS Strategic Goals:

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

Our enhanced performance management processes have resulted in the improved targeting of resources to meet the health care needs of American Indian and Alaska Native (AI/AN) people. For FY 2009, maintaining the status quo for most of the IHS and HHS strategic objectives will be challenging. And while the IHS has succeeded in reducing overall mortality for our population by 28 percent over the past 30 years, this progress is offset by a trend of growing disparities in mortality rates between the AI/AN population and our country's population overall during the same period. Our FY 2009 budget request represents the commitment of the IHS and our stakeholders to the IHS mission by efficiently and effectively meeting the health care needs of the AI/AN people.

Robert G. McSwain
Acting Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2009 Performance Budget Submission to Congress

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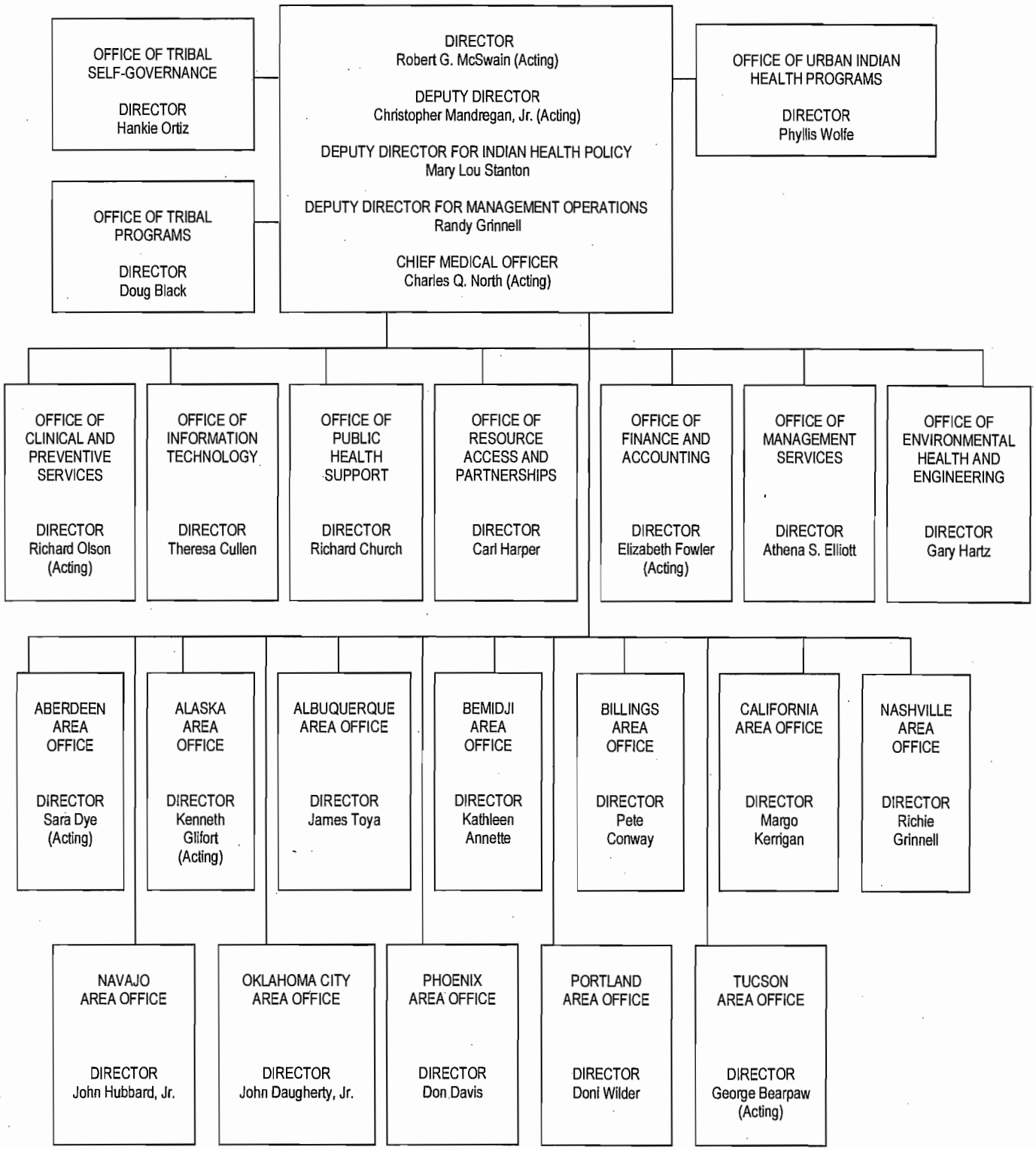
DEPARTMENT OF HEALTH AND HUMAN SERVICES

INDIAN HEALTH SERVICE

Approved: [signature]

Date: JAN 3 1 2008



EXECUTIVE SUMMARY

Agency Mission

The mission of the Indian Health Service is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

United States Government and Indian Nations

The provision of Federal health services to American Indians and Alaska Natives is based on a special relationship between Indian Tribes and the United States. The Indian Commerce Clause of the United States Constitution, as well as numerous treaties and court decisions, have affirmed this special relationship and the plenary power of Congress to create statutes that benefit Indian people. Principal among these statutes is the Snyder Act of 1921, which provides the basic authority for health services provided by the Federal Government to American Indians and Alaska Natives.

The Indian Health Service and Its Partnership with Tribes

For more than 120 years, Federal responsibility for American Indian and Alaska Native health care passed among different government branches. In 1955, this responsibility was officially transferred to the Public Health Service.

In the 1970s, Federal Indian policy was re-evaluated by the Nixon Administration, which adopted a policy of Indian self-determination. This policy promotes Tribal administration of Federal Indian programs, including health care. Self-Determination does not lessen any Federal obligation, but provides an opportunity for Tribes to assume the responsibility of providing health care for their members.

The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), as amended, and the Indian Health Care Improvement Act of 1976 (IHCIA), as amended, have provided new opportunities for the IHS and Tribes to deliver care. The IHCIA included specific authorizations for providing health care services to urban Indian populations, to administer an Indian health professions program, and the ability to collect from Medicare/Medicaid and other third party insurers for services rendered at IHS or Tribal facilities. Under the ISDEAA, many Tribes have assumed the administrative and program direction roles that were previously carried out by the Federal government. Tribes currently administer over one-half of IHS resources through ISDEAA contracts and compacts. The IHS administers the remaining resources and manages those facilities where Tribes have elected not to contract or compact their health programs.

Overview of Budget Request

The FY 2009 President's Budget request for the IHS is $3,324,862,000 in discretionary budget authority—a decrease of $21,317,000 below the FY 2008 enacted funding level.

Increases

Staffing and Operating Costs for New/Expanded Facilities (+$25 million)
In FY 2009, three newly constructed or expanded facilities will be provided additional staffing. They reflect an investment of more than $36 million in the construction of the facilities to expand access to care in locations where existing capacity is most overextended.

Indian Health Care Improvement Fund (+$10 million)
The Indian Health Care Improvement Fund was established by Congress to address funding inequities for Indian health care programs. To diminish health care service backlogs, this program increase will be allocated to IHS and Tribal service sites with the greatest deficiencies as measured by the Federal Disparities Index. Funding will allow highly deficient sites, those funded at less than 40% of need, to expand health care services and reduce backlogs for primary care.

Base Adjustment from 2008 President's Budget to 2008 Enacted (+$24.7 million)
This increase reflects base adjustments to activities from the FY 2008 level.

Decreases

Alcohol and Substance Abuse (-$11.3 million)
Funding for alcohol and substance abuse is reduced. The methamphetamine initiatives from FY 2008 and provision of other alcohol and substance abuse treatment and prevention services will be continued at a diminished level.

Urban Indian Health Program (-$34.5 million)
The Urban Indian Health Program budget is eliminated in the FY 2009 President's Budget request to allow IHS funds to be focused on providing health care on or near Indian reservations. The 2006 Program Assessment Rating Tool (PART) evaluation of this program found the beneficiaries of these programs to have access to other health care in the urban areas where they reside.

Indian Health Professions (-$14.4 million)
Funding for the Indian Health Professions programs is reduced in this budget request. Continuation funding for scholarship students and extension contracts for loan repayment recipients will be funded.

Health Care Facilities Construction (-$20.8 million)
Funding for construction of new health facilities is reduced in this budget request to focus on the provision of health services to American Indian and Alaska Native patients. Funds are provided to continue the construction of the replacement hospital at Barrow, Alaska.

All Purpose Table
Indian Health Service

(Dollars in Thousands)

Jan 15, 2008

Program	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate
SERVICES			
Hospitals & Health Clinics	1,411,336	1,484,016	1,521,934
Dental Health	125,396	133,637	137,944
Mental Health	60,882	63,531	65,824
Alcohol & Substance Abuse	148,226	173,243	161,988
Contract Health Services	543,099	579,334	588,161
Total, Clinical Services	2,288,939	2,433,762	2,475,851
Public Health Nursing	52,445	55,939	58,307
Health Education	14,287	14,991	15,229
Community Health Reps.	54,891	54,925	55,795
Immunization AK	1,681	1,733	1,760
Total, Preventive Health	123,304	127,587	131,091
Urban Health	33,691	34,547	0
Indian Health Professions	31,375	36,291	21,866
Tribal Management	2,438	2,490	2,529
Direct Operations	63,631	63,624	62,632
Self-Governance	5,763	5,836	5,928
Contract Support Costs	269,730	267,398	271,636
Total, Other Services	406,628	410,184	364,591
TOTAL, SERVICES	2,818,871	2,971,533	2,971,533
FACILITIES			
Maintenance & Improvement	54,668	52,889	52,889
Sanitation Facilities Construction	94,003	94,253	94,253
Health Care Facilities Construction	25,664	36,584	15,800
Facilities & Environmental Health Support	165,272	169,638	169,105
Equipment	21,619	21,282	21,282
TOTAL, FACILITIES	361,226	374,646	353,329
TOTAL, BUDGET AUTHORITY	3,180,097	3,346,179	3,324,862
COLLECTIONS			
Medicare	160,953	162,069	162,069
Medicaid	515,844	527,482	527,482
Subtotal, M / M	*676,797*	*689,551*	*689,551*
Private Insurance	90,151	90,151	90,151
Total, M / M / PI	*766,948*	*779,702*	*779,702*
Quarters	6,288	6,288	6,288
TOTAL, COLLECTIONS	773,236	785,990	785,990
Special Diabetes Program for Indians	150,000	150,000	150,000
TOTAL, SDPI	150,000	150,000	150,000
TOTAL, PROGRAM LEVEL	4,103,333	4,282,169	4,260,852

Indian Health Service
FY 2009 Budget Request
Detail of Changes -- Congressional Justification
(Dollars in Thousands)

Jan 15, 2008

Sub Sub Activity	FY 2007 Actual	FY 2008 Enacted	Base Adjustment	Curr. Svcs: Staffing for New Fac.	Prog Increase: Indian Health Care Improv. Fund	FY 2009 Estimate
SERVICES:						
Hospitals & Health Clinics	1,411,336	1,484,016	10,051	17,867	10,000	1,521,934
Dental Health	125,396	133,637	2,118	2,189	0	137,944
Mental Health	60,882	63,531	1,007	1,286	0	65,824
Alcohol & Substance Abuse	148,226	173,243	(11,255)	0	0	161,988
Contract Health Services	543,099	579,334	8,827	0	0	588,161
Total, Clinical Svcs	2,288,939	2,433,762	10,748	21,342	10,000	2,475,851
Public Health Nursing	52,445	55,939	886	1,482	0	58,307
Health Education	14,287	14,991	238	0	0	15,229
Comm. Health Reps	54,891	54,925	870	0	0	55,795
Immunization AK	1,681	1,733	27	0	0	1,760
Total, Prev Hlth	123,304	127,587	2,021	1,482	0	131,091
Urban Health	33,691	34,547	(34,547)	0	0	0
Indian Health Professions	31,375	36,291	(14,425)	0	0	21,866
Tribal Management	2,438	2,490	39	0	0	2,529
Direct Operations	63,631	63,624	(992)	0	0	62,632
Self-Governance	5,763	5,836	92	0	0	5,928
Contract Support Costs	269,730	267,398	4,238	0	0	271,636
Total, Other Services	406,628	410,185	(45,595)	0	0	364,591
Total, Services	2,818,871	2,971,533	(32,826)	22,824	10,000	2,971,533
FACILITIES:						
Maintenance & Improvement	54,668	52,889	0	0	0	52,889
Sanitation Facilities Construction	94,003	94,253	0	0	0	94,253
Hlth Care Facilities Construction	25,664	36,584	(20,784)	0	0	15,800
Facil. & Envir. Hlth Supp	165,272	169,638	(2,709)	2,176	0	169,105
Equipment	21,619	21,282	0	0	0	21,282
Total, Facilities	361,226	374,646	(23,493)	2,176	0	353,329
TOTAL, Budget Authority	3,180,097	3,346,179	(56,319)	25,000	10,000	3,324,862
COLLECTIONS:						
Medicare	160,953	162,069	0	0	0	162,069
Medicaid	515,844	527,482	0	0	0	527,482
Subtotal, M / M	*676,797*	*689,551*	*0*	*0*	*0*	*689,551*
Private Insurance	90,151	90,151	0	0	0	90,151
Subtotal, M / M / PI	*766,948*	*779,702*	*0*	*0*	*0*	*779,702*
Quarters	6,288	6,288	0	0	0	6,288
TOTAL, COLLECTIONS	773,236	785,990	0	0	0	785,990
Spec.Diabetes Prog for Indians	150,000	150,000	0	0	0	150,000
TOTAL, SDPI	150,000	150,000	0	0	0	150,000
TOTAL, Program Level	4,103,333	4,282,169	(56,319)	25,000	10,000	4,260,852

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Sub Sub Activity	2007 Enacted Budget Authority	2007 Enacted Private Insurance Collections	2007 Enacted Medicare/ Medicaid	2007 Enacted Personnel Quarters	2007 Enacted Total Program Level	2008 Enacted Budget Authority	2008 Enacted Private Insurance Collections	2008 Enacted Medicare/ Medicaid	2008 Enacted Personnel Quarters	2008 Enacted Total Program Level
SERVICES:										
Hospitals & Health Clinics	1,411,336	90,151	676,797 [2/]	0	2,178,284	1,484,016	90,151	689,551 [2/]	0	2,263,718
Dental Health	125,396	0	0	0	125,396	133,637	0	0	0	133,637
Mental Health	60,882	0	0	0	60,882	63,531	0	0	0	63,531
Alcohol & Substance Abuse	148,226	0	0	0	148,226	173,243	0	0	0	173,243
Contract Health Services	543,099	0	0	0	543,099	579,334	0	0	0	579,334
Total, Clinical Services	2,288,939	90,151	676,797	0	3,055,887	2,433,761	90,151	689,551	0	3,213,463
Public Health Nursing	52,445	0	0	0	52,445	55,938	0	0	0	55,938
Health Education	14,287	0	0	0	14,287	14,991	0	0	0	14,991
Comm. Health Reps.	54,891	0	0	0	54,891	54,925	0	0	0	54,925
Immunization AK	1,681	0	0	0	1,681	1,733	0	0	0	1,733
Total, Preventive Health	123,304	0	0	0	123,304	127,587	0	0	0	127,587
Urban Health	33,691	0	0	0	33,691	34,547	0	0	0	34,547
Indian Health Professions	31,375	0	0	0	31,375	36,291	0	0	0	36,291
Tribal Management	2,438	0	0	0	2,438	2,490	0	0	0	2,490
Direct Operations	63,631	0	0	0	63,631	63,624	0	0	0	63,624
Self-Governance	5,763	0	0	0	5,763	5,835	0	0	0	5,835
Contract Support Costs	269,730	0	0	0	269,730	267,398	0	0	0	267,398
TOTAL, SERVICES	2,818,871	90,151	676,797	0	3,585,819	2,971,533	90,151	689,551	0	3,751,235
FACILITIES:										
Maintenance & Improvement	54,668	0	0	6,288	60,956	52,889	0	0	6,288	59,177
Sanitation Facilities Construction	94,003	0	0	0	94,003	94,253	0	0	0	94,253
Health Care Facs. Constr.	25,664	0	0	0	25,664	36,584	0	0	0	36,584
Facil. & Envir. Health Support	165,272	0	0	0	165,272	169,638	0	0	0	169,638
Equipment	21,619	0	0	0	21,619	21,282	0	0	0	21,282
TOTAL, FACILITIES	361,226	0	0	6,288	367,514	374,646	0	0	6,288	380,934
TOTAL, IHS	3,180,097	90,151	676,797	6,288	3,953,333	3,346,179	90,151	689,551	6,288	4,132,169
Special Diabetes Program for Indians [1/]	150,000	0	0	0	150,000	150,000	0	0	0	150,000
GRAND TOTAL	3,330,097	90,151	676,797	6,288	4,103,333	3,496,179	90,151	689,551	6,288	4,282,169

[1/] The Special Diabetes Program for Indians is reauthorized for a total of $150,000,000 in FY 2009.

[2/] Includes $29,203,000 in Medicaid/Medicare for CMS estimates of tribal collections as well as $109,266,000 for tribal direct collection estimates, which began in FY 2002.

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Sub Sub Activity	2009 Request					Increase/Decrease of 2009 Over 2008				
	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	1,521,934	90,151	689,551 [2/]	0	2,301,636	37,918	0	0	0	37,918
Dental Health	137,944	0	0	0	137,944	4,307	0	0	0	4,307
Mental Health	65,824	0	0	0	65,824	2,293	0	0	0	2,293
Alcohol & Substance Abuse	161,988	0	0	0	161,988	(11,255)	0	0	0	(11,255)
Contract Health Services	588,161	0	0	0	588,161	8,827	0	0	0	8,827
Total, Clinical Services	2,475,851	90,151	689,551	0	3,255,553	42,090	0	0	0	42,090
Public Health Nursing	58,307	0	0	0	58,307	2,369	0	0	0	2,369
Health Education	15,229	0	0	0	15,229	238	0	0	0	238
Comm. Health Reps.	55,795	0	0	0	55,795	870	0	0	0	870
Immunization AK	1,760	0	0	0	1,760	27	0	0	0	27
Total, Preventive Health	131,091	0	0	0	131,091	3,504	0	0	0	3,504
Urban Health	0	0	0	0	0	(34,547)	0	0	0	(34,547)
Indian Health Professions	21,866	0	0	0	21,866	(14,425)	0	0	0	(14,425)
Tribal Management	2,529	0	0	0	2,529	39	0	0	0	39
Direct Operations	62,632	0	0	0	62,632	(992)	0	0	0	(992)
Self-Governance	5,928	0	0	0	5,928	93	0	0	0	93
Contract Support Costs	271,636	0	0	0	271,636	4,238	0	0	0	4,238
Total, Other Services	364,591	0	0	0	364,591	(45,594)	0	0	0	(45,594)
TOTAL, SERVICES	2,971,533	90,151	689,551	0	3,751,235	0	0	0	0	0
FACILITIES:										
Maintenance & Improvement	52,889	0	0	6,288	59,177	0	0	0	0	0
Sanitation Facilities Construction	94,253	0	0	0	94,253	0	0	0	0	0
Health Care Facs. Constr.	15,800	0	0	0	15,800	(20,784)	0	0	0	(20,784)
Facil. & Envir. Health Support	169,105	0	0	0	169,105	(533)	0	0	0	(533)
Equipment	21,282	0	0	0	21,282	0	0	0	0	0
TOTAL, FACILITIES	353,329	0	0	6,288	359,617	(21,317)	0	0	0	(21,317)
TOTAL, IHS	3,324,862	90,151	689,551	6,288	4,110,852	(21,317)	0	0	0	(21,317)
Special Diabetes Program for Indians [1/]	150,000	0	0	0	150,000	0	0	0	0	0
GRAND TOTAL	3,474,862	90,151	689,551	6,288	4,260,852	(21,317)	0	0	0	(21,317)

[1/] The Special Diabetes Program for Indians is reauthorized for a total of $150,000,000 in FY 2009.

[2/] Includes $29,203,000 in Medicaid/Medicare for CMS estimates of tribal collections as well as $109,266,000 for tribal direct collection estimates, which began in FY 2002.

INDIAN HEALTH SERVICE
STAFFING AND OPERATING COSTS FOR NEW / EXPANDED FACILITIES
FY 2009 Requirements
(Dollars in Thousands)

Jan 9, 2008

Opening Date:	Joint Venture [2]		Lawton, OK Outpatient Expansion January 2007		PIMC SW Ambulatory Center October 2008		TOTAL	
Sub Sub Activity	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount
Hospitals & Health Clinics		$4,044	78	$7,732	74	$6,091	152	$17,867
Dental Health			8	789	16	1,400	24	2,189
Mental Health			3	380	11	906	14	1,286
Total, Clinical Services	0	$4,044	89	$8,901	101	$8,397	190	$21,342
Public Health Nursing			6	732	7	750	13	1,482
Total, Preventive Health	0	0	6	732	7	750	13	1,482
Total, Services	0	$4,044	95	$9,633	108	$9,147	203	$22,824
Facilities Support [1]			7	1,241	6	935	13	2,176
Sub-total, FEHS	0	0	7	1,241	6	935	13	2,176
Total, Facilities	0	$0	7	$1,241	6	$935	13	$2,176
Grand Total	**0**	**$4,044**	**102**	**$10,874**	**114**	**$10,082**	**216**	**$25,000**

[1] Includes utilities

[2] There are a number of Joint Venture projects in progress; priority will be given to a project completed during FY 2009

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

Sub Activity	Federal Health Administration								Tribal Health Administration								
	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	FY 2007 Enacted
SERVICES																	
Hospitals & Health Clinics	740,821	0	0	0	0	0	0	740,821	670,515	0	0	0	0	0	0	670,515	1,411,336
Dental Health	75,187	0	0	0	0	0	0	75,187	50,209	0	0	0	0	0	0	50,209	125,396
Mental Health	32,120	0	0	0	0	0	0	32,120	28,762	0	0	0	0	0	0	28,762	60,882
Alcohol & Substance Abuse	22,135	0	0	0	0	0	0	22,135	126,091	0	0	0	0	0	0	126,091	148,226
Contract Health Services	263,364	0	0	0	0	0	0	263,364	279,735	0	0	0	0	0	0	279,735	543,099
Subtotal (CS)	1,133,627	0	0	0	0	0	0	1,133,627	1,155,312	0	0	0	0	0	0	1,155,312	2,288,939
Public Health Nursing	0	0	30,321	0	0	0	0	30,321	0	22,124	0	0	0	0	0	22,124	52,445
Health Education	0	0	3,921	0	0	0	0	3,921	0	10,366	0	0	0	0	0	10,366	14,287
Community Health Repr.	0	0	1,000	0	0	0	0	1,000	0	53,891	0	0	0	0	0	53,891	54,891
Immunization AK	0	0	0	0	0	0	0	0	0	1,681	0	0	0	0	0	1,681	1,681
Subtotal (PH)	0	0	35,242	0	0	0	0	35,242	0	88,062	0	0	0	0	0	88,062	123,304
Urban Health Project	0	6,602	0	0	0	0	0	6,602	0	0	27,089	0	0	0	0	27,089	33,691
Indian Health Professions	0	0	0	31,375	0	0	0	31,375	0	0	0	0	0	0	0	0	31,375
Tribal Management	0	0	0	55	0	0	0	55	0	0	0	2,383	0	0	0	2,383	2,438
Direct Operations	0	0	0	0	47,298	0	0	47,298	0	0	0	16,333	0	0	0	16,333	63,631
Self-Governance	0	0	0	0	0	3,872	0	3,872	0	0	0	0	1,891	0	0	1,891	5,763
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	269,730	0	269,730	269,730
Subtotal (OS)	0	6,602	0	31,430	47,298	3,872	0	89,201	0	0	27,089	18,716	1,891	269,730	0	317,427	406,628
Total, Services	1,133,627	6,602	35,242	31,430	47,298	3,872	0	1,258,070	1,155,312	88,062	27,089	18,716	1,891	269,730	0	1,560,801	2,818,871
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	29,533	29,533	0	0	0	0	0	0	25,135	25,135	54,668
Sanitation Facilities Constr.	0	0	0	0	0	0	32,901	32,901	0	0	0	0	0	0	61,102	61,102	94,003
Health Care Facs. Constr.	0	0	0	0	0	0	2,000	2,000	0	0	0	0	0	0	23,664	23,664	25,664
Facs. & Env. Health Sup	0	0	0	0	0	0	118,166	118,166	0	0	0	0	0	0	47,106	47,106	165,272
Equipment	0	0	0	0	0	0	8,661	8,661	0	0	0	0	0	0	12,958	12,958	21,619
Total, Facilities	0	0	0	0	0	0	191,262	191,261	0	0	0	0	0	0	169,965	169,965	361,226
TOTAL, IHS	1,133,627	6,602	35,242	31,430	47,298	3,872	191,262	1,449,331	1,155,312	88,062	27,089	18,716	1,891	269,730	169,965	1,730,766	3,180,097

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

	Federal Health Administration								Tribal Health Administration								
Sub Activity	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	FY 2008 Enacted
SERVICES																	
Hospitals & Health Clinics	769,432	0	0	0	0	0	0	769,432	714,584	0	0	0	0	0	0	714,584	1,484,016
Dental Health	77,696	0	0	0	0	0	0	77,696	55,941	0	0	0	0	0	0	55,941	133,637
Mental Health	32,747	0	0	0	0	0	0	32,747	30,784	0	0	0	0	0	0	30,784	63,531
Alcohol & Substance Abuse	26,804	0	0	0	0	0	0	26,804	146,439	0	0	0	0	0	0	146,439	173,243
Contract Health Services	276,441	0	0	0	0	0	0	276,441	302,893	0	0	0	0	0	0	302,893	579,334
Subtotal (CS)	1,183,120	0	0	0	0	0	0	1,183,120	1,250,641	0	0	0	0	0	0	1,250,641	2,433,761
Public Health Nursing	0	0	31,294	0	0	0	0	31,294	0	24,644	0	0	0	0	0	24,644	55,938
Health Education	0	0	3,905	0	0	0	0	3,905	0	11,086	0	0	0	0	0	11,086	14,991
Community Health Repr.	0	0	190	0	0	0	0	190	0	54,735	0	0	0	0	0	54,735	54,925
Immunization AK	0	0	0	0	0	0	0	0	0	1,733	0	0	0	0	0	1,733	1,733
Subtotal (PH)	0	0	35,389	0	0	0	0	35,389	0	92,198	0	0	0	0	0	92,198	127,587
Urban Health Project	0	6,344	0	0	0	0	0	6,344	0	0	28,203	0	0	0	0	28,203	34,547
Indian Health Professions	0	0	0	36,291	0	0	0	36,291	0	0	0	0	0	0	0	0	36,291
Tribal Management	0	0	0	19	0	0	0	19	0	0	0	2,471	0	0	0	2,471	2,490
Direct Operations	0	0	0	0	47,040	0	0	47,040	0	0	0	16,584	0	0	0	16,584	63,624
Self-Governance	0	0	0	0	0	3,897	0	3,897	0	0	0	0	1,938	0	0	1,938	5,835
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	267,398	0	267,398	267,398
Subtotal (OS)	0	6,344	0	36,310	47,040	3,897	0	93,592	0	0	28,203	19,055	1,938	267,398	0	316,593	410,185
Total, Services	1,183,120	6,344	35,389	36,310	47,040	3,897	0	1,312,100	1,250,641	92,198	28,203	19,055	1,938	267,398	0	1,659,433	2,971,533
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	29,011	29,011	0	0	0	0	0	0	23,878	23,878	52,889
Sanitation Facilities Constr.	0	0	0	0	0	0	32,989	32,989	0	0	0	0	0	0	61,264	61,264	94,253
Health Care Facs. Constr.	0	0	0	0	0	0	2,208	2,208	0	0	0	0	0	0	34,376	34,376	36,584
Facs. & Env. Health Sup	0	0	0	0	0	0	120,517	120,517	0	0	0	0	0	0	49,121	49,121	169,638
Equipment	0	0	0	0	0	0	8,533	8,533	0	0	0	0	0	0	12,749	12,749	21,282
Total, Facilities	0	0	0	0	0	0	193,259	193,258	0	0	0	0	0	0	181,388	181,388	374,646
TOTAL, IHS	1,183,120	6,344	35,389	36,310	47,040	3,897	193,259	1,505,358	1,250,641	92,198	28,203	19,055	1,938	267,398	181,388	1,840,821	3,346,179

FY 2009 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

	Federal Health Administration								Tribal Health Administration								
Sub Activity	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	FY 2009 Estimate
SERVICES																	
Hospitals & Health Clinics	797,826	0	0	0	0	0	0	797,826	724,108	0	0	0	0	0	0	724,108	1,521,934
Dental Health	81,156	0	0	0	0	0	0	81,156	56,788	0	0	0	0	0	0	56,788	137,944
Mental Health	34,565	0	0	0	0	0	0	34,565	31,259	0	0	0	0	0	0	31,259	65,824
Alcohol & Substance Abuse	25,127	0	0	0	0	0	0	25,127	136,861	0	0	0	0	0	0	136,861	161,988
Contract Health Services	280,722	0	0	0	0	0	0	280,722	307,439	0	0	0	0	0	0	307,439	588,161
Subtotal (CS)	1,219,395	0	0	0	0	0	0	1,219,395	1,256,456	0	0	0	0	0	0	1,256,456	2,475,851
Public Health Nursing	0	0	33,289	0	0	0	0	33,289	0	25,018	0	0	0	0	0	25,018	58,307
Health Education	0	0	3,970	0	0	0	0	3,970	0	11,259	0	0	0	0	0	11,259	15,229
Community Health Repr.	0	0	206	0	0	0	0	206	0	55,589	0	0	0	0	0	55,589	55,795
Immunization AK	0	0	0	0	0	0	0	0	0	1,760	0	0	0	0	0	1,760	1,760
Subtotal (PH)	0	0	37,465	0	0	0	0	37,465	0	93,626	0	0	0	0	0	93,626	131,091
Urban Health Project	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Indian Health Professions	0	0	0	21,866	0	0	0	21,866	0	0	0	0	0	0	0	0	21,866
Tribal Management	0	0	0	20	0	0	0	20	0	0	0	2,509	0	0	0	2,509	2,529
Direct Operations	0	0	0	0	46,303	0	0	46,303	0	0	0	16,329	0	0	0	16,329	62,632
Self-Governance	0	0	0	0	0	3,960	0	3,960	0	0	0	0	1,968	0	0	1,968	5,928
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	271,636	0	271,636	271,636
Subtotal (OS)	0	0	0	21,886	46,303	3,960	0	72,149	0	0	0	18,838	1,968	271,636	0	292,442	364,591
Total, Services	1,219,395	0	37,465	21,886	46,303	3,960	0	1,329,008	1,256,456	93,626	0	18,838	1,968	271,636	0	1,642,525	2,971,533
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	29,011	29,011	0	0	0	0	0	0	23,878	23,878	52,889
Sanitation Facilities Constr.	0	0	0	0	0	0	32,989	32,989	0	0	0	0	0	0	61,264	61,264	94,253
Health Care Facs. Constr.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15,800	15,800	15,800
Facs. & Env. Health Sup	0	0	0	0	0	0	120,756	120,756	0	0	0	0	0	0	48,349	48,349	169,105
Equipment	0	0	0	0	0	0	8,533	8,533	0	0	0	0	0	0	12,749	12,749	21,282
Total, Facilities	0	0	0	0	0	0	191,290	191,289	0	0	0	0	0	0	162,040	162,040	353,329
TOTAL, IHS	1,219,395	0	37,465	21,886	46,303	3,960	191,290	1,520,298	1,256,456	93,626	0	18,838	1,968	271,636	162,040	1,804,565	3,324,862

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, ~~$3,018,624,000~~ *$2,971,533,000*, together with payments received during the fiscal year pursuant to 42 U.S.C. 238(b) *and 238b* [1] 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 ~~$588,515,000~~ *$588,161,000* for contract medical care, including ~~$27,000,000~~ *$25,000,000* for the Indian Catastrophic Health Emergency Fund, shall remain available until expended: ~~*Provided further*, That no less than $35,094,000 is provided for maintaining operations of the urban Indian health program:~~ [2] *Provided further*, That of the funds provided, up to ~~$32,000,000,~~*$18,000,000* 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 [$14,000,000] *$0* is provided for a methamphetamine and suicide prevention and treatment initiative,[of which up to $5,000,000 may be used for mental health, suicide prevention, and behavioral issues associated with methamphetamine use]: *Provided further*, That notwithstanding any other provision of law, these funds shall be allocated outside all other distribution methods and formulas at the discretion of the Director of the Indian Health Service and shall remain available until expended:~~ [3] *Provided further*, That funds provided in this Act may be used for one-year contracts and grants which are to be performed in two fiscal years, so long as the total obligation is recorded in the year for which the funds are appropriated: *Provided further*, That the amounts collected by the

Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act shall remain available until expended for the purpose of achieving compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act (exclusive of planning, design, or construction of new facilities): *Provided further*, That funding contained herein, and in any earlier appropriations Acts for scholarship programs under the Indian Health Care Improvement Act (25 U.S.C. 1613) shall remain available until expended: *Provided further*, That amounts received by tribes and tribal organizations under title IV of the Indian Health Care Improvement Act shall be reported and accounted for and available to the receiving tribes and tribal organizations until expended: *Provided further*, That, notwithstanding any other provision of law, of the amounts provided herein, not to exceed ~~$267,398,000~~*$271,636,000* shall be for payments to tribes and tribal organizations for contract or grant support costs associated with contracts, grants, self-governance compacts or annual funding agreements between the Indian Health Service and a tribe or tribal organization pursuant to the Indian Self-Determination Act of 1975, as amended, prior to or during fiscal year ~~2008~~*2009*, of which not to exceed $5,000,000 may be used for contract support costs associated with new or expanded self-determination contracts, grants, self-governance compacts or annual funding agreements: *Provided further*, That the Bureau of Indian Affairs may collect from the Indian Health Service and tribes and tribal organizations operating health facilities pursuant to Public Law 93-638 such individually identifiable health information relating to disabled children as may be necessary for the purpose of carrying out its functions under the Individuals with Disabilities Education Act, (20 U.S.C. 1400, et seq.): *Provided further*, That funds available for the Indian Health Care Improvement Fund may be used, as needed, to carry out activities typically funded under the Indian Health Facilities account. (Department of the Interior, Environment, and Related Agencies Appropriations Act, 2008.)

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, ~~$380,583,000~~*$353,329,000* to remain available until expended: *Provided*, That notwithstanding any other provision of law, funds appropriated for the planning, design, construction or renovation of health facilities for the benefit of ~~an~~ *a federally-recognized* [4] Indian tribe or tribes may be used to purchase land for sites to construct, improve, or enlarge health or related facilities: *Provided further*, That not to exceed $500,000 shall be used by the Indian Health Service to purchase TRANSAM equipment from the Department of Defense for distribution to the Indian Health Service and tribal facilities: *Provided further*, That none of the funds appropriated to the Indian Health Service may be used for sanitation facilities construction for new homes funded with grants by the housing programs of the United States Department of Housing and Urban Development: *Provided further*, That not to exceed $1,000,000 from this account and the ``Indian Health Services'' account shall be used by the Indian Health Service to obtain ambulances for the Indian Health Service and tribal facilities in conjunction with an existing interagency agreement between the Indian Health Service and the General Services Administration: *Provided further*, That not to exceed $500,000 shall be placed in a Demolition Fund, available until expended, to be used by the Indian Health Service for demolition of Federal buildings. (Department of the Interior, Environment, and Related Agencies Appropriations Act, 2008.)

ADMINISTRATIVE PROVISIONS, INDIAN HEALTH SERVICE

Appropriations in this Act to the Indian Health Service shall be available for services as authorized by 5 U.S.C. 3109 but at rates not to exceed the per diem rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. 5376; hire of passenger motor vehicles and aircraft; purchase of medical equipment; purchase of reprints; purchase, renovation and erection of modular buildings and renovation of existing facilities; payments for telephone service in private residences in the field, when

authorized under regulations approved by the Secretary; and for uniforms or allowances therefor as authorized by 5 U.S.C. 5901-5902; and for expenses of attendance at meetings which are concerned with the functions or activities for which the appropriation is made or which will contribute to improved conduct, supervision, or management of those functions or activities.

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

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

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

~~None of the funds made available to the Indian Health Service in this Act shall be used for any assessments or charges by the Department of Health and Human Services unless identified in the budget justification and provided in this Act, or approved by the House and Senate Committees on Appropriations through the reprogramming process.~~ [5]

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

None of the funds made available to the Indian Health Service in this Act shall be used to implement the final rule published in the Federal Register on September 16, 1987,

by the Department of Health and Human Services, relating to the eligibility for the health care services of the Indian Health Service until the Indian Health Service has submitted a budget request reflecting the increased costs associated with the proposed final rule, and such request has been included in an appropriations Act and enacted into law.

With respect to functions transferred by the Indian Health Service to tribes or tribal organizations, the Indian Health Service is authorized to provide goods and services to those entities, on a reimbursable basis, including payment in advance with subsequent adjustment. The reimbursements received therefrom, along with the funds received from those entities pursuant to the Indian Self-Determination Act, may be credited to the same or subsequent appropriation account that provided the funding, 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. (Department of the Interior, Environment, and Related Agencies Appropriations Act, 2008.)

GENERAL PROVISIONS

SEC. 409. 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*) [6] 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 ~~2007~~ *2008* for such purposes, except that for the Bureau of Indian Affairs, *Federally recognized* [7] 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.

~~SEC. 418. (a) Notwithstanding any other provision of law and until October 1, 2009, the Indian Health Service may not disburse funds for the provision of health care services pursuant to Public Law 93-638 (25 U.S.C. 450 et seq.) to any Alaska Native village or Alaska Native village corporation that is located within the area served by an Alaska Native regional health entity.~~

~~(b) Nothing in this section shall be construed to prohibit the disbursal of funds to any Alaska Native village or Alaska Native village corporation under any contract or compact entered into prior to May 1, 2006, or to prohibit the renewal of any such agreement.~~

~~(c) For the purpose of this section, Eastern Aleutian Tribes, Inc. and the Council of Athabascan Tribal Governments shall be treated as Alaska Native regional health entities to which funds may be disbursed under this section.~~ [8]

Language Analysis

Language Provision	Explanation
SERVICES	
[1] 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, ~~$3,018,624,000~~ *$2,971,533,000*, together with payments received during the fiscal year pursuant to 42 U.S.C. 238(b) *and 238b*	This is added to make language more accurate by correcting a previous omission.
[2] ~~*Provided further*, That no less than $35,094,000 is provided for maintaining operations of the urban Indian health program:~~	Language is not needed because program has not been proposed for funding in FY 2009.
[3] ~~*Provided further*, That [$14,000,000] *$0* is provided for a methamphetamine and suicide prevention and treatment initiative,[of which up to $5,000,000 may be used for mental health, suicide prevention, and behavioral issues associated with methamphetamine use]: *Provided further*, That notwithstanding any other provision of law, these funds shall be allocated outside all other distribution methods and formulas at the discretion of the Director of the Indian Health Service and shall remain available until expended:~~	Language is not needed because program has not been proposed for funding in FY 2009.
FACILITIES	
[4] *Provided*, That notwithstanding any other provision of law, funds appropriated for the planning, design, construction or renovation of health facilities for the benefit of ~~an~~ *a federally-recognized* Indian tribe or tribes may be used to purchase land for sites to construct, improve, or enlarge health or related facilities:	Added to make language more accurate in clarifying which tribes are eligible for IHS services.
ADMINISTRATIVE PROVISIONS	
[5] ~~None of the funds made available to the Indian Health Service in this Act shall be used for any assessments or charges by the Department of Health and Human Services unless identified in the budget justification and provided in this Act, or approved by the House and Senate Committees on Appropriations through the reprogramming process.~~	Language restricts Department's flexibility in managing overall resources for the Agency.

GENERAL PROVISIONS	
[6, 7] SEC. 409. 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*) [6] 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 2007 for such purposes, except that for the Bureau of Indian Affairs, *Federally recognized* [7] 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 2008) to the funds available in law and accompanying the report language in those years for the Bureau of Indian Affairs and Indian Health Service. Added to make language more accurate in clarifying which tribes are eligible for IHS services.
[8] ~~SEC. 418. (a) Notwithstanding any other provision of law and until October 1, 2009, the Indian Health Service may not disburse funds for the provision of health care services pursuant to Public Law 93-638 (25 U.S.C. 450 et seq.) to any Alaska Native village or Alaska Native village corporation that is located within the area served by an Alaska Native regional health entity.~~ ~~(b) Nothing in this section shall be construed to prohibit the disbursal of funds to any Alaska Native village or Alaska Native village corporation under any contract or compact entered into prior to May 1, 2006, or to prohibit the renewal of any such agreement.~~ ~~(c) For the purpose of this section, Eastern Aleutian Tribes, Inc. and the Council of Athabascan Tribal Governments shall be treated as Alaska Native regional health entities to which funds may be disbursed under this section.~~	Language restricts Tribal self-determination.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
SERVICES

Amounts Available for Obligations

	FY 2007	FY 2008	FY 2009
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$2,826,222,000	$3,018,624,000	$2,971,533,000
Across-the-board reductions (Interior)	$0	($47,091,000)	$0
Subtotal, Appropriation (Interior)	$2,826,222,000	$2,971,533,000	$2,971,533,000
Supplemental (PL 110-28)	($7,300,000)	$0	$0
Subtotal, adjusted appropriation	$2,818,922,000	$2,971,533,000	$2,971,533,000
Mandatory Appropriation:			
Appropriation	$150,000,000	$150,000,000	$150,000,000
Offsetting Collections:			
Federal sources	$461,000,000	$456,000,000	$456,000,000
Non-federal sources	$506,000,000	$506,000,000	$506,000,000
Subtotal	$967,000,000	$962,000,000	$962,000,000
Unobligated Balance, Start of Year	182,000,000	182,000,000	182,000,000
Unobligated Balance End of Year	182,000,000	182,000,000	182,000,000
Total Obligations	$3,935,922,000	$3,933,533,000	$3,933,533,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FACILITIES

Amounts Available for Obligations

	FY 2007	FY 2008	FY 2009
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$353,926,000	$380,583,000	$353,329,000
Across-the-board reductions (Interior)	$0	($5,937,000)	$0
Subtotal, Appropriation (Interior)	$353,926,000	$374,646,000	$353,329,000
Supplemental (PL 110-28)	$7,300,000	$0	$0
Subtotal, adjusted appropriation	$361,226,000	$374,646,000	$353,329,000
Offsetting Collections:			
Federal sources	$1,000,000	$1,000,000	$1,000,000
Subtotal	$1,000,000	$1,000,000	$1,000,000
Unobligated Balance, Start of Year	250,000,000	247,000,000	247,000,000
Unobligated Balance End of Year	247,000,000	247,000,000	247,000,000
Total Obligations	$365,226,000	$375,646,000	$354,329,000

INDIAN HEALTH SERVICE
SERVICES
Summary of Changes

FY 2008	$2,971,533,000
Total estimated budget authority	2,971,533,000
Less Obligations	(2,971,533,000)
FY 2009 President's Budget	2,971,533,000
Less Obligations	(2,971,533,000)
Net Change	0
Less Obligations	0

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$4,239,000
2 FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	17,686,000
3 Tribal Pay Cost	--	n/a	--	21,850,000
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	(2,989,000)
6 Increased Cost of Travel	--	35,867,000	--	1,055,000
7 Increased Cost of Transportation & Things	--	8,630,000	--	184,000
8 Increased Cost of Printing	--	678,000	--	18,000
9 Increased Cost of Rents, Communications, & Utilties	--	25,744,000	--	453,000
10 Increased Cost of Health Care Provided under Contracts & Grants	--	417,585,000	--	14,815,000
11 Increased Cost of Supplies	--	98,243,000	--	3,306,000
12 Increased Cost of Medical or other Equipment	--	11,602,000	--	580,000
13 Increased Cost of Land & Structure	--	115,000	--	0
14 Increased Cost of Grants	--	1,715,057,000	--	33,884,000
15 Increased Cost of Insurance / Indemnities	--	305,000	--	14,000
16 Increased Cost of Interest / Dividends	--	110,000	--	2,000
17 Population Growth	--	n/a	--	38,827,000
Subtotal, Built-In	--	2,313,936,000	--	133,924,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	n/a	203	22,824,000
C. Base Adjustment:	--	0	--	16,146,000
D. Indian Health Care Improvement Fund	--	0	--	10,000,000
TOTAL INCREASES	--	2,313,936,000	203	182,894,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(133,922,000)
B. Program Decreases:	--	0	--	(48,972,000)
TOTAL DECREASES	--	0	--	(182,894,000)
NET CHANGE	--	**$2,313,936,000**	--	**$0**

INDIAN HEALTH SERVICE
Clinical Services
Summary of Changes

FY 2008	$2,433,762,000
Total estimated budget authority	2,433,762,000
Less Obligations	(2,433,762,000)
FY 2009 President's Budget	2,475,851,000
Less Obligations	(2,475,851,000)
Net Change	42,089,000
Less Obligations	(42,089,000)

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$3,853,000
2 FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	16,039,000
3 Tribal Pay Cost	--	n/a	--	18,981,000
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	(2,705,000)
6 Increased Cost of Travel	--	33,455,000	--	1,009,000
7 Increased Cost of Transportation & Things	--	7,438,000	--	159,000
8 Increased Cost of Printing	--	589,000	--	16,000
9 Increased Cost of Rents, Communications, & Utilties	--	25,297,000	--	443,000
10 Increased Cost of Health Care Provided under Contracts & Grants	--	408,249,000	--	14,539,000
11 Increased Cost of Supplies	--	95,400,000	--	3,240,000
12 Increased Cost of Medical or other Equipment	--	10,133,000	--	558,000
13 Increased Cost of Land & Structure	--	115,000	--	0
14 Increased Cost of Grants	--	1,272,594,000	--	25,467,000
15 Increased Cost of Insurance / Indemnities	--	217,000	--	14,000
16 Increased Cost of Interest / Dividends	--	110,000	--	2,000
17 Population Growth	--	0	--	36,378,000
Subtotal, Built-In	--	1,853,597,000	--	117,993,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	190	21,342,000
C. Base Adjustment:	--	0	0	10,748,000
D. Indian Health Care Improvement Fund	--	0	0	10,000,000
TOTAL INCREASES	--	1,853,597,000	190	160,083,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(117,994,000)
TOTAL DECREASES	--	0	--	(117,994,000)
NET CHANGE	--	**$1,853,597,000**	--	**$42,089,000**

INDIAN HEALTH SERVICE
Hospitals & Health Clinics
Summary of Changes

FY 2008	$1,484,017,000
Total estimated budget authority	1,484,017,000
Less Obligations	(1,484,017,000)
FY 2009 President's Budget	1,521,934,000
Less Obligations	(1,521,934,000)
Net Change	37,917,000
Less Obligations	(37,917,000)

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$3,337,000
2 FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	13,896,000
3 Tribal Pay Cost	--	n/a	--	14,516,000
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	(2,345,000)
6 Increased Cost of Travel	--	8,288,000	--	168,000
7 Increased Cost of Transportation & Things	--	6,390,000	--	136,000
8 Increased Cost of Printing	--	581,000	--	16,000
9 Increased Cost of Rents, Communications, & Utilties	--	24,791,000	--	435,000
10 Increased Cost of Health Care Provided under Contracts & Grants	--	137,415,000	--	4,091,000
11 Increased Cost of Supplies	--	81,674,000	--	2,513,000
12 Increased Cost of Medical or other Equipment	--	8,298,000	--	398,000
13 Increased Cost of Land & Structure	--	115,000	--	0
14 Increased Cost of Grants	--	735,034,000	--	11,326,000
15 Increased Cost of Insurance / Indemnities	--	206,000	--	3,000
16 Increased Cost of Interest / Dividends	--	39,000	--	1,000
17 Population Growth	--	n/a	--	22,403,000
Subtotal, Built-In	--	1,002,831,000	--	70,894,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	216	17,867,000
C. Base adjustment:	--	0	0	10,051,000
D. Indian Health Care Improvement Fund	--	13,782,000	0	10,000,000
TOTAL INCREASES	--	1,016,613,000	216	108,812,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	(70,895,000)
TOTAL DECREASES	--	0	0	(70,895,000)
NET CHANGE	--	**$1,016,613,000**	**216**	**$37,917,000**

INDIAN HEALTH SERVICE
Dental Health
Summary of Changes

FY 2008	$133,637,000
Total estimated budget authority	133,637,000
Less Obligations	(133,637,000)
FY 2009 President's Budget	137,944,000
Less Obligations	(137,944,000)
Net Change	4,307,000
Less Obligations	(4,307,000)

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$329,000
2 FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	1,309,000
3 Tribal Pay Cost	--	n/a	--	1,079,000
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	(216,000)
6 Increased Cost of Travel	--	895,000	--	20,000
7 Increased Cost of Transportation & Things	--	415,000	--	12,000
8 Increased Cost of Printing	--	7,000	--	0
9 Increased Cost of Rents, Communications, & Utilties	--	51,000	--	1,000
10 Increased Cost of Health Care Provided under Contracts & Grants	--	8,187,000	--	314,000
11 Increased Cost of Supplies	--	4,327,000	--	257,000
12 Increased Cost of Medical or other Equipment	--	865,000	--	45,000
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	48,016,000	--	924,000
15 Increased Cost of Insurance / Indemnities	--	0	--	0
16 Increased Cost of Interest / Dividends	--	0	--	0
17 Population Growth	--	0	--	2,035,000
Subtotal, Built-In	--	62,763,000	--	6,109,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	24	2,189,000
C. Base Adjustment:	--	0	0	2,118,000
TOTAL INCREASES	--	62,763,000	24	10,416,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	(6,109,000)
TOTAL DECREASES	--	0	0	(6,109,000)
NET CHANGE	--	**$62,763,000**	**24**	**$4,307,000**

INDIAN HEALTH SERVICE
Mental Health
Summary of Changes

FY 2008	$63,531,000
Total estimated budget authority	63,531,000
Less Obligations	(63,531,000)
FY 2009 President's Budget	65,824,000
Less Obligations	(65,824,000)
Net Change	2,293,000
Less Obligations	(2,293,000)

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$127,000
2 FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	544,000
3 Tribal Pay Cost	--	n/a	--	622,000
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	(94,000)
6 Increased Cost of Travel	--	394,000	--	9,000
7 Increased Cost of Transportation & Things	--	403,000	--	8,000
8 Increased Cost of Printing	--	2,000	--	0
9 Increased Cost of Rents, Communications, & Utilties	--	61,000	--	1,000
10 Increased Cost of Health Care Provided under Contracts & Grants	--	4,228,000	--	209,000
11 Increased Cost of Supplies	--	2,039,000	--	55,000
12 Increased Cost of Medical or other Equipment	--	177,000	--	4,000
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	30,841,000	--	478,000
15 Increased Cost of Insurance / Indemnities	--	0	--	0
16 Increased Cost of Interest / Dividends	--	0	--	0
17 Population Growth	--	0	--	968,000
Subtotal, Built-In	--	38,145,000	--	2,931,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	14	1,286,000
C. Base Adjustment:	--	0	0	1,007,000
TOTAL INCREASES	--	38,145,000	14	5,224,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	(2,931,000)
TOTAL DECREASES	--	0	0	(2,931,000)
NET CHANGE	--	**$38,145,000**	**14**	**$2,293,000**

INDIAN HEALTH SERVICE
Alcohol & Substance Abuse
Summary of Changes

FY 2008	$173,243,000
Total estimated budget authority	173,243,000
Less Obligations	(173,243,000)
FY 2009 President's Budget	161,988,000
Less Obligations	(161,988,000)
Net Change	(11,255,000)
Less Obligations	11,255,000

		FY 2008 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$57,000
2	FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	266,000
3	Tribal Pay Cost	--	n/a	--	2,764,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	(46,000)
6	Increased Cost of Travel	--	351,000	--	6,000
7	Increased Cost of Transportation & Things	--	132,000	--	3,000
8	Increased Cost of Printing	--	2,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	303,000	--	6,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	6,715,000	--	252,000
11	Increased Cost of Supplies	--	688,000	--	24,000
12	Increased Cost of Medical or other Equipment	--	204,000	--	5,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	151,442,000	--	2,150,000
15	Increased Cost of Insurance / Indemnities	--	11,000	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	0	--	2,429,000
	Subtotal, Built-In	--	159,848,000	0	7,916,000
	TOTAL INCREASES	--	159,848,000	0	7,916,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	(7,916,000)
B. Base Adjustment:		--	0	0	(11,255,000)
	TOTAL DECREASES	--	0	0	(19,171,000)
NET CHANGE		--	**$159,848,000**	**0**	**($11,255,000)**

INDIAN HEALTH SERVICE
Contract Health Services
Summary of Changes

FY 2008	$579,334,000
Total estimated budget authority	579,334,000
Less Obligations	(579,334,000)
FY 2009 President's Budget	588,161,000
Less Obligations	(588,161,000)
Net Change	8,827,000
Less Obligations	(8,827,000)

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$3,000
2 FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	24,000
3 Tribal Pay Cost	--	n/a	--	0
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	(4,000)
6 Increased Cost of Travel	--	23,475,000	--	806,000
7 Increased Cost of Transportation & Things	--	3,000	--	0
8 Increased Cost of Printing	--	0	--	0
9 Increased Cost of Rents, Communications, & Utilties	--	92,000	--	0
10 Increased Cost of Health Care Provided under Contracts & Grants	--	251,754,000	--	9,673,000
11 Increased Cost of Supplies	--	4,910,000	--	391,000
12 Increased Cost of Medical or other Equipment	--	0	--	106,000
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	298,492,000	--	10,589,000
15 Increased Cost of Insurance / Indemnities	--	0	--	11,000
16 Increased Cost of Interest / Dividends	--	69,000	--	1,000
17 Population Growth	--	n/a	--	8,543,000
Subtotal, Built-In	--	578,795,000	--	30,143,000
B. Base Adjustment:	--	0	--	8,827,000
TOTAL INCREASES	--	578,795,000	--	38,970,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(30,143,000)
TOTAL DECREASES	--	0	--	(30,143,000)
NET CHANGE	--	**$578,795,000**	--	**$8,827,000**

INDIAN HEALTH SERVICE
Preventive Health
Summary of Changes

FY 2008	$127,587,000
Total estimated budget authority	127,587,000
Less Obligations	(127,587,000)
FY 2009 President's Budget	131,091,000
Less Obligations	(131,091,000)
Net Change	3,504,000
Less Obligations	(3,504,000)

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$141,000
2 FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	585,000
3 Tribal Pay Cost	--	n/a	--	1,918,000
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	(101,000)
6 Increased Cost of Travel	--	427,000	--	9,000
7 Increased Cost of Transportation & Things	--	850,000	--	20,000
8 Increased Cost of Printing	--	9,000	--	0
9 Increased Cost of Rents, Communications, & Utilties	--	71,000	--	1,000
10 Increased Cost of Health Care Provided under Contracts & Grants	--	3,075,000	--	126,000
11 Increased Cost of Supplies	--	1,741,000	--	46,000
12 Increased Cost of Medical or other Equipment	--	426,000	--	13,000
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	85,302,000	--	1,525,000
15 Increased Cost of Insurance / Indemnities	--	10,000	--	0
16 Increased Cost of Interest / Dividends	--	0	--	0
17 Population Growth	--	0	--	1,943,000
Subtotal, Built-In	--	91,911,000	0	6,226,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	13	1,482,000
C. Base Adjustment:	--	0	0	2,021,000
TOTAL INCREASES	--	91,911,000	13	9,729,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	(6,225,000)
TOTAL DECREASES	--	0	0	(6,225,000)
NET CHANGE	--	**$91,911,000**	**13**	**$3,504,000**

INDIAN HEALTH SERVICE
Public Health Nursing
Summary of Changes

FY 2008	$55,939,000
Total estimated budget authority	55,939,000
Less Obligations	(55,939,000)
FY 2009 President's Budget	58,307,000
Less Obligations	(58,307,000)
Net Change	2,368,000
Less Obligations	(2,368,000)

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$124,000
2 FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	518,000
3 Tribal Pay Cost	--	n/a	--	475,000
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	(89,000)
6 Increased Cost of Travel	--	331,000	--	6,000
7 Increased Cost of Transportation & Things	--	917,000	--	19,000
8 Increased Cost of Printing	--	17,000	--	0
9 Increased Cost of Rents, Communications, & Utilties	--	82,000	--	1,000
10 Increased Cost of Health Care Provided under Contracts & Grants	--	2,332,000	--	91,000
11 Increased Cost of Supplies	--	1,560,000	--	36,000
12 Increased Cost of Medical or other Equipment	--	505,000	--	6,000
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	25,512,000	--	424,000
15 Increased Cost of Insurance / Indemnities	--	11,000	--	0
16 Increased Cost of Interest / Dividends	--	0	--	0
17 Population Growth	--	0	--	852,000
Subtotal, Built-In	--	31,267,000	0	2,463,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	13	1,482,000
C. Base Adjustment:	--	0	0	886,000
TOTAL INCREASES	--	31,267,000	13	4,831,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	(2,463,000)
TOTAL DECREASES	--	0	0	(2,463,000)
NET CHANGE	--	**$31,267,000**	**13**	**$2,368,000**

INDIAN HEALTH SERVICE
Health Education
Summary of Changes

FY 2008	$14,991,000
Total estimated budget authority	14,991,000
Less Obligations	(14,991,000)
FY 2009 President's Budget	15,229,000
Less Obligations	(15,229,000)
Net Change	238,000
Less Obligations	(238,000)

		FY 2008 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$16,000
2	FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	62,000
3	Tribal Pay Cost	--	n/a	--	227,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	(11,000)
6	Increased Cost of Travel	--	111,000	--	2,000
7	Increased Cost of Transportation & Things	--	42,000	--	1,000
8	Increased Cost of Printing	--	11,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	21,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	195,000	--	18,000
11	Increased Cost of Supplies	--	709,000	--	9,000
12	Increased Cost of Medical or other Equipment	--	111,000	--	7,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	10,937,000	--	173,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	0	--	228,000
	Subtotal, Built-In	--	12,137,000	0	732,000
B. Base Adjustment:		--	0	0	238,000
	TOTAL INCREASES	--	12,137,000	0	970,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	0	(732,000)
				0	
	TOTAL DECREASES	--	0	--	(732,000)
NET CHANGE		--	**$12,137,000**	--	**$238,000**

INDIAN HEALTH SERVICE
Community Health Representatives
Summary of Changes

FY 2008	$54,925,000
Total estimated budget authority	54,925,000
Less Obligations	(54,925,000)
FY 2009 President's Budget	55,795,000
Less Obligations	(55,795,000)
Net Change	870,000
Less Obligations	(870,000)

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$1,000
2 FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	5,000
3 Tribal Pay Cost	--	n/a	--	1,179,000
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	(1,000)
6 Increased Cost of Travel	--	36,000	--	1,000
7 Increased Cost of Transportation & Things	--	7,000	--	0
8 Increased Cost of Printing	--	1,000	--	0
9 Increased Cost of Rents, Communications, & Utilties	--	12,000	--	0
10 Increased Cost of Health Care Provided under Contracts & Grants	--	516,000	--	17,000
11 Increased Cost of Supplies	--	43,000	--	1,000
12 Increased Cost of Medical or other Equipment	--	9,000	--	0
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	53,863,000	--	899,000
15 Increased Cost of Insurance / Indemnities	--	0	--	0
16 Increased Cost of Interest / Dividends	--	0	--	0
17 Population Growth	--	0	--	837,000
Subtotal, Built-In	--	54,487,000	0	2,939,000
C. Base Adjustment:	--	0	0	870,000
TOTAL INCREASES	--	54,487,000	0	3,809,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(2,939,000)
TOTAL DECREASES	--	0	--	(2,939,000)
NET CHANGE	--	**$54,487,000**	--	**$870,000**

INDIAN HEALTH SERVICE
Immunization AK
Summary of Changes

FY 2008	$1,733,000
Total estimated budget authority	1,733,000
Less Obligations	(1,733,000)
FY 2009 President's Budget	1,760,000
Less Obligations	(1,760,000)
Net Change	27,000
Less Obligations	(27,000)

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$0
2 FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	0
3 Tribal Pay Cost	--	n/a	--	37,000
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	0
6 Increased Cost of Travel	--	0	--	0
7 Increased Cost of Transportation & Things	--	0	--	0
8 Increased Cost of Printing	--	0	--	0
9 Increased Cost of Rents, Communications, & Utilties	--	0	--	0
10 Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
11 Increased Cost of Supplies	--	0	--	0
12 Increased Cost of Medical or other Equipment	--	0	--	0
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	1,733,000	--	29,000
15 Increased Cost of Insurance / Indemnities	--	0	--	0
16 Increased Cost of Interest / Dividends	--	0	--	0
17 Population Growth	--	0	--	26,000
Subtotal, Built-In	--	1,733,000	0	92,000
C. Base Adjustment:	--	0	0	27,000
TOTAL INCREASES	--	1,733,000	0	119,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	0	(92,000)
TOTAL DECREASES	--	0	0	(92,000)
NET CHANGE	--	**$1,733,000**	--	**$27,000**

INDIAN HEALTH SERVICE
Other
Summary of Changes

FY 2008	$410,184,000
Total estimated budget authority	410,184,000
Less Obligations	(410,184,000)
FY 2009 President's Budget	364,591,000
Less Obligations	(364,591,000)
Net Change	(45,593,000)
Less Obligations	45,593,000

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$245,000
2 FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	1,062,000
3 Tribal Pay Cost	--	n/a	--	951,000
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	(183,000)
6 Increased Cost of Travel	--	1,934,000	--	37,000
7 Increased Cost of Transportation & Things	--	226,000	--	5,000
8 Increased Cost of Printing	--	60,000	--	2,000
9 Increased Cost of Rents, Communications, & Utilties	--	332,000	--	9,000
10 Increased Cost of Health Care Provided under Contracts & Grants	--	6,293,000	--	150,000
11 Increased Cost of Supplies	--	531,000	--	20,000
12 Increased Cost of Medical or other Equipment	--	844,000	--	9,000
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	350,418,000	--	6,892,000
15 Increased Cost of Insurance / Indemnities	--	77,000	--	0
16 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	0	--	506,000
Subtotal, Built-In	--	360,715,000	--	9,705,000
B. Base Adjustment:	--	0	--	3,377,000
TOTAL INCREASES	--	360,715,000	--	13,082,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(9,703,000)
B. Program Decreases:	--	0	--	(48,972,000)
TOTAL DECREASES	--	0	--	(58,675,000)
NET CHANGE	--	**$360,715,000**	--	**($45,593,000)**

INDIAN HEALTH SERVICE
Urban Indian Health
Summary of Changes

FY 2008	$34,547,000
Total estimated budget authority	34,547,000
Less Obligations	0
FY 2009 President's Budget	0
Less Obligations	0
Net Change	(34,547,000)
Less Obligations	34,547,000

		FY 2008 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$8,000
2	FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	18,000
3	Tribal Pay Cost	--	n/a	--	604,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	(6,000)
6	Increased Cost of Travel	--	156,000	--	2,000
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	6,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	22,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	1,992,000	--	62,000
11	Increased Cost of Supplies	--	31,000	--	0
12	Increased Cost of Medical or other Equipment	--	243,000	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	30,090,000	--	445,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	0	--	506,000
	Subtotal, Built-In	--	32,540,000	--	1,639,000
	TOTAL INCREASES	--	32,540,000	--	1,639,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,639,000)
B. Program Decreases:					
	Urban Indian Health Program	--	0	--	(34,547,000)
	TOTAL DECREASES	--	0	--	(36,186,000)
NET CHANGE		--	**$32,540,000**	--	**($34,547,000)**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2008	$36,291,000
Total estimated budget authority	36,291,000
Less Obligations	(36,291,000)
FY 2009 President's Budget	21,866,000
Less Obligations	(21,866,000)
Net Change	(14,425,000)
Less Obligations	14,425,000

		FY 2008 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$9,000
2	FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	46,000
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	(8,000)
6	Increased Cost of Travel	--	20,000	--	2,000
7	Increased Cost of Transportation & Things	--	1,000	--	0
8	Increased Cost of Printing	--	31,000	--	1,000
9	Increased Cost of Rents, Communications, & Utilties	--	0	--	3,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	500,000	--	3,000
11	Increased Cost of Supplies	--	0	--	1,000
12	Increased Cost of Medical or other Equipment	--	7,000	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	33,806,000	--	588,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	0	--	0
	Subtotal, Built-In	--	34,365,000	--	645,000
	TOTAL INCREASES	--	34,365,000	0	645,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(645,000)
B. Program Decrease		--	0	--	(14,425,000)
	TOTAL DECREASES	--	0	--	(15,070,000)
NET CHANGE		--	**$34,365,000**	--	**($14,425,000)**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2008	$2,490,000
Total estimated budget authority	2,490,000
Less Obligations	(2,490,000)
FY 2009 President's Budget	2,529,000
Less Obligations	(2,529,000)
Net Change	39,000
Less Obligations	(39,000)

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$0
2 FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	0
3 Tribal Pay Cost	--	n/a	--	0
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	0
6 Increased Cost of Travel	--	11,000	--	0
7 Increased Cost of Transportation & Things	--	1,000	--	0
8 Increased Cost of Printing	--	0	--	0
9 Increased Cost of Rents, Communications, & Utilties	--	2,000	--	0
10 Increased Cost of Health Care Provided under Contracts & Grants	--	46,000	--	1,000
11 Increased Cost of Supplies	--	1,000	--	0
12 Increased Cost of Medical or other Equipment	--	2,000	--	0
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	2,427,000	--	95,000
15 Increased Cost of Insurance / Indemnities	--	0	--	0
16 Increased Cost of Interest / Dividends	--	0	--	0
17 Population Growth	--	0	--	0
Subtotal, Built-In	--	2,490,000	--	96,000
C. Base Adjustment:	--	0	--	39,000
TOTAL INCREASES	--	2,490,000	--	135,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(96,000)
TOTAL DECREASES	--	0	--	(96,000)
NET CHANGE	--	**$2,490,000**	--	**$39,000**

INDIAN HEALTH SERVICE
Direct Operations
Summary of Changes

FY 2008	$63,624,000
Total estimated budget authority	63,624,000
Less Obligations	(63,624,000)
FY 2009 President's Budget	62,632,000
Less Obligations	(62,632,000)
Net Change	(992,000)
Less Obligations	992,000

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$224,000
2 FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	971,000
3 Tribal Pay Cost	--	n/a	--	347,000
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	(167,000)
6 Increased Cost of Travel	--	1,636,000	--	31,000
7 Increased Cost of Transportation & Things	--	221,000	--	5,000
8 Increased Cost of Printing	--	23,000	--	1,000
9 Increased Cost of Rents, Communications, & Utilties	--	308,000	--	6,000
10 Increased Cost of Health Care Provided under Contracts & Grants	--	2,013,000	--	57,000
11 Increased Cost of Supplies	--	456,000	--	12,000
12 Increased Cost of Medical or other Equipment	--	558,000	--	7,000
13 Increased Cost of Land & Structure	--	0	--	0
14 Increased Cost of Grants	--	15,276,000	--	227,000
15 Increased Cost of Insurance / Indemnities	--	77,000	--	0
16 Increased Cost of Interest / Dividends	--	0	--	0
17 Population Growth	--	0	--	0
Subtotal, Built-In	--	20,568,000	--	1,721,000
TOTAL INCREASES	--	20,568,000	--	1,721,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(1,721,000)
B. Base Adjustment:	--	0	--	(992,000)
TOTAL DECREASES	--	0	--	(2,713,000)
NET CHANGE	--	**$20,568,000**	--	**($992,000)**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2008	$5,836,000
Total estimated budget authority	5,836,000
Less Obligations	(5,836,000)
FY 2009 President's Budget	5,928,000
Less Obligations	(5,928,000)
Net Change	92,000
Less Obligations	(92,000)

		FY 2008 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$4,000
2	FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	27,000
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	(5,000)
6	Increased Cost of Travel	--	111,000	--	2,000
7	Increased Cost of Transportation & Things	--	3,000	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	0	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	1,742,000	--	27,000
11	Increased Cost of Supplies	--	43,000	--	7,000
12	Increased Cost of Medical or other Equipment	--	34,000	--	2,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	1,421,000	--	104,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Population Growth	--	0	--	0
	Subtotal, Built-In	--	3,354,000	--	168,000
B. Base Adjustment:		--	0	--	92,000
	TOTAL INCREASES	--	3,354,000	--	260,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(168,000)
	TOTAL DECREASES	--	0	--	(168,000)
NET CHANGE		--	**$3,354,000**	--	**$92,000**

INDIAN HEALTH SERVICE
Contract Support Costs
Summary of Changes

FY 2008	$267,398,000
Total estimated budget authority	267,398,000
Less Obligations	(267,398,000)
FY 2009 President's Budget	271,636,000
Less Obligations	(271,636,000)
Net Change	4,238,000
Less Obligations	(4,238,000)

		FY 2008 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	$0
2	FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	0	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
11	Increased Cost of Supplies	--	0	--	0
12	Increased Cost of Medical or other Equipment	--	0	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	267,398,000	--	5,433,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	267,398,000	--	5,433,000
B. Base Adjustment:		--	0	--	4,238,000
	TOTAL INCREASES	--	267,398,000	--	9,671,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(5,433,000)
	TOTAL DECREASES	--	0	--	(5,433,000)
NET CHANGE		--	**$267,398,000**	--	**$4,238,000**

INDIAN HEALTH SERVICE
FACILITIES
Summary of Changes

FY 2008	$374,646,000
Total estimated budget authority	374,646,000
Less Obligations	(374,646,000)
FY 2009 President's Budget	353,329,000
Less Obligations	(353,329,000)
Net Change	(21,317,000)
Less Obligations	21,317,000

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	463,000
2 FY 2009 Pay Raise at 2.9% civilians and 3.4% CO (9 mos.)	--	n/a	--	1,946,000
3 Tribal Pay Cost	--	n/a	--	925,000
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	(324,000)
6 Increased Cost of Travel	--	3,446,000	--	55,000
7 Increased Cost of Transportation & Things	--	3,255,000	--	65,000
8 Increased Cost of Printing	--	51,000	--	0
9 Increased Cost of Rents, Communications, & Utilties	--	17,365,000	--	307,000
10 Increased Cost of Health Care Provided under Contracts & Grants	--	124,361,000	--	1,773,000
11 Increased Cost of Supplies	--	7,407,000	--	135,000
12 Increased Cost of Medical or other Equipment	--	12,272,000	--	295,000
13 Increased Cost of Land & Structure	--	5,641,000	--	326,000
14 Increased Cost of Grants	--	111,082,000	--	1,786,000
15 Increased Cost of Insurance / Indemnities	--	1,911,000	--	0
16 Increased Cost of Interest / Dividends	--	69,000	--	0
17 Increased Cost of Service & Supply Fund	--	0	--	0
18 Population Growth	--	0	--	2,472,000
Subtotal, Built-In	--	286,860,000	--	10,224,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	13	2,176,000
TOTAL INCREASES	--	286,860,000	13	12,400,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(10,224,000)
B. Base Funding Reduction	--	0	--	(23,493,000)
TOTAL DECREASES	--	0	--	(33,717,000)
NET CHANGE	**--**	**$286,860,000**	**--**	**($21,317,000)**

INDIAN HEALTH SERVICE
Maintenance & Improvement
Summary of Changes

FY 2008	$52,889,000
Total estimated budget authority	52,889,000
Less Obligations	(52,889,000)
FY 2009 President's Budget	52,889,000
Less Obligations	(52,889,000)
Net Change	0
Less Obligations	0

		FY 2008 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	0
2	FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	97,000	--	1,000
7	Increased Cost of Transportation & Things	--	34,000	--	1,000
8	Increased Cost of Printing	--	4,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	195,000	--	2,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	17,793,000	--	240,000
11	Increased Cost of Supplies	--	3,879,000	--	69,000
12	Increased Cost of Medical or other Equipment	--	409,000	--	19,000
13	Increased Cost of Land & Structure	--	3,659,000	--	157,000
14	Increased Cost of Grants	--	26,627,000	--	537,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	5,000	--	0
	Subtotal, Built-In	--	52,702,000	--	1,026,000
C. Base Adjustment:		--	0	--	0
	TOTAL INCREASES	--	52,702,000	--	1,026,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,026,000)
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	(1,026,000)
NET CHANGE		**--**	**$52,702,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Sanitation Facilities Construction
Summary of Changes

FY 2008	$94,253,000
Total estimated budget authority	94,253,000
Less Obligations	(94,253,000)
FY 2009 President's Budget	94,253,000
Less Obligations	(94,253,000)
Net Change	0
Less Obligations	0

		FY 2008 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	0
2	FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	66,000	--	2,000
7	Increased Cost of Transportation & Things	--	634,000	--	15,000
8	Increased Cost of Printing	--	10,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	105,000	--	1,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	69,353,000	--	1,278,000
11	Increased Cost of Supplies	--	719,000	--	11,000
12	Increased Cost of Medical or other Equipment	--	340,000	--	0
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	17,091,000	--	297,000
15	Increased Cost of Insurance / Indemnities	--	4,000	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	88,322,000	--	1,604,000
	TOTAL INCREASES	--	88,322,000	--	1,604,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,604,000)
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	(1,604,000)
NET CHANGE		**--**	**$88,322,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2008	$36,584,000
Total estimated budget authority	36,584,000
Less Obligations	(36,584,000)
FY 2009 President's Budget	15,800,000
Less Obligations	(15,800,000)
Net Change	(20,784,000)
Less Obligations	(24,000,000)

		FY 2008 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	0
2	FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	11,000	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	20,000	--	0
10	Increased Cost of Health Care Provided under Contracts & Grants	--	29,600,000	--	84,000
11	Increased Cost of Supplies	--	6,000	--	0
12	Increased Cost of Medical or other Equipment	--	3,281,000	--	20,000
13	Increased Cost of Land & Structure	--	1,548,000	--	168,000
14	Increased Cost of Grants	--	188,000	--	22,000
15	Increased Cost of Insurance / Indemnities	--	1,906,000	--	0
16	Increased Cost of Interest / Dividends	--	24,000	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	36,584,000	--	294,000
	TOTAL INCREASES	--	36,584,000	--	294,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(294,000)
B. Base Funding Reduction		--	0	--	(20,784,000)
	TOTAL DECREASES	--	0	--	(21,078,000)
NET CHANGE		**--**	**$36,584,000**	**--**	**($20,784,000)**

INDIAN HEALTH SERVICE
Facilities & Environmental Health Support
Summary of Changes

FY 2008	$169,638,000
Total estimated budget authority	169,638,000
Less Obligations	(169,638,000)
FY 2009 President's Budget	169,105,000
Less Obligations	(169,105,000)
Net Change	(533,000)
Less Obligations	533,000

	FY 2008 Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	463,000
2 FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	1,946,000
3 Tribal Pay Cost	--	n/a	--	925,000
4 Within Grade Increase	--	n/a	--	0
5 Two Days Pay	--	n/a	--	(324,000)
6 Increased Cost of Travel	--	3,283,000	--	183,000
7 Increased Cost of Transportation & Things	--	2,576,000	--	158,000
8 Increased Cost of Printing	--	37,000	--	1,000
9 Increased Cost of Rents, Communications, & Utilties	--	16,688,000	--	1,287,000
10 Increased Cost of Health Care Provided under Contracts & Grants	--	6,872,000	--	523,000
11 Increased Cost of Supplies	--	2,728,000	--	200,000
12 Increased Cost of Medical or other Equipment	--	1,543,000	--	106,000
13 Increased Cost of Land & Structure	--	0	--	1,000
14 Increased Cost of Grants	--	54,202,000	--	3,711,000
15 Increased Cost of Insurance / Indemnities	--	1,000	--	0
16 Increased Cost of Interest / Dividends	--	40,000	--	1,000
17 Increased Cost of Service & Supply Fund	--	0	--	0
18 Population Growth	--	2,472,000	--	0
Subtotal, Built-In	--	90,442,000	--	9,181,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	--	2,176,000
TOTAL INCREASES	--	90,442,000	--	11,357,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(9,181,000)
B. Base Adjustment:	--	0	--	(2,709,000)
TOTAL DECREASES	--	0	--	(11,890,000)
NET CHANGE	**--**	**$90,442,000**	**--**	**($533,000)**

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

FY 2008	$90,424,000
Total estimated budget authority	90,424,000
Less Obligations	(90,424,000)
FY 2009 President's Budget	91,156,000
Less Obligations	(91,156,000)
Net Change	732,000
Less Obligations	(732,000)

		FY 2008 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	211,000
2	FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	937,000
3	Tribal Pay Cost	--	n/a	--	462,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	(162,000)
6	Increased Cost of Travel	--	822,000	--	16,000
7	Increased Cost of Transportation & Things	--	1,078,000	--	20,000
8	Increased Cost of Printing	--	5,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	15,995,000	--	284,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	4,503,000	--	85,000
11	Increased Cost of Supplies	--	2,071,000	--	38,000
12	Increased Cost of Medical or other Equipment	--	699,000	--	20,000
13	Increased Cost of Land & Structure	--	0	--	1,000
14	Increased Cost of Grants	--	25,860,000	--	191,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	3,000	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	1,335,000
	Subtotal, Built-In	--	51,036,000	--	3,438,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	2,176,000
	TOTAL INCREASES	--	51,036,000	--	5,614,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(3,438,000)
B. Base Adjustment:		--	0	--	(1,444,000)
	TOTAL DECREASES	--	0	--	(4,882,000)
NET CHANGE		**--**	**$51,036,000**	**--**	**$732,000**

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

FY 2008	$64,576,000
Total estimated budget authority	64,576,000
Less Obligations	(64,576,000)
FY 2009 President's Budget	63,545,000
Less Obligations	(63,545,000)
Net Change	(1,031,000)
Less Obligations	1,031,000

		FY 2008 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	202,000
2	FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	793,000
3	Tribal Pay Cost	--	n/a	--	361,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	(126,000)
6	Increased Cost of Travel	--	1,530,000	--	23,000
7	Increased Cost of Transportation & Things	--	1,454,000	--	28,000
8	Increased Cost of Printing	--	5,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	633,000	--	8,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	332,000	--	38,000
11	Increased Cost of Supplies	--	539,000	--	14,000
12	Increased Cost of Medical or other Equipment	--	844,000	--	17,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	26,140,000	--	173,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	5,000	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	915,000
	Subtotal, Built-In	--	31,482,000	--	2,446,000
	TOTAL INCREASES	--	31,482,000	--	2,446,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(2,446,000)
B. Base Adjustment:		--	0	--	(1,031,000)
	TOTAL DECREASES	--	0	--	(3,477,000)
NET CHANGE		**--**	**$31,482,000**	**--**	**($1,031,000)**

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

FY 2008	$14,638,000
Total estimated budget authority	14,638,000
Less Obligations	(14,638,000)
FY 2009 President's Budget	14,404,000
Less Obligations	(14,404,000)
Net Change	(234,000)
Less Obligations	234,000

		FY 2008 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	50,000
2	FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	216,000
3	Tribal Pay Cost	--	n/a	--	102,000
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	(36,000)
6	Increased Cost of Travel	--	931,000	--	13,000
7	Increased Cost of Transportation & Things	--	44,000	--	1,000
8	Increased Cost of Printing	--	27,000	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	60,000	--	9,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	2,037,000	--	37,000
11	Increased Cost of Supplies	--	118,000	--	2,000
12	Increased Cost of Medical or other Equipment	--	0	--	2,000
13	Increased Cost of Land & Structure	--	0	--	0
14	Increased Cost of Grants	--	2,202,000	--	13,000
15	Increased Cost of Insurance / Indemnities	--	1,000	--	0
16	Increased Cost of Interest / Dividends	--	32,000	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	222,000
	Subtotal, Built-In	--	5,452,000	--	631,000
	TOTAL INCREASES	--	5,452,000	--	631,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(631,000)
B. Base Adjustment:		--	0	--	(234,000)
	TOTAL DECREASES	--	0	--	(865,000)
NET CHANGE		**--**	**$5,452,000**	**--**	**($234,000)**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2008	$21,282,000
Total estimated budget authority	21,350,000
Less Obligations	(21,350,000)
FY 2009 President's Budget	21,282,000
Less Obligations	(21,282,000)
Net Change	0
Less Obligations	0

		FY 2008 Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2008 Pay Raise at 3.5% (3 mos.)	--	n/a	--	0
2	FY 2009 Pay Raise at 2.9% civilian and 3.4% CO (9 mos.)	--	n/a	--	0
3	Tribal Pay Cost	--	n/a	--	0
4	Within Grade Increase	--	n/a	--	0
5	Two Days Pay	--	n/a	--	0
6	Increased Cost of Travel	--	0	--	0
7	Increased Cost of Transportation & Things	--	0	--	0
8	Increased Cost of Printing	--	0	--	0
9	Increased Cost of Rents, Communications, & Utilties	--	357,000	--	3,000
10	Increased Cost of Health Care Provided under Contracts & Grants	--	743,000	--	11,000
11	Increased Cost of Supplies	--	75,000	--	1,000
12	Increased Cost of Medical or other Equipment	--	6,699,000	--	217,000
13	Increased Cost of Land & Structure	--	434,000	--	0
14	Increased Cost of Grants	--	12,974,000	--	553,000
15	Increased Cost of Insurance / Indemnities	--	0	--	0
16	Increased Cost of Interest / Dividends	--	0	--	0
17	Increased Cost of Service & Supply Fund	--	0	--	0
18	Population Growth	--	0	--	0
	Subtotal, Built-In	--	21,282,000	--	785,000
	TOTAL INCREASES	--	21,282,000	--	785,000
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(785,000)
B. Base Funding Reduction		--	0	--	0
	TOTAL DECREASES	--	0	--	(785,000)
NET CHANGE		**--**	**$21,282,000**	**--**	**$0**

INDIAN HEALTH SERVICE

Authorizing Legislation

(Dollars in Thousands)

Jan 14, 2008

	FY 2008		FY 2009	
	Amount Authorized	Enacted	Amount Authorized	President's Budget
1. Services Appropriation:	$2,971,533	$2,971,533	$2,971,533	$2,971,533
25 U.S.C. 13, Act and P.L. 83-568, Transfer Act, 42 U.S.C. 2001. Snyder Act, Title V, P.L. 94-437, Indian Health Care Improvement Act (IHCIA), as amended. Title I, Indian Health Manpower. Indian Self Determination and Education Assistance Act, P.L. 93-638, as amended, Sections 103(b)(2) and 103(e). Titles III & V, Self Governance Demonstration Program, Indian Self Determination Act, as amended. P.L. 100-472 Section 106(a)(2) A&B P.L. 106-260 Tribal Self Governance Amendment of 2000.				
2. Facilities Appropriation:	374,646	374,646	353,329	353,329
Indian Sanitation Facilities Act P.L. 86-121, P.L. 101-512, Section 704 of the IHCIA P.L. 103-413, P.L. 102-573				
P.L. 98-473, Quarters Return Funds	6,288	6,288	6,288	6,288
3. Public and Private Collections:	779,702	779,702	779,702	779,702
Economy Act 31 U.S.C. 686 Section 301, P.L. 94-437, Title V of IHCIA.				
4. Special Diabetes Program for Indians:	$150,000	$150,000	$150,000	$150,000
111 STAT. 574 (P.L. 105-33) 114.2763A-525, (P.L. 106-554, Sec. 432)				
Unfunded authorizations:	0	0	0	0
Total appropriations:	$4,282,169	$4,282,169	$4,260,852	$4,260,852
Total appropriations against Definite authorizations:	$4,282,169	$4,282,169	$4,260,852	$4,260,852

INDIAN HEALTH SERVICE
Appropriation History Table
Services

Jan 16, 2008

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2000	$2,094,922,000	$2,085,407,000	$2,094,922,000	$2,078,967,000
Rescission (PL 106-113)	-	-	-	($4,794,000)
2001	$2,271,055,000	$2,106,178,000	$2,184,421,000	$2,240,658,000
Supplemental (PL 106-554)				$30,000,000
Rescission (PL 106-554)	-	-	-	($4,995,000)
2002	$2,387,014,000	$2,390,014,000	$2,388,614,000	$2,389,614,000
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	$2,971,533,000			

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

Jan 16, 2008

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2000	$317,465,000	$312,478,000	$189,252,000	$318,580,000
Rescission (PL 106-113)	-	-	-	($2,025,000)
2001	$349,374,000	$336,423,000	$349,650,000	$363,904,000
Rescission (PL 106-554)	-	-	-	($801,000)
2002	$319,795,000	$369,795,000	$362,854,000	$369,487,000
2003	$370,475,000	$362,571,000	$391,865,000	$376,190,000
Rescission (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	$353,329,000			

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

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$2,288,939,000	$2,433,762,000	$2,475,851,000	+$42,089,000
HH&C	*1,411,336,000*	*1,484,016,000*	*1,521,934,000*	*+37,918,000*
Dental Health	*125,396,000*	*133,637,000*	*137,944,000*	*+4,307,000*
Mental Health	*60,882,000*	*63,531,000*	*65,824,000*	*+2,293,000*
Alcohol/Subs Abuse	*148,226,000*	*173,243,000*	*161,988,000*	*-11,255,000*
CHS	*543,099,000*	*579,334,000*	*588,161,000*	*+8,827,000*
FTE	**7,584**	**7,623**	**7,653**	**+30**

SUMMARY OF THE BUDGET REQUEST

The FY 2009 budget request of $2,475,851,000 and 7,653 FTE is an increase of $42,089,000 and 30 FTE over the FY 2008 Enacted of $2,433,762,000 and 7,623 FTE. 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 over 600 health care facilities providing care to 1.9 million AI/AN primarily in services areas that are rural, isolated and underserved.

Hospitals & Health Clinics $1.522 billion (+$37.9 million) – H&HC supports essential personal health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, etc. In addition, the program includes public/community health initiatives targeting health conditions disproportionately affecting AI/AN such as specialized programs for diabetes, maternal and child health, youth services, communicable diseases including HIV/AIDS, tuberculosis, and hepatitis, and a continuing emphasis on women's and elders' health.

Dental Health $137.9 million (+$4.307 million) – The Dental Program is oriented toward preventive and basic care, and 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 remain 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.

Mental Health $65.8 million (+$2.293 million) – The Mental Health/Social Services (MH/SS) program is 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 AI/AN individuals and their communities; it must be considered integral in the healing process.

Alcohol & Substance Abuse $162.0 million (-$11.255 million) – The Alcohol and Substance Abuse Program (ASAP) provides 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 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.

Contract Health Services $588.2 million (+$8.827 million) – The CHS program purchases essential healthcare services not available in IHS/Tribal facilities and includes inpatient and outpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, and physical therapy, etc.

Summary Table -- The following table displays performance measures that are considered over-arching because all of the programs in this section contribute toward the achievement of targets.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
21/RPMS -E	**Patient Safety[1]:** Development and deployment of patient safety measurement system. **(RPMS – E)**	4 Areas	All Areas	3 Areas	3 Areas	7 Sites	64 Sites	+10 Sites	+11 Sites	N/A
TOHP -4	Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) populations served by tribal health programs[2,3].	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N//A	Jan/2015 55.3
RPMS -1	Develop comprehensive electronic health record (EHR) with clinical guidelines for select chronic diseases.	Not Met	Met	Cardiovascular	Met	Maintain All	Met	Comprehensive EHR	Eliminate	N/A
RPMS -2	Derive all clinical measures from RPMS and integrate with EHR[4].	37/12	41/12	38/12	41/12	41/12	41/12	59/12	61/12	N/A
RPMS -3	Number of sites to which electronic health record is deployed.	N/A	20	40	40	40	50	All	Eliminate	N/A
FAA-2	Years of Potential Life Lost in American Indian/Alaska Native population[2,3].	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Jan/20126 3.4
28	**Unintentional Injury Rate[2]:** Unintentional injuries mortality rate in AI/AN population.	Dec/2008	Dec/2009	94.8	Dec/2010	94.8	Dec/2011	94.2	Change to Long Term Measure	Dec/2016
FAA-3	**Unintentional Injury Rate[2]:** Unintentional injuries mortality rate in AI/AN population.	Dec/2008	Dec/2009	92.2	Dec/2010	92.2	Dec/2011	92.2	Change to Long term Measure	Dec/2016

[1]*In FY 2006 this measure tracked the number of Areas with a medical error reporting system. Prior to FY 2006, this measure tracked the number of Areas with a medication error reporting system.*
[2]*Long Term Measure; reportable in 2015or 2016.*
[3]*Three year rate centered on mid-year.*
[4]*Clinical Measures/Area*

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

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$1,411,336,000	$1,484,016,470	$1,521,934,000	+$37,917,530
FTE	6,415	6,420	6,435	+15

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

FY 2009 Authorization .....Expired 2000

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Hospitals and Health Clinics is by far the largest activity within the IHS budget, amounting to nearly one half of the IHS budget authority. It supports essential personal health services for American Indians and Alaska Natives (AI/AN) including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, etc. In addition, the program includes public/community health initiatives targeting health conditions disproportionately affecting AI/AN such as specialized programs for diabetes, maternal and child health, youth services, communicable diseases including HIV/AIDS, tuberculosis, and hepatitis, and a continuing emphasis on women's and elders' health. The IHS system of care is unique in that personal health care services are integrated with public 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 public health initiatives is primarily funded through the Hospitals and Health Clinics budget.

Almost one-half of the H&HC budget is transferred under P.L. 93-638 contracts or compacts to Tribal governments or Tribal organizations which provide these individual and community health services for the Federal Government. This is reflected in the outputs table which shows that approximately 54 percent of the outpatient workload and 38 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 local level. A small percentage of the funds (<0.5%) is distributed to Tribes

via small competitive grant programs; examples include eldercare, children and youth, women's health, and health promotion and disease prevention grants.

Although the health status of AI/AN has increased significantly in the past 50 years since the inception of the IHS, the average life expectancy at birth is 72.3 years compared to the U.S. all races life expectancy of 76.9. The IHS and Tribes primarily serve small, rural populations with mainly primary medical care and community-health services, relying on the private sector for much of the secondary and all of the tertiary medical care needs. A few of our hospitals do provide secondary medical services such as ophthalmology, orthopedics, etc. Of 46 IHS or Tribal hospitals, only one has an average daily census of >45 patients. Nineteen of 46 hospitals have operating rooms; the majority do not. This speaks to their focus on primary and community based care, not on secondary or tertiary care.

The following are brief descriptions of several specific activities funded through H&HC:

Emergency Services – The IHS' Emergency Services staff office establishes emergency management goals and objectives consistent with those of the Department of Health and Human Services, Department of Homeland Security, and other Federal agencies in addressing mission critical elements, strategic plans, policies, procedures, continuity of operations (COOP), deployment, physical security, and public health infrastructure. IHS is:

(1) building capacity in public health infrastructure and emergency preparedness through linkages among its hospitals and clinics with local, county, Tribal and State agencies and non-governmental organizations throughout the country;
(2) working to assure that the needs of Tribal communities are addressed by States which have received targeted funding for emergency preparedness and response;
(3) working with and expanding the capacity of 83 Tribal and 2 IHS local emergency medical services (EMS) by providing technical assistance to enhance their ability to provide optimum emergency medical access, response and care in Indian Country;
(4) enhancing IHS' ability to deploy staff for national and international emergencies as was done for the tsunami in southeast Asia, for hurricanes Katrina and Rita that hit Louisiana and Mississippi, and most recently for the wild fires in southern California;
(5) preparing its hospitals and clinics to diagnose and treat victims of a bioterrorism or other mass casualty situations such as pandemic influenza;
(6) measuring the effectiveness of IHS critical infrastructure protection programs though a systematic effort of inspection and review; and
(7) participating in numerous local, regional, and national exercises to test response capabilities and enhance linkages with public safety elements at all levels.

IHS has developed a comprehensive emergency management program that focuses on strengthening an all-hazards response capability in the Agency as well as in AI/AN communities. This program provided key efforts in the enhancement of the Department's Emergency Preparedness Program in response to the President's *Hurricane Katrina Lessons Learned* report and in the development of pandemic influenza plans at Federal,

State, local, and Tribal government levels. A satellite communications system has been deployed linking IHS Headquarters with the 12 Area Offices. All of these efforts are in support of HHS Departmental Strategic Goal of "enhancing the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges."

Alcohol Screening and Brief Intervention – The IHS has initiated a major alcohol intervention (funded through the H&HC budget activity), the Alcohol Screening and Brief Intervention (ASBI) program, to address alcohol abuse and injury prevention, very serious inter-related issues in Indian Country. It is aimed at breaking the alcohol–injury cycle by taking advantage of the "teachable moment" when an injured patient presents at an IHS or Tribal hospital emergency department as a result of possible alcohol or other drug intoxication. The ASBI program is being implemented system-wide in all IHS and Tribal hospitals.

The ASBI is similar to the Screening, Brief Intervention, Referral, and Treatment (SBIRT) program of SAMHSA with which IHS collaborates. We are also working with the American College of Surgeons and level I and II referral trauma centers and their SBIRT programs. In FY 2007, IHS conducted six ASBI train-the-trainer conferences around the country and has trained over 200 physicians, nurses, behavioral and allied health professionals in this intervention methodology. In FY 2008, IHS will broaden the scope of the ASBI program to include IHS-Tribal primary care and behavioral health clinics. As funding becomes available a performance measure will be developed to determine how well our hospital emergency departments and ambulatory clinics are screening for hazardous alcohol use in injured individuals in the 15 – 34 age range and providing a brief counseling intervention to decrease future injuries or death.

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

In FY 2007, the IHS and Tribes spent approximately $279 million on pharmaceuticals. While the rate of cost increase has been dramatically reduced over the last 2 years (due to a number of high cost medications becoming available as generic products and negotiated discounts through the Department of Veterans Affairs (VA) Pharmaceutical Prime Vendor program), pharmaceutical costs for the Indian Health Service and our Tribal partners has increased an average of 8.9 percent per year for the last five fiscal years. The interventions to control costs include greater use of bulk purchasing methods through the pharmaceutical prime vendor (about 90 percent of all purchases) and the 340B program (almost 10 percent of purchases), increased use of a limited but more efficacious formulary, and education of providers about specific pharmacoeconomic strategies. These activities are closely linked to 5 of 6 diabetes GPRA performance measures which are based on effective lifestyle and pharmaceutical management. The effort to manage high cost pharmaceuticals was enhanced by IHS pharmacy residency activities. The residency programs now operate in 12 communities and stimulate innovative thinking

about the control of pharmaceutical costs and less expensive, but more effective approaches to patient care.

Health Promotion/Disease Prevention – The IHS is increasing access to preventive and curative services for Indian communities by targeting health programs reflecting community health status to provide the most effective services to the most people. However, these prevention strategies are often difficult to maintain since the impact of the programs is often distant in time and community attention to these efforts may wane in the face of more immediate concerns such as treatment for trauma and for acute and chronic diseases.

In FY 2008, the agency continues to implement a major initiative on Health Promotion and Disease Prevention (HP/DP); it is one of the Director's three health priorities. This initiative was launched in FY 2005 to reduce health disparities. Although the IHS is the model health system in integrating individual and community health, increased emphasis is being focused on both clinical and community-based health promotion and disease prevention efforts. The main focus is on our collective ability to develop and implement programs that will prevent disease, not focusing exclusively on treatment of disease. Some of these strategies include:

- Focusing on those traditional practices and values of Indian communities which have a strong role in promoting wellness.
- Promotion and implementation of effective programs in the schools and communities.
- Continuation of the Healthy Native Communities Fellowship program, teaching community members the skills needed for building healthy communities and serving as catalysts for change at the community level.
- Identification and dissemination of best practices in clinical and community-based HP/DP interventions, such as the "Just Move It" campaign.
- Engaging youth and strengthening families to make healthy lifestyle choices. The agency is working closely with the national youth organizations, such as Boys and Girls Clubs and United National Indian Tribal Youth, Inc. (UNITY), to promote healthy lifestyles for AI/AN children and youth.
- Engaging professional HP/DP experts, as well as Federal, Tribal, and community leaders through the Prevention Task Force and Policy Advisory Committee to guide this initiative to eliminate health disparities.

In FY 2005, $2 million of new funding was appropriated for HP/DP activities in the H&HC budget activity. This has been used to fund the Healthy Native Communities Fellowship program and to develop a new small HP/DP grant program to support HP/DP programs at the community level; these programs are continuing in FY 2008. The focus of the grants is to support healthy lifestyles and choices such as eating healthier, being physically active, and avoiding tobacco, alcohol, and other harmful substances to decrease cardiovascular disease, cancer, diabetes, obesity, and unintentional injuries. This initiative supports HHS Strategic Objective 2.3, to "promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery."

All of these HP/DP activities have a direct or indirect effect on most of the 22 H&HC performance measures.

Chronic Care Initiative – The IHS has a long and successful history of addressing acute, infectious diseases. Today, however, increasing chronic disease burdens are challenging the Indian health system. The IHS recognizes that, in addition to health promotion and disease prevention, the health status of AI/AN communities depends on how effectively we address the increasing incidence of chronic diseases like diabetes, cardiovascular disease, asthma, obesity, depression, and some cancers.

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

The Chronic Disease Initiative directs a campaign of continual and measurable improvements in our health care system to:

1. Provide knowledge, skills, and support to the Indian health system as sites explore, test, and implement fundamental system changes.
2. Facilitate the improvement work of groups of organizations within the Indian health system as they improve the quality of chronic disease care.
3. Accelerate the spread and utilization of effective practices based on the chronic care model throughout the Indian health system.

At the end of FY 2006, the IHS began an innovative effort to bring together five Federal and one Tribal program to test foundational changes in the delivery of care for chronic disease. The number of pilot sites was expanded to 14 in FY 2007. These health care programs will leverage healthcare delivery changes and information systems to improve patient self-management skills and patient activation, and to create patient care teams that are designed for efficiency and effectiveness. The successes that will be developed in the pilot sites will then be spread to additional sites over the next few years as a larger group of facilities join the collaborative effort. This has begun in FY 2008 and will utilize peer-to-peer learning based on the natural leaders who have emerged in the early phases of the initiative. These leaders will provide local sites with the knowledge and support to pursue an ever-widening campaign for ongoing health care system improvement. Experiences at local sites will be shared between these health care facilities in a collaborative fashion to increase their chances of success and speed of change.

To some extent, outcome evaluation of these proposed clinical system changes will be based upon existing performance measures, and, as the number of IHS/Tribal sites implementing the CCI expands, the effect on the majority of H&HC performance measures will increase. Because of the CCI's emphasis on clinical screening as well as chronic disease management, it will directly impact most of the H&HC measures such as the 6 diabetes measures, the 3 cancer screening measures, the 3 immunization measures, the cardiovascular disease comprehensive assessment, etc. In addition, new

measurements will be developed as appropriate. The CCI measurement domains include (1) clinical prevention bundled measures; (2) management and prevention of chronic conditions bundled measures; (3) costs, looking at dollars spent outside primary care (intent is to decrease emergency room and specialty care referrals); and (4) patient experience, including activation, access, satisfaction, etc.

Information technology (IT) – Health care is information intensive and dependent on technology to assure that appropriate health information is available whenever and wherever it is needed. Information technology is essential to effective health care delivery and efficient resource management in the IHS. IHS IT is based on an architecture that incorporates government and industry standards for the collection, processing and transmission of information. IHS IT is managed as strategic investments by senior management, fully integrated with the agency's programs, and critical to improving service delivery as reflected in this and other budget activity narratives and displayed in the accompanying budget exhibits. The IHS has a long history of successfully integrating health information technology (HIT) and health service delivery. Continued HIT investment is required to avoid interruption and degradation of vital health services.

The Resource and Patient Management System (RPMS) is the IHS enterprise health information system. RPMS consists of more than 60 software applications and is used at approximately 400 IHS, tribal and urban (I/T/U) locations. These applications include clinical quality reporting, as well as a newly released integrated case management application. IHS has deployed an electronic health record (EHR) graphical user interface (GUI) application. To date, this application has been implemented in more than 106 facilities nationwide, and an ambitious training and deployment program has been established. The IHS RPMS-Electronic Health Record provides computer-based physician order entry, encounter documentation, access to medical literature and other essential capabilities.

Costs of the IHS IT infrastructure (development, support, licensing, contracts, bandwidth, training of staff, and others) have risen dramatically in the past decade. Ongoing funding for information technology helps ensure that IHS is able to meet these needs. Our current HIT application suite (RPMS) is considered a leading HIT system in many areas, including wellness, population and public health, chronic care management and electronic clinical quality reporting. The IHS works closely with the Office of the National Coordinator for Health Information Technology, Centers for Medicare and Medicaid Services, Agency for Healthcare Research and Quality, Veterans Health Administration, Department of Defense, and other Federal entities on IT initiatives to ensure that the direction of our HIT system is consistent with other Federal agencies. In addition, IHS has routinely shared HIT artifacts (design and requirement documents, clinical quality logic, etc.) with both public and private organizations.

IHS has also continued to expand its support for telehealth. Telehealth enables a “best practice” model of specialist health care delivery. Such a model of enhanced access, improved clinical quality, and organizational cost-efficiency is possible through the

emerging tools of expert tele-consultation and home monitoring/care coordination. These tools are increasingly emphasized as priorities within the U.S. health care system. This emphasis was recently demonstrated by the American Health Information Community (AHIC) recommendation to the DHHS Secretary that remote monitoring be a critical part of the Office of the National Coordinator chronic care management priority.

Many telehealth clinical tools were initially developed in support of acute illness care; telehealth expansion specifically targets chronic care and a comprehensive approach to integrated specialty service delivery. Clinical problems and chronic conditions targeted for enhanced service delivery include: diabetes care, cardiovascular care, and mental health care. Ongoing federal investments in telehealth include items such as the Alaska Federal Health Care Access Network (AFHCAN) enterprise telemedicine solution and the IHS Joslin Vision Network program. The telehealth program closely integrates its planning, implementation, and evaluation activities with the IHS Director's three health initiatives on chronic care, behavioral health, and health promotion/disease prevention.

Finally, IHS strives to improve its IT infrastructure to support Presidential, Secretarial and IHS goals and priorities. This infrastructure is fundamental to HIT and health care operations. Compliance with E-Gov initiatives has the potential to dramatically increase the exchange of health care information. Recent Executive Orders and American Health Information Community (AHIC) activities have identified priority areas as well as domains with potential for early breakthroughs in the adoption of interoperability standards.

FUNDING HISTORY

Fiscal Year	Amount	Program Increase (non-add)
2004	$1,249,781,000	
2005	$1,289,418,000	$11,093,000 – IHCIF*
2006	$1,339,488,000	
2007	$1,411,336,000	
2008 Enacted	$1,484,016,000	$13,782,000 – IHCIF*

* Indian Health Care Improvement Fund

BUDGET REQUEST

The FY 2009 budget request is $1,521,934,000; an increase of $37,917,530 over the FY 2008 enacted level. Hospitals and Health Clinics funding will provide personal health care services for acute, chronic, and emergency conditions as well as clinical preventive services for approximately 1.9 million people; public/community health initiatives targeting health conditions affecting AI/AN; health promotion and disease prevention; emergency preparedness and response; and complex health information technology that supports both personal health services and public health initiatives.

Funding will provide:

- Approximately $798 million to be distributed to Federally-administered hospitals and clinics.

- Approximately $724 million to be distributed to Tribally operated hospitals and clinics through P.L. 93-638 compacts and contracts to provide similar services that the IHS would provide if these programs were directly Federally administered.
- Of the $1.522 billion H&HC budget request –
  - $10 million is for the Indian Health Care Improvement Fund. These funds will be allocated to IHS and Tribal service sites with less than 40 percent of need according to a methodology defined in the Indian Health Care Improvement Act. Funding will allow highly deficient sites to expand health care services and reduce backlogs for primary care.
  - $18 million / 152 FTE to provide staffing and operating costs for a new ambulatory care clinic in Phoenix, AZ, for an expanded outpatient department at the Lawton, OK Indian Hospital and for a joint venture. Funding these new facilities allows IHS to expand provision of health care in those areas where existing capacity is most overextended:

Facility	Amount	Federal FTE
PIMC, AZ SW Ambulatory Center	$6,091,000	74
Lawton, OK Indian Hospital	$7,732,000	78
Joint Venture	$4,044,000	0
Grand Total:	**$17,867,000**	**152**

Twenty-two Government Performance and Results Act (GPRA) key performance measures are directly related to the H&HC budget. These measures include a variety of clinical measures such as prenatal HIV screening, pap smear and mammography screening, domestic violence screening, improving automated extraction of clinical performance measures and data quality, immunization rates, community-based cardiovascular disease and obesity prevention, depression screening, and reducing tobacco usage. Although the IHS has many more clinical measures, these 22 are the only ones being reported as GPRA measures and only evaluate the performance of a portion the of clinical care program, as all aspects of primary and some secondary clinical care of individuals, involving thousands of disease states, are provided through the H&HC budget. Each of the approximately 1.9 million individuals cared for in the Indian Health System is unique and requires individual attention and care, so that each individual is a unique "output." Assessing performance data from the most current reported data demonstrates effective H&HC outcomes. In FY 2007, the IHS met or exceeded 19 H&HC performance measures, whereas three were not met. Those not met were each only 1 percent under the goal; e.g. the target for pap smears was 60 percent but only 59 percent was achieved. Some of these performance measures are very resource intensive. The level of performance measure achievement is similar to that for the past several years.

Two of the 22 key results of programs funded through H&HC which are GPRA measures will be discussed. These are just examples from the key measures and are not necessarily any more important than the other 20 measures. Most of these measures relate to direct clinical care and are all important for the agency to meet its mission of elevating the health of Indian people to the highest level.

Diabetes – The agency continues to make significant progress in addressing chronic diseases. A primary focus has been in the treatment and prevention of diabetes and its complications. Diabetes continues to be a growing problem in AI/AN communities. Of particular concern, the incidence of the disease is increasing rapidly in youth and young adults.

Supplemental funding, key Tribal involvement, collaboration with other Federal agencies, and community emphasis all contributed to the IHS meeting or exceeding four of six diabetes performance measures. Ongoing interventions include more effective pharmaceuticals, more aggressive screening for the secondary effects of diabetes, earlier intervention when complications are identified, and emphasizing greater patient compliance with care regimens. The level and quality of services provided to over 100,000 diabetics throughout the IHS are audited annually to improve standardized care and patient outcomes. A wide range of IHS developed performance measures including foot care, eye care, end organ status, and adequacy of blood sugar control have been incorporated into the National Committee for Quality Assurance/American Diabetes Association national performance diabetes care benchmarks. Six of these are reported as GPRA indicators. Over two-thirds of Tribal communities have programs in place for community-wide prevention of diabetes, and 83 percent of Tribal communities offer primary prevention programs for children and youth.

Diabetes is the leading cause of end stage renal disease (ESRD) or kidney failure, a growing problem in Indian communities. Early identification of patients at risk through screening for protein in the urine (proteinuria) helps prevent or delay the need for dialysis or renal transplant. Proteinuria is also an independent predictor of cardiovascular disease, the number one killer of AI/AN adults. In conjunction with other diabetes standards of care (blood sugar control and blood pressure control), this GPRA performance measure is intended to increase screening of diabetic patients for nephropathy in order to prevent or delay kidney failure by use of angiotensin-converting enzyme (ACE) inhibitors, medications proven to delay or prevent the onset of kidney failure. IHS use of ACE inhibitors has been steadily increasing since 1993. And since 1996 the rate of new cases of kidney failure in AI/AN patients with diabetes has been *decreasing*, despite the fact that rates continue to rise in African American and Caucasian diabetic populations. In FY 2006 IHS exceeded the target to increase the proportion of patients with diagnosed diabetes assessed for nephropathy to 50 percent, by an additional 5 percent of patients assessed. For FY 2007, this measure was changed to require quantitative testing in addition to or instead of the previous qualitative screening method, and a new baseline was established at 40%. The change in the measure was done in order to encourage a better assessment of diabetes related kidney damage.

Accreditation/Certification – The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care, and the Centers for Medicare and Medicaid Services (CMS) regularly conduct in-depth quality reviews of IHS and Tribal hospitals. The average accreditation grid scores are consistent with the average score for all U.S. hospitals. The most frequently cited area for improvement is physical plant safety and efficiency because some IHS facilities are

Long-Term Objective: By 2010, increase to 70 percent the proportion of diagnosed diabetic patients who receive an annual diabetic retinal examination.										
6	**Diabetic Retinopathy:** Proportion of patients with diagnosed diabetes who receive an annual retinal examination. IHS - All	55%	50%	50%/ Baseline[3]	52/49%[3]	49%	49%	49%	47%	N/A
6	Tribally Operated Health Programs	45%	50%	50%[4]	48%	48%	48%	48%	46%	N/A
Long-Term Objective: By 2010, increase to 90 percent the proportion of eligible women who have had a Pap screen within the previous three years.										
7	**Pap Smear Rates:** Proportion of eligible women who have had a Pap screen within the previous three years. IHS - All	58%	60%	60%	59%	60%	59%	59%	56%	N/A
7	Tribally Operated Health Programs	59%	61%	61%	61%	61%	61%	61%	58%	N/A
Long-Term Objective: By 2010, increase to 70 percent the proportion of eligible women who have had a mammogram screening within the previous two years.										
8	**Mammogram Rates:** Proportion of eligible women who have had mammography screening within the previous two years. IHS - All	40%	41%	41%	41%	41%	43%	43%	40%	N/A
8	Tribally Operated Health Programs	43%	44%	44%	44%	44%	45%	45%	42%	N/A
Long-Term Objective: By 2010, increase to 50 percent the proportion of eligible patients who have had appropriate colorectal cancer screening.										
9	**Colorectal Cancer Screening Rates:** Proportion of eligible patients who have had appropriate colorectal cancer screening. IHS - All	N/A	N/A	Baseline	22%	22%	26%	26%	24%	N/A
9	Tribally Operated Health Programs	N/A	N/A	Baseline	26%	26%	29%	29%	27%	N/A

Long-Term Objective: By 2010, increase childhood combined immunization rates to 80 percent.										
24	**Combined (4:3:1:3:3) immunization rates:** AI/AN children patients aged 19-35 months. IHS - All	81[5]/72%	75%	75%	78/80[6]%	78%	78%	78%	76%	N/A
24	Tribally Operated Health Programs	N/A	54%	54%	74%	74%	72%	72%	70%	N/A
Long-Term Objective: By 2010 decrease YPLL by 20 percent over the 2002 level.										
31	**Childhood Weight Control:** Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher. IHS - All	60%[1]	64%[1]	Baseline	24%	24%	24%	24%	Change to Long Term Measure	Oct/2010 4%
31	Tribally Operated Health Programs	59%[8]	63%[8]	Baseline	25%	25%	25%	25%	Change to Long Term Measure	Oct/2010 5%
Long-Term Objective: Hospital admissions per 100,000 service population for long term complications of diabetes in federally administered facilities.										
FAA-E	Hospital admissions per 100,000 service population for long term complications of diabetes in federally administered facilities[9].	194.3	185.4	183.5	Sep/2008	181.7	Sep/ 2009	179.9	179.9	N/A
Long-Term Objective: By FY 2010, reduce the proportion of children ages 2-5 with a BMI of 95 percent or higher by 16 percent.										
FAA-1	Children ages 2-5 years with a BMI of 95 percent or higher.	N/A	N/A	Baseline	23.2%	23%	24%	24%	Change to Long Term Measure	Dec/2010 4%
FAA-4	Proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed.	N/A	N/A	N/A	N/A	N/A	N/A	Baseline	Maintain	N/A

Long-Term Objective: The purpose of Tribally-Operated Health Programs (TOHPs) is to use tribal self-governance and self-determination to improve the health of American Indians and Alaska Natives (AI/ANs).										
TOHP-2	Number of designated annual clinical performance goals met.	7/10	11/14	11/13	10/13	13/16	14/16	14/17	14/17	N/A
TOHP-3	Percentage of AI/AN patients with diagnosed diabetes served by tribal health programs that achieve ideal blood sugar control. (Long Term Measure)	28.1%	33%	None	33%	N/A	N/A	N/A	N/A	Oct/2014 40%
Long-Term Objective: By 2010, increase screening rates for intimate partner violence to 40 percent.										
16	**Domestic (Intimate Partner) Violence Screening:** Proportion of women who are screened for domestic violence at health care facilities. IHS-All	14%	13%	14%	28%	28%	36%	36%	36%	N/A
16	Tribally Operated Health Programs	5%	9%	10%	24%	24%	30%	30%	30%	N/A
Long-Term Objectives: By 2010, increase adult influenza and pneumococcal vaccination rates to 90 percent.										
25	Influenza vaccination rates among adult patients aged 65 years and older. IHS-All	54%	59%[11]	59%	58%	59%	59%	59%	58%	N/A
25	Tribally Operated Health Programs	53%	54%[11]	54%	53%	54%	55%	55%	54%	N/A
26	Pneumococcal vaccination rates among adult patients aged 65 years and older. IHS-All	69%	69%	72%	74%	76%	79%	79%	77%	N/A
26	Tribally Operated Health Programs	69%	62%	63%	69%	69%	73%	73%	71%	N/A

Long-Term Objective 1: By 2010 decrease YPLL by 20 percent over the 2002 level.										
33	**HIV Screening:** Proportion of pregnant women screened for HIV.	Not Met[12]	54%	55%	65%	65%	74%	74%	72%	33

[1]*First figure in results column is Diabetes audit data; second is CRS.*
[2]*DDTP changed the methodology for nephropathy assessment in 2006 to coincide more closely with the CRS methodology. In order to compare nephropathy audit data on the same basis, reports using this methodology have been generated for 2003, 2004, and 2005 as follows: 2003 – 53%, 2004 – 55%, 2005 – 57%.*
[3]*For FY 2006, two numbers were required and reported: first figure represents results at designated sites, second is results for all sites. FY 2006 target is to maintain at designated pilot sites and establish baseline at all sites. As of FY 2007, examination rates at designated pilot sites will not be reported separately.*
[4]*FY 2005 results reported to OMB in PART submission are the established baseline for TOHP.*
[5]*Vaccination rates for children ages 3-27 months.*
[6]*Rate reflects National Immunization Report.*
[7]*In FY 2005 and FY 2006, this measure tracked the proportion of patients ages 23 and older who receive blood cholesterol screening. Prior to FY 2005 measure was: Number of community-directed pilot cardiovascular disease prevention programs.*
[8]*Measure tracked the proportion of patients for whom BMI (Body Mass Index) data can be measured.*
[9]*FY 2005 data, the data systems were switched from Legacy NPIRS to National Data Warehouse. 2004 data was recalculated for the new baseline year for comparability. There were also methodology changes for tribal hospitals to reflect changes in ownership and to correct geographic errors.*
[10]*FY 2005 data, the data systems were switched from Legacy NPIRS to National Data Warehouse. 2004 data was recalculated for the new baseline year for comparability. There were also methodology changes for tribal hospitals to reflect changes in ownership and to correct geographic errors.*
[11]*Measure on hold in FY 2005 due to influenza vaccine shortage.*
[12]*Prior to FY 2005, measure was: Screen for HIV infections in high risk groups at designated sites.*

- At the FY 2009 funding, the IHS expected performance in measures is expected to decline. However, during FY 2009, the IHS will attempt to maintain 100 percent accreditation of all IHS-operated hospitals and outpatient clinics (excluding tribally operated facilities).
- Integration of new Healthcare Information Technology Standards Panel (HITSP) standards into our current applications will be delayed. International Classification of Disease (ICD) 10 will not be integrated into RPMS.

Output

(dollars in millions)

Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Estimate	FY 2009 Estimate
			Estimate	Actual	Estimate	Actual(*)		
Inpatient Admissions IHS Direct	39,382	38,477	38,500	37,138	37,000	34,849	35,700	34,900
Tribal Direct	21,263	20,524	20,500	21,143	20,000	21,774	22,300	21,800
Total Admissions	60,645	59,001	59,000	58,281	57,000	56,623	58,000	56,700
Outpatient Visits IHS Direct	4,404,394	4,470,163	4,470,200	4,597,439	4,291,400	4,702,131	4,810,300	4,710,700
Tribal Direct	5,029,888	5,326,571	5,326,600	5,520,562	5,113,500	5,596,663	5,725,400	5,606,900
Total Visits	9,434,282	9,796,734	9,796,800	10,173,528	9,404,900	10,298,794	10,535,700	10,317,600
Appropriated Amount ($ Million)	$1,249.781	$1,289.418	$1,339.488		$1,411.336		$1,484.016	$1,521.934

* These figures represent advance release data. Actual figures when they are released in the inpatient and outpatient memoranda may be different due to new facts discovered in the next two months. They are the best available estimates of these numbers at this time.

Area Allocation – Hospitals & Health Clinics

SERVICES	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate
Aberdeen	125,002,427	129,277,044	130,152,661
Alaska	238,581,198	246,739,785	248,411,000
Albuquerque	61,922,256	64,039,766	64,473,520
Bemidji	72,772,409	75,260,954	75,770,710
Billings	57,890,539	59,870,180	60,275,691
California	58,968,318	60,984,815	61,397,876
Nashville	47,904,633	49,542,793	49,878,355
Navajo	199,737,396	206,567,670	207,966,791
Oklahoma	236,759,651	255,492,390	264,954,890
Phoenix	137,188,951	141,880,302	148,932,285
Portland	64,462,333	66,666,704	67,118,250
Tucson	17,399,234	17,994,223	18,116,101
Headquarters	92,746,655	95,918,245	100,611,918
Undistributed Funds	0	13,781,600	23,874,949
Total, H&HC	**1,411,336,000**	**1,484,016,470**	**1,521,935,000**

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

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$1,411,336,000	$1,484,016,000	$1,521,934,000	+$37,918,000
Epi Centers	*$4,826,000*	*$4,971,000*	*$5,386,000*	*+$415,000*
FTE	*12*	*12*	*12*	*0*

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

Authorizing Legislation..... 25 U.S.C. 13, Snyder Act, P.L. 83-568, Transfer Act 42 U.S.C. 2001 Section 214(a) (1) Public Law 94-437, Indian Health Care Improvement Act, as amended

FY 2008 Authorization .....expired 2000

Allocation Method.....Cooperative Agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

In FY 1996 Congress authorized the innovative IHS Tribal Epidemiology Center program. The purpose was to develop Epidemiology Centers and public health infrastructure through the augmentation of existing programs with expertise in epidemiology and a history of regional support.

Epidemiology provides the foundation for all public health activities. Tribal governments and health facilities as well as IHS direct-service sites deliver public health services such as immunization and cancer prevention and control programs to American Indian and Alaska Native communities throughout the country. Efficient delivery of these service and development of effective interventions to improve health requires in-depth knowledge of the causes of illness and mortality among the population.

The IHS Division of Epidemiology and Disease Prevention (DEDP) is the national coordinating center and collaborates with the 11 TECs to collect, analyze, interpret, and disseminate health information critical to identifying diseases to target, suggesting strategies for successful interventions and testing the effectiveness of health interventions that have been implemented.

Initially, four Tribal Epidemiology Centers (TECs) were selected following competition and recommendations from an objective review panel and funded up to $155,000 each through cooperative agreements.

Starting in FY 2000, the four original TECs and two new centers were funded for another five years. Three new centers were added in FY 2005, and then in FY 2006, after the most recent competitive 5-year cooperative agreement award process, the IHS TEC program was expanded to include eleven TECs. In FY 2008, IHS will continue to fund the IHS national coordinating center in Albuquerque and 11 Tribal epidemiology centers through cooperative agreements with American Indian or Alaska Native Tribes and Tribal organizations, such as Indian health boards, at an average of approximately $400,000 each. The existing TECs serve a major portion of the AI/AN population in 11 regions. IHS also anticipates funding one additional TEC to serve the California area tribes.

In FY 2009, the IHS will continue to enhance the ability of the Indian health system to collect and manage data more effectively to better understand and develop the link between public health problems and behavior, socioeconomic conditions, and geography. The IHS will also continue to support the Tribal epidemiology program in their efforts to provide technical training in public health practice and prevention-oriented research and promoting public health career pathways for tribal communities and members.

Operating from within Tribal organizations, TECs are uniquely positioned to provide support to local disease surveillance and control programs, and also in assessing the effectiveness of public health programs. In addition, TECs work to improve data needed for GPRA reporting and monitoring of the Healthy People 2010 objectives. All TECs monitor the health status of tribes in their region, producing reports annually or biannually for constituent tribes. Following standardization of these reports across all TECs in FY 2008, the IHS National Coordinating Center will be able to produce a composite picture of Indian health.

TECs provide critical support to Tribes who self-govern their health programs. Data generated locally and analyzed by TECs enable Tribes to evaluate Tribal and community-specific health status data so that planning and decision-making can best meet the needs of their Tribal membership. Because these data are used at the local level, immediate feedback is provided to the local data systems which also can lead to improvements in Indian health data overall.

IHS health priorities, as determined by Tribal recommendations, often might be a direct result of the work of TECs. All TECs strive to monitor health status of tribes in their region, producing reports annually or biannually for constituent tribes.

Over 90 percent of the budget, or $4,971,600, will be provided to 12 Tribal Epidemiology Centers (TECs) through Cooperative Agreements. A fully staffed/funded TEC would be composed of at least one physician or doctoral-level epidemiologist, two Masters-level epidemiologists, one statistician, and support staff.

FY 2009 Tribal Epidemiology Centers Allocation (Estimate) *		
Alaska Native Tribal Health Consortium	Anchorage, AK	$ 414,300
Albuquerque American Indian Health Board	Albuquerque, NM	414,300
Great Lakes Inter-Tribal Council	Lac du Flambeau, WI	414,300
Inter Tribal Council of Arizona	Phoenix, AZ	414,300
Montana/Wyoming Tribal Leaders Council	Billings, MT	414,300
Navajo Nation Division of Health	Window Rock, AZ	414,300
Northern Plains – Aberdeen Area	Rapid City, SD	414,300
Northwest Portland Area Indian Health Board	Portland, OR	414,300
Oklahoma City Area Inter-Tribal Health Board	Oklahoma City, OK	414,300
Seattle Indian Health Board	Seattle, WA	414,300
United South and Eastern Tribes, Inc.	Nashville, TN	414,300
NEW California TEC	CA	
IHS Division of Epidemiology (DEDP)	Albuquerque, NM	414,300
TOTAL		**$5,386,000**

FUNDING HISTORY

Fiscal Year	Amount
2004	$2,450,000
2005	$4,915,000
2006	$4,525,802
2007	$4,826,000
2008 Enacted	$4,971,600

BUDGET REQUEST

The FY 2009 Hospitals and Health Clinics (H&HC) budget request includes $5,386,000 for Epidemiology Centers; an increase of $415,000 over the FY 2008 Enacted level.

The total funding for Epidemiology Centers will meet the inflationary costs associated with the operation of the TECs, especially in recruiting and keeping qualified medical and professional staff.

This program continues to promote HHS Goal 4 to enhance the capacity and productivity of the Nation's health science research enterprise.

In the expanding environment of Tribally-operated health programs, epidemiology centers provide additional public health services, such as disease control and prevention programs. Some existing centers provide additional assistance to Tribal participants in such areas as sexually transmitted disease control and HIV and cancer prevention. They also assist Tribes in activities such as conducting behavioral risk factor surveys in order to establish baseline data for successfully evaluating intervention and prevention activities.

The TEC program continues to support tribal communities by providing technical training in public health practice and prevention-oriented research and promoting public health career pathways for tribal members. Efforts to supplement the TEC programs are coordinated with the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) to optimize federal resource utilization, create stronger interagency partnerships, and prevent costly duplication of effort. *This program continues to promote HHS Goal 4 to enhance the capacity and productivity of the Nation's health science research enterprise.*

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

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$125,396,000	$133,637,000	$137,944,000	+$4,307
FTE	726	731	741	+10

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

FY 2009 Authorization.....Expired 2000

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Dental Program has been in existence since the inception of the IHS in 1955. The Dental Program raises the oral health status of the AI/AN population to the highest possible level through the provision of quality preventive and treatment services at both the community and clinic levels. The Dental Program is oriented toward preventive and basic care and 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 remain 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.

The dental program maintains data and tracking of the three key program objectives – dental sealant, dental access, and topical fluorides. During the most recently completed Government Performance and Result Act (GPRA) data collection period, the dental program exceeded the access to care target by 1 percent, the topical fluoride objective by 13 percent, and narrowly missed meeting the sealant objective by 0.5 percent. The performance represents a significant accomplishment because it was achieved during a year in which the dental provider vacancy rate was at 32 percent.

In FY 2007, the dental program utilized the Dental Clinical and Preventive Support Centers to achieve the program performance targets. The Dental Clinical and Preventive Support Centers were designed and implemented in FY 2000 to help augment the dental public health infrastructure necessary to best meet the oral health need of the AI/AN community. The primary purpose is to provide technical support, training, and assistance in clinical and preventive aspects of dental programs providing care to the AI/AN

community. Each of the support centers approaches the target based on the assessed needs of their Area but all strive towards providing the technical support, training and assistance needed for the improvement of access of care and quality of care provided to the AI/AN. The current support centers continue to develop and implement the unique and innovative programs to address the needs of the AI/AN community. The FY 2007 activities of the Support Center includes but not limited to:

- Coordinated the dental referral and recall appointments for expectant mothers, caregivers, infants and preschoolers
- Increased Tribal infrastructure to deliver community-based primary prevention and oral health education programs
- Conducted ongoing oral health assessments in Tribal communities where prevention programs are in place
- Conducted fluoridation advocacy for area communities that do not have fluoridated water
- Increased access through partnership with public/private organization to provide dental care

	Support Center	**States**	**Area**
1	AK Native Tribal Health Consortium	AK	Alaska
2	All Indian Pueblo Council	NM	Albuquerque
3	Intertribal Council of Arizona	AZ, UT, CO	Phoenix/Tucson
4	Northwest Portland Area Indian Health Board	OR, WA, ID	Portland
5	Salish & Kootenai Tribes of Flathead	MT, WY	Billings
6	CA Rural Indian Health Board	CA	California
7	Aberdeen Area Tribal Chairmen's Health Board	ND, SD, NB	Aberdeen
8	Nashville Area Dental Support Center	TN	Nashville

For FY 2007, the Dental Program placed approximately a quarter of a million sealants to the teeth of roughly 90,000 patients. One of the challenges that the program will face is that many adolescents already experience a higher prevalence of dental sealants, making it increasingly difficult to maintain current levels of sealant placement production. This represents a significant victory for IHS Dental Program, as greater percentage of eligible tooth surfaces have been protected by dental sealants.

FUNDING HISTORY

Fiscal Year	Amount
2004	$104,513,000
2005	$109,023,000
2006	$117,731,000
2007	$125,396,000
2008 Enacted	$133,637,000

BUDGET REQUEST

The FY 2009 budget request is $137,944,000; an increase of $4,307,000 over the FY 2008 Enacted level. The request provides funding for preventive, basic, and emergency dental care to the AI/AN population. The total funding will provide:

- Approximately $81.387 million will be distributed for provision of direct health care services to the approximately 1.9 million AI/ANs throughout the 12 Areas. Including:
  - $2.189 million / 24 FTE for staffing and operating costs for 2 new facilities -- Phoenix Indian Medical Center Southwest Ambulatory, Phoenix, AZ, and Lawton Hospital Expansion, Lawton, OK. Funding these new and expanding facilities allows IHS to increase basic dental care and emergency care to the AI/AN population.

Facility	Amount	Federal FTE	Tribal Positions
PIMC SW Ambulatory Center, Phoenix, AZ	$1,400,000	16	0
Lawton Hospital Expansion, Lawton, OK	789,000	8	0
Grand Total:	**$2,189,000**	**24**	**0**

- Approximately $56.555 million, or 40 percent, is contracted and/or compacted by Tribes. The Tribes utilized the funding to provide basic and emergency dental care to their members. For example, the tribes in the Oklahoma Area are using a portion of the funding to support the Oklahoma Dental Clinical and Preventive Support Center with their community and school based prevention programs.

Under the President's Health Information Technology Plan initiative, the IHS expects to continue the implementation of the Electronic Dental Record (EDR) in FY 2009 to:

- Increase patient safety
- Reduce medical/dental errors
- Increase patient visits through improved scheduling and diagnostic capabilities.
- Increase third party revenues through more effective and efficient billing practices
- Improving patient tracking and clinical functionality.

The requested budget amount will allow for the implementation of the community and clinic based oral health programs, such as dental sealant programs, topical fluoride programs, and additional program designs to increase access of care for the AI/AN population. The budget will result in:

- 5,400 fewer Topical Fluoride placed
- 12,000 fewer dental sealants placed
- 1% few patient receiving dental services
- 50,000 fewer patient visits
- 154,000 fewer dental services provided

The plans for FY 2009 are to increase emphasis on the oral health promotion and disease prevention programs with activities such as school-based dental sealant programs, community water fluoridation programs and periodontal treatment programs for high-risk patients; to increase collaboration with the Dental Clinical and Preventive Support Centers to increase awareness and education with community-based and school-based prevention programs; and to expand the collaboration with the American Dental Association (ADA) on oral health promotion and disease prevention initiatives identified

at the recent oral health summit held jointly between the ADA, IHS and American Indian and Alaska Native community members. The specific examples of the utilization of the support centers to achieve the goals for FY 2009 included but not limited to:

- Provide biannual comprehensive dental program reviews, with emphasis on improving the efficiency and effectiveness of the dental programs to each of the eight IHS and tribal dental programs in the Billings Area.
- Increase access to dental care to Diabetic patients in the Phoenix Area by establishing two periodontal treatment programs for diabetics.
- Provide training and technical assistance in sealant application to at least two staff members at 18 dental clinics in the Aberdeen Area.
- Maintain the original 5 pilot sites of Health Start Programs currently using Xylitol gum in their classrooms in the Aberdeen Area. Plans to increase Xylitol gum programs to all sites in the Aberdeen Area.
- Maintaining the 43 (out of 55) fluoridated community water systems in the Aberdeen Area.
- Conduct fluoridated advocacy for communities who do not have fluoridated water in the Oklahoma Area.
- Increase access through partnership with the public/private organization to provide care in a mobile dental clinic in the Oklahoma Area.
- Provide programs about the effect of tobacco on the oral health.

Outcome Table

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2010, improve the oral health of the AI/AN population.									
12	**Topical Fluorides[1]:** Number of American Indian and Alaska Native patients receiving at least one topical fluoride application**.**	+0.1%	113,324[2]/ 85,318	85,318	95,439	95,439	107,934	107,934	102,537
13	**Dental Access:** Percent of patients who receive dental services.	24%	24%	24%	23%	24%	25%	25%	24%
14	**Dental Sealants[3]:** Number of sealants placed per year in AI/AN patients.	287,158	249,882	249,882	246,645	246,645	245,449	245,449	233,177

[1]The FY 2005 measure target included both number of applications and number of patients. Prior to FY 2005 this measure calculated increase in number of individuals with access to fluoridated water.
*[2]The number of topical fluoride **applications**. In 2006, (measure changed to only track number of patients).*
[3]Data source changed from NPIRS to CRS in FY 2005; the FY 2004 CRS sealant result is 230,295.

Output Table

(data and dollars in millions)

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.
				Target / Est.	Actual	Target / Est.	Actual		
	Dental Vacancy Rates	22%	21%	18%	28%	21%	34%		
	Patient Visits			1.0		1.0	NA	1.0	1.0
	# of Services			3.0		3.0	NA	3.2	3.3
	Appropriated Amount	$104.5	$109.0	$117.7		$125.4		$133.7	$137.9

Area Allocation

Dental -- Allocation by Area

SERVICES	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate
Aberdeen	12,442,415	12,989,096	13,194,937
Alaska	17,346,780	18,108,944	18,395,921
Albuquerque	7,770,545	8,111,959	8,240,511
Bemidji	3,651,336	3,811,764	3,872,170
Billings	6,658,532	6,951,087	7,061,243
California	1,310,051	1,367,610	1,389,283
Nashville	2,394,722	2,499,939	2,539,556
Navajo	26,316,787	27,473,065	27,908,437
Oklahoma	23,721,989	27,495,970	28,720,704
Phoenix	10,583,415	11,048,418	12,623,503
Portland	7,140,560	7,454,294	7,572,424
Tucson	1,602,806	1,673,229	1,699,745
Headquarters	4,456,062	4,651,848	4,725,567
Undistributed Funds	0	0	0
Total, Dental	**125,396,000**	**133,637,222**	**137,944,000**

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

	FY 2007 Enacted	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$60,882,000	$63,531,000	$65,824,000	+$2,293,000
FTE	279	279	288	+9

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

FY 2009 Authorization.....Expired 2000

Allocation Method..... Direct Federal/Intramural Contract; Grants and P.L. 93-638 Self-Determination Contracts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The purpose of the Mental Health/Social Service (MH/SS) program is to support the unique balance, resiliency, and strength of our American Indian and Alaska Native (AI/AN) cultures. We strive to support AI/AN communities in eliminating behavioral health diseases and conditions by: 1) maximizing positive behavioral health and resiliency in individuals, families and communities; 2) improving the overall health care of AI/ANs; 3) reducing the prevalence and incidence of behavioral health diseases; 4) supporting the efforts of AI/AN communities toward achieving excellence in holistic behavioral health treatment, rehabilitation, and prevention services for individuals and their families; 5) advocating for and supporting Tribal behavioral treatment and prevention efforts; 6) promoting the capacity for self-determination and self-governance; and 7) advocating for AI/ANs and service providers by actively participating in professional, regulatory, educational, and community organizations at the National, State, urban and Tribal levels.

The MH/SS program is a community-oriented clinical and preventive mental health service program that provides inpatient hospitalization, outpatient mental health and related services, crisis triage, case management, prevention programming, and outreach services. The MH/SS program provides general executive direction and recruitment of MH/SS program staff to 12 Area Offices (regional) that, in turn, provide resource distribution, program monitoring and evaluation activities, and technical support to 163 Service Units. These Service Units consist of IHS and Tribal programs whose MH/SS staffs are responsible for the delivery of comprehensive mental health care to over 1.9 million AI/AN. Mental Health is crucial for the well being of AI/AN individuals and their communities.

The most common MH/SS program model is an acute, crisis-oriented outpatient service staffed by one or more mental health professionals. Many Tribes have administrative control over and delivery of the majority of mental health and substance abuse programs through tribal contracts and compacts. Such local programs are community based and have direct knowledge of their population and what interventions can be effectively implemented. Many of the I/T/U mental health programs that provide services in times of crises do not have enough staff to operate 24/7. Therefore, when an emergency occurs, the clinic and service units will often have to contract out to non-IHS hospitals and crisis centers. Inpatient services are often purchased from non-IHS hospitals or provided by State or County mental health hospitals. Medical and clinical social work are usually provided by one or more social workers who assist with discharge planning and provide family intervention for child abuse, suicide, domestic violence, parenting skills, and marital counseling.

Director's Behavioral Health Initiative: Behavioral Health is an integral part in the promotion, treatment and prevention of diseases. Many health conditions are linked to life-long behavior patterns, and therefore can be prevented by a change in lifestyle. By focusing on effective behavioral health techniques and integrating Tribal traditions and customs, we can bring proven behavioral health strategies and specific health promotion and disease prevention programs to American Indian and Alaskan Native (AI/AN) communities. Significant disparities exist within the AI/AN communities that can lead to behavioral health problems. Issues such as substance abuse, domestic violence, forced cultural change, education, poverty, lack of economic opportunity, and isolation can lead to physical and psychological problems.

The objective of the director's Behavioral Health Initiative is to improve the physical, mental, social, and spiritual well-being of AI/AN people by implementing strategies that will integrate and adapt various types of behavioral health techniques on a Federal, Urban and Tribal level, by focusing on the following areas:

- ***Methamphetamine Reduction***: Methamphetamine use in Indian country can be described in a single word "Crisis". It is a crisis for individuals, families, communities, agencies and tribal governments. Most of the services for methamphetamine prevention programs are on the Tribal community level. The IHS is supporting Tribal programs through funding, national networking, training, and educational services. In the IHS system, clinical services are provided.

- ***Suicide Prevention***: Suicide for AI/ANs in the IHS service area is 3 times higher than the national average. Suicide clustering is also a phenomenon known to occur in Indian country, affecting entire communities. Most of the suicide prevention programs are on the Tribal community level. The DBH focuses efforts in the areas of emergency preparedness, training, national networking and educational services.

- ***Child/Family Protection***: Domestic violence affects all communities, but AI/AN women and children are particularly vulnerable to abuse. With AI/AN children having the second highest rate of maltreatment and 1 in 3 AI/AN women will be physical/sexually abused in their lifetime. To help victims of violence, the IHS

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

- ***BH Management Information System (MIS)***: Used to provide direct clinical services, as well as sharing patient care documents and electronic charts across wide geographic areas in real-time (in accordance with HIPPA regulations). In 2006, a GPRA indicator for Depression Screening was implemented on order to screen for depression, potential suicide risk and suicide clustering, providing clinicians with more accurate data and documentation tools in order to develop a comprehensive treatment plan and intervention.

Current and Recent Activities -- IHS has several programs that target suicide, such as:

A. The IHS National Suicide Prevention Program (NSPN) -- The IHS National Suicide Prevention Network (NSPN) project benefits AI/AN communities by providing them with culturally appropriate information about evidence-based and promising practices, training opportunities, suicide prevention education, and other relevant information and tools to create or tailor to their own suicide prevention needs and programs.

- In 2007, provided five IHS Areas with the highest rates of suicide (Aberdeen, Alaska, Bemidji, Billings, and Tucson Areas) with $20,000 each to develop Area-wide suicide prevention strategies and assist communities in crises with train the trainer training in evidence-based and promising suicide prevention practices. These areas are to begin implementing this program in FY 2008.
- One product of the NSPN project is the IHS Community Suicide Prevention website which can be found under the IHS.gov website at http://www.ihs.gov/NonMedicalPrograms/nspn/
- Another NSPN activity is providing AI/AN communities in crises (e.g., experiencing clusters) or in need of suicide prevention, with training or funding for training and other activities, as determined by the Tribe, which are based on culturally appropriate promising and/or evidence-based practices in the area of suicide prevention education and intervention. For example, IHS is collaborating with Tribal, State and Federal agencies, as well as private organizations, to implement and adapt the Applied Suicide Intervention Skills Training (ASIST) in several communities across Indian Country. The ASIST program is listed on the evidence based registry by the Suicide Prevention Resource Centers (SPRC) website, an organization funded by SAMHSA. One promising practice that has been used in several Areas is the Native Hope curriculum. In 2006, the IHS NSPN project provided training opportunities to approximately 15 communities, and 4 Area wide trainings to the 4 Areas with the highest rate of suicides.

B. The Emergency Medical Services/Preparedness Division -- The ES is benefiting AI/AN Communities by utilizing the IHS Emergency Response to Suicide Model to assess, respond, augment, mitigate and stabilize communities experiencing significant suicide clusters and epidemics. For example, in FY 2006 - 2007, the IHS Emergency Services staff coordinated and managed the deployment of PHS mental health clinicians

through the Office of Force Readiness and Deployment (OFRD) to the Confederated Tribes of Colville reservation from August 2006 – March 2007.

C. Inter-Agency and Other Collaborations -- IHS' collaboration with Tribal, local, State, Federal and other organizations (e.g., Indian Health Boards) benefits the Tribes by sharing scarce resources to provide national and area wide suicide prevention awareness campaigns, suicide prevention conferences and trainings. Some of these collaborations included: the Joint IHS & SAMHSA National Behavioral Health Conference (5th annual) which provided training on a variety of behavioral health topics, including co-occurring disorders, methamphetamine and suicide prevention/intervention training, was held in Albuquerque, NM, June 2007 to a record attendance of over 500 participants; working in collaboration with the National LifeLine (1-800-SUICIDE crises line) and the Suicide Prevention Resource Center (SPRC) to develop and disseminate culturally appropriate information and resources for suicide prevention in Indian Country both which are funded by SAMHSA; IHS established a National Tribal Advisory Workgroup on Behavioral Health and Alcohol and Substance Abuse in 2007; through an Interagency Agreement with ACF, the IHS conducted staff training for IHS, Tribes, and other agencies and organizations to provide child protection services to AI/AN children and families.

D. Resource Patient Management System (RPMS) -- The Suicide Reporting Form (SRF) in the Resource and Patient Management System (RPMS) provides aggregate report options that can be analyzed and interpreted to inform program planning activities in support of Agency and Department suicide prevention and behavioral health initiatives. The reports are helpful in understanding the use and value of the suicide form in practice, and in understanding the problem of suicide in Indian country. Health care providers are instructed to complete a SRF when they become aware of a patient that has attempted or completed suicide or who reports suicide ideation with intent and plan. This provides useful information to health care providers for treatment planning and care coordination. In addition, in 2007 IHS implemented the GPRA Indicator for Depression Screening of adults ages 18 and over. The system is now deployed and in operation in over 250 clinical sites across the country. Depression screening improves detection, referral, and treatment of mental health needs.

FUNDING HISTORY

Fiscal Year	Amount
2004	$53,294,000
2005	$55,060,000
2006	$58,455,000
2007	$60,882,000
2008 Enacted	$63,531,207

BUDGET REQUEST

The FY 2009 budget request of $65,824,000 is an increase of $2,293,000 over the FY 2008 Enacted level of $63,531,207. The total funding will provide:

- Approximately $34,886,720 will be distributed for provision of direct health care services to the approximately 1.9 million AI/ANs throughout the 12 Areas in Federally operated health care facilities and Headquarters, including $1.286 million / 14 FTE for staffing and operating costs for 2 new and expanding facilities -- Phoenix Indian Medical Center Southwest Ambulatory, Phoenix, AZ, and Lawton Hospital Expansion, Lawton, OK. Funding for these facilities allows the IHS to expand the provision of health care in those areas where capacity has been expanded to address critical health care needs.

Facility	Amount	Federal FTE	Tribal Positions
PIMC SW Ambulatory Center, Phoenix, AZ	$906,000	11	0
Lawton Hospital Expansion, Lawton, OK	$380,000	3	0
Grand Total:	**$1,286,000**	**14**	**0**

- Approximately $30,937,280, or 47 percent, of the total request is contracted and/or compacted by the Tribes. The Tribes utilize the funding to provide basic and emergency mental health and social services treatment, rehabilitation and prevention services to their members.

The Indian Health Service (IHS) FY 2009 target for Suicide Surveillance is to increase the incidence of suicidal behavior reporting by healthcare providers to 1,846 completed Suicide Report Forms (SRF). Data collection, training (i.e., webex), and aggregate reporting for I/T/U facilities will increase the use of the Suicide Report Form and contribute to understanding suicides in Indian country and gaps in data.

The FY 2009 target for depression screening for patients over age 18 is 24 percent. Data collection, management, training, and improvement efforts at I/T/U facilities will increase and improve depression screening rates. Indian Health Service will continue to provide useful tools and training materials on the Indian Health Service website to improve depression screening rates.

Outcome Table

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2010, decrease YPLL by 20 percent over the 2002 level.									
29	**Suicide Surveillance**: Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals.	Plan	Integrated (Met)	Baseline	1,603	1,603	1,674	1,758	1846
Long-Term Objective 2: By 2010, improve treatment and prevention effectiveness through development and deployment of enhanced automated health systems to all IHS direct, Tribal and Urban sites using RPMS.									
18	**Behavioral Health**[1]: Proportion of adults ages 18 and over who are screened for depression. IHS-All	+7%[2]	+4%	Baseline	15%	15%	24%	24%	24%
18	Tribally Operated Health Programs	N/A	N/A	Baseline	14%	14%	21%	21%	21%

[1]*Prior to 2006 this measure tracked the number of programs reporting minimum agreed-to behavioral health-related data to warehouse.*
[2]*Revised from 2.3 percent, 5/2005; changes FY 2004 performance from Not Met to Met.*

Output Table

(dollars in millions)

Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Estimate	FY 2009 Estimate
			Estimate	Actual	Estimate	Actual		
Outpatient Visits	204,560	372,337		276,200		276,200	283,105	279,900
Inpatient Days	253	252		269		279	279	288
Appropriated Amount ($ Million)	$53.3	$55.1	$58.5		$60.9		$63.5	$65.8

Area Allocation – Mental Health

SERVICES	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate
Aberdeen	8,156,146	8,429,551	8,563,137
Alaska	5,906,926	6,104,934	6,201,681
Albuquerque	4,124,236	4,262,486	4,330,035
Bemidji	2,081,404	2,151,175	2,185,265
Billings	3,590,110	3,710,455	3,769,256
California	1,417,317	1,464,828	1,488,041
Nashville	1,460,483	1,509,440	1,533,361
Navajo	13,119,299	13,559,076	13,773,950
Oklahoma	8,736,639	9,637,862	10,170,595
Phoenix	5,957,646	6,157,355	7,160,929
Portland	3,948,812	4,081,182	4,145,858
Tucson	1,341,556	1,386,526	1,408,499
Headquarters	1,041,426	1,076,336	1,093,393
Undistributed Funds	0	0	0
Total, Mental Health	**60,882,000**	**63,531,207**	**65,824,000**

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

	FY 2007 Enacted	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$148,226,000	$173,243,000	$161,988,000	-$11,255,000
FTE	162	191	187	-4

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

FY 2009 Authorization.....Expired 2000

Allocation Method..... Direct Federal/Intramural Contract; Grants and P.L. 93-638 Self-Determination Contracts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The purpose of the Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral health status of American Indians/Alaska Natives (AI/ANs) to the highest possible level through the provision of 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 ASAP exists as part of an integrated Behavioral Health Team (BHT) that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in AI/AN communities. Approximately 5 percent of the employees in IHS-funded ASAP are Federal staff with Tribal and Urban staff comprising 95 percent. The reported certified counselor and professional licensure rates continue at 85 percent. ASAP measures its ability to raise the behavioral health status of AI/AN by ensuring that Youth Residential Treatment Centers (YRTC) are licensed and/or accredited and that mothers to-be receive the appropriate screenings for Fetal Alcohol Syndrome (FAS).

The 12 Residential Treatment Centers provide substance abuse and co-occurring mental health treatment services to AI/AN. Presently there are 11 operating Youth Regional Treatment Centers (YRTC) and 1 Adult Treatment Center. Congress authorized the construction of youth regional treatment centers in each IHS Area but some Tribes have elected to run their own programs. Some IHS areas such as Alaska, California and Navajo, divided their funds to provide residential services for two programs. The YRTCs that are congressionally authorized for the California Area IHS are in the implementation stage with Program Justification Documents approved by IHS Headquarters. An additional youth residential treatment center is being constructed in Nevada as a satellite of the Arizona YRTC.

In FY 2007 all but two centers continued to be accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF). One of the remaining two is licensed by the state, and the other is pending state licensure while negotiating tribal sovereignty issues with the state. This accreditation ensures that AI/AN youth receive the appropriate care and treatment for their addiction. The YRTCs in conjunction with IHS Headquarters have monthly teleconferences to share information and encourage licensure and/or accreditation.

In addition to the RTCs, many of the approximately 300 Tribal and Urban alcohol programs are State-licensed/certified and/or accredited. There are more than a dozen AI/AN alcohol and substance abuse adult residential treatment centers, including two serving pregnant women and/or women with children.

Alcohol & Substance Abuse - Youth and Adult Regional Treatment Centers				
	Name	**Town**	**State**	**IHS Area**
1	Graf-Healing Place	Fairbanks	AK	Alaska
2	Raven's Way	Sitka	AK	Alaska
3	*Desert Visions	Sacaton	AZ	Phoenix
4	Hayool K'aal Hooghan Adult TC	Chinle	AZ	Navajo
5	*Unity	Cherokee	NC	Nashville
6	*New Sunrise	San Fidel	NM	Albuquerque
7	Shiprock Adolescent TC	Shiprock	NM	Navajo
8	Jack Brown	Tahlequah	OK	Oklahoma
9	Wemble Naalam T'at'aksni House	Klamath Falls	OR	Portland
10	*Chief Gall	Mobridge	SD	Aberdeen
11	Healing Lodge of Seven Nations	Spokane	WA	Portland

* Federally operated

TeleBehavioral Health activities in FY 2007 revolved primarily around identifying the scope and extent of TeleBehavioral Health implementation (20+ active programs varying in size from several hours per month to a primary care site to complex programs serving multiple sites), clarifying and establishing TeleBehavioral Health data sets including a retrospective review of use from 2003 through 2007 that suggests a marked ramp-up in service provision (24 contacts in 2003 to 1659 contacts in 2007), proposing a TeleBehavioral Health clinic code to improve tracking in the future that has since been approved and is ready for implementation, reviewing existing MIS processes and identifying changes needed to support TeleBehavioral Health implementation, modeling potential funding models to improve scalability of TeleBehavioral Health services, negotiating funding policy changes with states resulting in significant improvements in potential TeleBehavioral Health funding support in at least one state (Arizona), and establishing a national level project manager for TeleBehavioral Health services.

Ongoing behavioral health data systems and software development are program priorities for IHS which includes the widely deployed Behavioral Health System v3.0. The Behavioral Health GUI focuses on the Data Entry module of BHS v3.0 with the goal of facilitating direct provider entry of clinical data including alcohol screenings. Data collection, management, training, and improvement efforts include expansion of the behavioral health management information system to I/T/U facilities to increase and improve alcohol screenings. Two integrated behavioral health clinical documentation

and data platforms have been deployed and there are currently over 340 clinics and Tribal programs reporting to the IHS National Database using one of these platforms. The FY 2007 target for alcohol screenings to prevent Fetal Alcohol Syndrome (FAS) was 28 percent. Due to these efforts, not only was IHS able to meet the target but IHS exceeded the target by 13 percent.

Even with the focused activities undertaken in FY 2007, significant disparities among AI/AN (relative to the general population) exist across the spectrum of substance abuse problems. The AI/AN drug-related death rate is 18 percent higher than the rate for the overall U.S. population. Among youths aged 12 to 17, the rate of current illicit drug use was highest among AI/ANs (23.0 percent for combined 2000 and 2001 data).

FUNDING HISTORY

Fiscal Year	Amount	Program Increase (non-add)
2004	$138,250,000	
2005	$139,073,000	
2006	$143,198,000	
2007	$148,226,000	
2008 Enacted	$173,242,587	$13,781,600 -- Methamphetamine

BUDGET REQUEST

The FY 2009 budget request of $161,988,000 is a decrease of $11,255,000 in unrequested funds over the FY 2008 enacted level of $173,243,000. The funding will provide:

- Approximately $21,868,380, or 13.5 percent, will be distributed for the provision of direct health care services to the approximately 1.9 million AI/ANs throughout the 12 Areas in Federally operated health care facilities and Headquarters. Of that, $30 million is provided from the Omnibus Appropriations Act of 2001 for the prevention and treatment of alcohol and substance abuse for AI/ANs -- $15 million is allocated to the Alaska Area Office for the Alaska Natives and the remaining $15 million allocated to the remaining 11 Areas according to the former Alcohol and Substance Abuse Workgroup's recommendations.
- Approximately $140,119,620, or 86.5 percent, is contracted and/or compacted by Tribes. The Tribes utilized the funding to provide alcohol and substance abuse prevention and treatment services to their members.
- In FY 2008, Alcohol & Substance Abuse received a program increase of $13,781,600 for the methamphetamine and suicide prevention and treatment initiatives. Activities funded in FY 2008 include:
  - $6,600,000 to fund a three-year grant program to establish or enhance methamphetamine prevention and treatment programs for I/T/Us;
  - $2,400,000 to fund a three-year grant program to establish or enhance suicide prevention programs for I/T/Us;

- $1,200,000 to fund the existing Residential Treatment Centers' methamphetamine and suicide initiatives;
- $1,800,000 to enhance the TeleBehavioral Health program;
- $700,000 for the administration of these new grants and to provide evaluation over the three-year grant program;
- $500,000 to fund the Suicide Intervention Pilot Project at the designated five IHS Area Offices;
- $300,000 to help fund the Emergency Medical Services/Preparedness; and
- $281,000 to help fund the IHS Sexual Assault Pilot Project.

The FY 2009 target for Residential Treatment Centers is that 100 percent will be accredited. There are 11 programs that are accredited and/or licensed with 1 program pending licensure. In order to meet the FY 2009 target, the 11 programs will maintain licensure and the 1 program will become licensed by their State. The programs will maintain state licensure and accreditation through compliance with standards of care set forth through their licensing and accrediting bodies with technical assistance provided by the IHS Division of Behavioral Health and Area Offices. One program is negotiating with the State to become licensed and is ready to submit their licensing application once the negotiation has been agreed upon.

Indian Health Service (IHS) recognizes the importance of screening and prevention of Fetal Alcohol Syndrome (FAS) and has an established an alcohol screening GPRA measure. The FY 2009 target for FAS prevention is to screen for alcohol use in female patients ages 15-44 at a rate of 41 percent. Data collection, management, training, and improvement efforts at I/T/U facilities will increase and improve alcohol screening rates. Indian Health Service will continue to provide useful tools and training materials on the Indian Health Service website to improve alcohol screening rates.

Outcome

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: Assure quality and effectiveness of Youth Regional Treatment Centers.									
10	**RTC Improvement/Accreditation:** Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more).	+2%	100%	100%	100%	100%	91%	100%	100%
Long-Term Objective 2: by 2010, reduce the rate of Fetal Alcohol Syndrome through appropriate screening and intervention for alcohol dependence in women of childbearing age.									
11	**Alcohol Screening (FAS Prevention)**: Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients. IHS-All	7%	11%	12%	28%	28%	41%	41%	41%
11	Tribally Operated Health Programs	9%	11%	12%	27%	27%	37%	37%	37%

Output Table

(dollars in millions)

Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Estimate	FY 2009 Estimate	Out-Year Target	Out-Year Target
			Estimate	Actual	Estimate	Actual				
Outpatient Visits		63,957		64,000		60,800	62,300	56,400	n/a	n/a
Inpatient Days		2,879		3,000		2,900	3,000	2,700	n/a	n/a
The proportion of methamphetamine patients who received enhanced treatment interventions within 6 months of implementation of the enhanced treatment program.	n/a	n/a	n/a		n/a			Baseline	+7%	+10%
Reduce the incidence of suicidal activities (ideation, attempts) in AI/AN grantee sites through prevention, training, surveillance, and intervention programs.	n/a	n/a	n/a		n/a			Baseline	-2%	-3%
Reduce the incidence of methamphetamine abuse in the AI/AN grant sites.	n/a	n/a	n/a		n/a		n/a	Baseline	-2%	-4%
The proportion of youth who participate in evidence-based prevention interventions.	n/a	n/a	n/a		n/a			Baseline	+7%	+10%
Establishment of trained suicide crisis response teams.	n/a	n/a	n/a		n/a			n/a	20	n/a
Increase telebehavioral health encounters.*	n/a	n/a	n/a		n/a		Baseline	+10%	+15%	n/a
Appropriated Amount ($ Million)	$138.2	$139.1	$143.2		$148.2		$173.2	$162.0	n/a	n/a

* Measures will be limited to funded sites only. Data from the initiative can be utilized to develop best practices and performance measures that can potentially be generalized to the population served by the Indian Health Service and national performance measures.

Area Allocation

Alcohol & Substance Abuse -- Allocation by Area

SERVICES	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate
Aberdeen	12,164,290	12,922,465	12,082,966
Alaska	27,422,942	29,132,157	27,239,607
Albuquerque	10,678,767	11,344,353	10,607,375
Bemidji	8,946,643	9,504,269	8,886,830
Billings	9,784,425	10,394,268	9,719,011
California	9,863,644	10,478,425	9,797,701
Nashville	7,461,832	7,926,913	7,411,947
Navajo	17,195,412	18,267,167	17,080,453
Oklahoma	13,228,229	14,052,717	13,139,792
Phoenix	12,569,988	15,349,812	14,352,622
Portland	14,705,450	15,622,011	14,607,138
Tucson	2,683,039	2,850,268	2,665,102
Headquarters	1,521,339	1,616,161	1,511,168
Undistributed Funds	0	13,781,600	12,886,288*
Total, A&SA	**148,226,000**	**173,242,587**	**161,988,000**

*The $12.886 million in the undistributed funds for FY 2009 are the undistributed funds (P.L. 106-914).

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

CONTRACT HEALTH SERVICES

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$543,099,000	$579,334,000	$588,161,000	+$8,827,000
FTE	2	2	2	+0

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

FY 2009 Authorization.....Expired 2000

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS CHS program originated under the Department of Interior, Bureau of Indian Affairs when authority to enter into health services contracts for American Indian and Alaska Natives (AI/AN) was provided under the Johnson O'Malley Act of 1934; then transferred to the Department of Health, Education, and Welfare in 1955 when IHS was established.

The contract health services (CHS) are used to supplement and complement other health care resources available to eligible AI/AN). The CHS program is administered through the 12 IHS Area Offices that include 163 IHS and Tribal service units. The CHS program purchases health care services for IHS beneficiaries from non-IHS providers. Purchasing health care services from non-IHS providers is essential to the overall IHS health care delivery system as many IHS hospitals and clinics cannot provide these services. These services are critical for Tribes and Service Units that do not have access to needed clinical services. Such programs are dependent on the CHS program to provide health care.

The CHS funds are used in situations where:

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

The CHS budget supports essential healthcare services from non-IHS or Tribal facilities and include, but are not limited to, inpatient and outpatient care, routine and emergency ambulatory care, medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, and physical therapy. Some additional services include treatment

and services for diabetes, cancer, heart disease, injuries, mental health, domestic violence, maternal and child health, elder care, refractions, ultrasound examinations, dental hygiene, orthopedic services, and transportation. These programmatic activities indirectly contribute towards measures within H&HC.

The CHS average patient daily load in FY 2007 was 208. The estimates for FY 2008 and 2009 are higher because the IHS is replacing its hospitals with outpatient care facilities. This trend has resulted in an increased reliance on the CHS resources for hospital-based care.

In FY 2007, the number of one-way trips for patient and escort travel was 35,700; in FY 2008 the estimated number of trips increases to 40,200. However, in FY 2009 the estimated number of one-way trips decreases to 39,100. This will continue to be a challenge for the CHS because access to care in remote areas of reservations will remain a challenge, and the increased cost of fuel places an additional financial burden on CHS resources.

The number of dental services provided in FY 2007 was 58,200. In FY 2008 the estimated number of dental services increases to 65,700. However, in FY 09 the number of dental services decreases to 63,000. Again, the rising cost of health care plays a critical role in the number of dental services that can be purchased. In addition, dental services provided must meet the highest medical priority in order to be funded.

The allocation of CHS funds from Headquarters to the Areas and from the Areas to the field are based on each area/service unit and tribes recurring historical base.

- Approximately $280.722 million would be distributed to the direct health care programs in the 12 Areas for Federally operated facilities.
- Approximately $307.439 million, or 52 percent, would be distributed to the contract or compact Tribes.

The CHS budget request also includes a Catastrophic Health Emergency Fund (CHEF) in the amount of $25,000,000 that provides funding for high cost cases and catastrophic costs that impact CHS programs. The CHEF offsets high cost contract care. The table below demonstrates what services were paid for in FY 2006 using the CHEF.

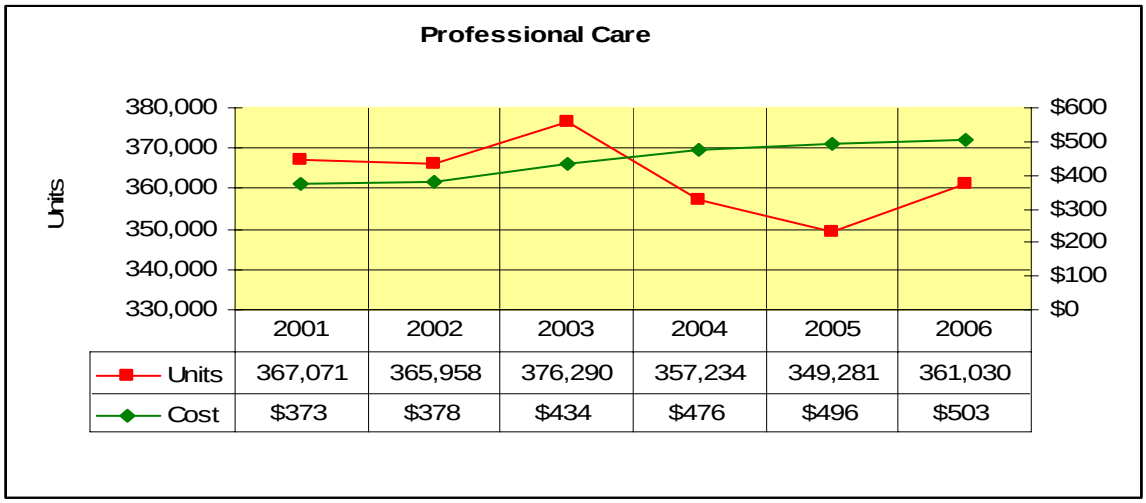
CHEF Payments by DIAGNOSIS FISCAL YEAR 2006

ICD-9-CM CODE	CATASTROPHIC ILLNESS OR EVENT	No.	CHEF AMOUNT	Organ Transplants
390-459.9	Diseases- Heart, Circulatory System	165	$ 4,664,799	1 Heart*
800-999.9	Injuries & Poisonings / MVA, GSW, Assaults	136	$ 2,895,403	
140-439.9	Neoplasms (Cancer)	103	$ 3,000,059	
520-573.9	Diseases-Digestive System	61	$ 1,516,363	1 Liver**
580-589.9	End Stage Renal/Genital Diseases	31	$ 1,722,314	
710.739.9	Diseases-Musculoskeletal system	42	$ 775,771	
460-519.9	Diseases-Respiratory System	23	$ 588,223	
240-279.3	Diabetes, Endocrine/Immunity Disorder	21	$ 668,578	
780-799.9	Symptoms, signs & ill-defined conditions	20	$ 352,317	
320-389.9	Diseases-Nervous System	14	$ 329,549	
680-709.9	Diseases-Skin & Subcutaneous Tissue	14	$ 239,234	
290-319.9	Mental Disorders/Substance Abuse	13	$ 226,451	
001-139.9	Infections & Parasitic Diseases	12	$ 504,675	
630-779.9	Pregnancy Complications/Premature Infants	7	$ 110,771	
740-759.9	Congenital Anomalies	6	$ 99,532	
280-289.9	Diseases-Blood Forming Organs	3	$ 41,138	
	TOTAL	671	$ 17,735,177	

* Billings Area, Northern Cheyenne
**Alaska

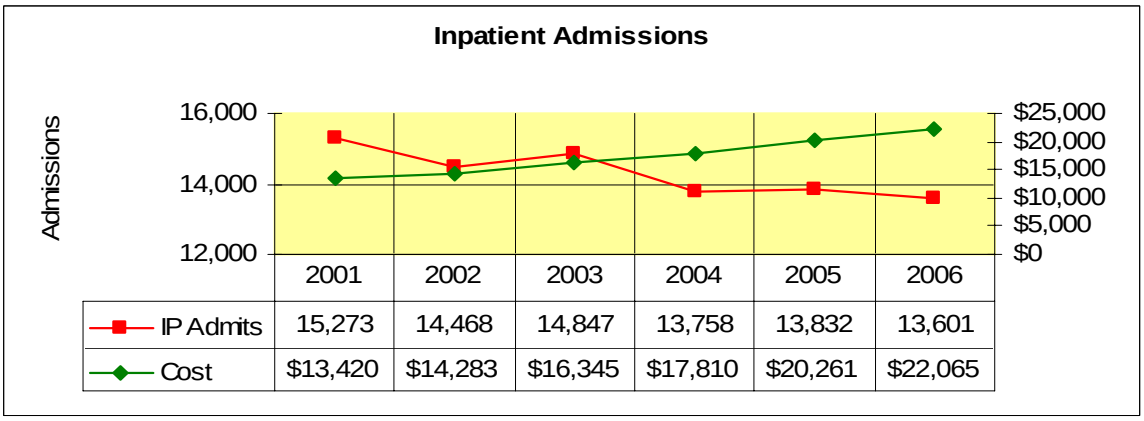
To assist the CHS program in maximizing its annual resources the program contracts with Blue Cross/Blue Shield of New Mexico as its fiscal intermediary (FI) to ensure that CHS payments are made in accordance with the IHS payment policy and the Medicare-like rates requirements as well as provide quality control. In addition, the FI coordinates benefits with other payers to stretch the CHS dollar. The FI also calculates payment rates as set forth in negotiated provider contracts. An important and integral function of the FI is to provide highly effective management reports relative to the provision of services to our patient population and provision of services by health care providers from the non-IHS community. These management reports are necessary to ensure the appropriateness of care and compliance with the intent and purpose of the use of CHS funds and overall effectiveness and management of the CHS program. The FI monitors data, processes payments, provides workload and financial data in support of the IHS statistical and financial program needs.

The IHS/CHS FI reports demonstrate that the annual medical costs continue to increase while the level of services provided annually is decreasing as follows:



	2001	2002	2003	2004	2005	2006
Units	367,071	365,958	376,290	357,234	349,281	361,030
Cost	$373	$378	$434	$476	$496	$503

- From FY2001 to FY2006, CHS purchased professional services decreased 6,041 or 2% from 367,071 to 361,030 units.
- At the same time, costs per visit increased $130 or by 35% from $373 to $503.



	2001	2002	2003	2004	2005	2006
IP Admits	15,273	14,468	14,847	13,758	13,832	13,601
Cost	$13,420	$14,283	$16,345	$17,810	$20,261	$22,065

- From FY 2001 to FY 2006 CHS Inpatient admissions declined by 11% from 15,277 to 13,601
- At the same time, inpatient billed costs per admission increased 64% from $13,420 to $22,065

In FY 2007, the CHS program successfully implemented Section 506 of the Medicare Modernization Act (MMA). The regulation requires Medicare participating hospitals to accept Medicare-like rates as payment in full. The IHS, Tribes, and Urban (I/T/U) health programs no longer have to pay full billed charges for inpatient services to hospitals that participate in the Medicare program. The Medicare-like rates will alleviate some inpatient costs.

FUNDING HISTORY

Fiscal Year	Amount	Program Increase (non-add)
2004	$479,070,000	
2005	$498,068,000	
2006	$517,297,000	
2007	$543,099,000	
2008 Enacted	$579,334,000	$18,704,000 – CHS and CHEF

BUDGET REQUEST

The FY 2009 budget request is $588,161,000; an increase of $8,827,000 over the FY 2008 Enacted level of $579,334,000. The amount set aside for the CHEF funding is $25 million in FY 2009, this is a $2 million decrease from FY 2008. This budget request will provide essential healthcare services from non-IHS facilities that include inpatient and outpatient care for both IHS and Tribal CHS programs.

The CHS efforts also address the Departmental and Agency goals of health promotion and disease prevention and the HHS strategic goal to reduce the major threats to the health and well-being of Americans and increases access to health care services while addressing the Secretary's 500-Day Plan and the President's Management Agenda that include wellness and prevention activities:

- HHS Strategic Objectives 1.2: Increase health care service availability and accessibility,
- HHS Strategic Objectives 1.3: Improving health care quality, safety, cost and value; and supports HHS priority of value-driven health care.
- Program activities directly support the HHS Strategic Goal 2: Provide accessible, quality health care, and
- Strategic Goal 3 HHS: Foster collaboration and innovation across the Indian health networks specifically supporting community-based approaches to decrease the health gap in the AI/AN population.

Outcome -- The CHS funds are used to supplement the IHS services that are not provided at the local IHS or Tribal facility. The CHS program supports all the GPRA objectives that address health care services.

Output -- The amount of contract care in relation to direct care dollars, and the types and amounts of services purchased under contract care vary among IHS Areas; the table below shows provisional budget obligations, or commitments, by general category of CHS expenditure from FY 2004 through 2007, with estimated obligations for 2008 and 2009.

(dollars in millions)

Key Outputs*	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate
General Med & Surgery Hospitalization: Average Daily Patient Load	226	217	229	208	236	230
Ambulatory Care: Outpatient Visits	495,711	497,889	505,717	485,000	516,000	503,700
Patient & Escort Travel: One-way	36,637	36,782	37,410	35,700	40,200	39,100
Dental Services	60,061	59,534	60,144	58,200	65,700	63,700
Appropriated Amount	$479.1	$498.1	$517.3	$543.1	$579.3	$588.2

*These IHS CHS outputs show the relative importance of four major contract care expenditure categories that are provided annually.

The change in IHS hospital replacements and emphasis on outpatient care has resulted in an increased reliance on CHS resources. Over the past 10 years, the IHS has initiated the replacement of hospitals with more cost effective comprehensive health care centers requiring the IHS to purchase inpatient, emergency room services and specialized care from outside sources. This trend reflects the transition of the Indian health care delivery from an acute care to a preventive and community-based patient care. These changes create a challenge to both IHS and Tribal CHS programs to be more expeditious and conscience on the way health care services are acquired. The Medicare-like rates will help to alleviate the financial challenge however; access to care in remote areas of reservations will remain a challenge.

Through the following activities CHS is working toward providing the highest level of health care to AI/ANs:

- Provide comprehensive support with emphasis on improving the efficiency and effectiveness of CHS programs through managed care initiatives.
- Provide National training and technical assistance for both IHS and Tribal CHS programs.
- Increase partnership with the IHS Business Office to maximize and access all third party resources.
- Promote health education and prevention initiatives
- Provide comprehensive healthcare services that improve life expectancy and address chronic disease that address morbidity and reduce the disparity in health status of AI/ANs as compared to the general U.S. population.
- Negotiate contracts for the best possible rates.
- Adhere to the CHS regulations and the IHS medical priority system.

Area Allocation

Contract Health Services -- Allocation by Area

SERVICES	FY 2007 Enacted	FY 2008 Enacted	FY 2009 Estimate
Aberdeen	61,862,196	64,240,876	65,450,212
Alaska	58,328,195	58,055,245	59,148,136
Albuquerque	26,180,121	27,180,365	27,692,036
Bemidji	36,965,837	37,975,832	38,690,728
Billings	46,714,154	47,051,006	47,936,743
California	26,667,050	27,762,039	28,284,661
Nashville	23,203,588	22,451,926	22,874,584
Navajo	62,075,461	63,568,337	64,765,013
Oklahoma	68,242,971	68,490,272	69,779,603
Phoenix	46,076,121	47,464,522	48,358,043
Portland	63,409,424	63,638,208	64,836,199
Tucson	13,227,555	14,060,039	14,324,720
Headquarters	10,146,327	10,816,698	11,020,323
Undistributed Funds - CHEF	0	26,578,800	25,000,000
Total, CHS	**543,099,000**	**579,334,166**	**588,161,000**

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

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$123,304,000	$127,587,000	$131,091,000	+$3,504,000
Public Health Nursing	*52,445,000*	*55,939,000*	*58,307,000*	*+2,368,000*
Health Education	*14,287,000*	*14,991,000*	*15,229,000*	*+238*
Comm. Health Reps	*54,891,000*	*54,925,000*	*55,795,000*	*+870*
Immunization AK	*1,681,000*	*1,733,000*	*1,760,000*	*+27*
FTE	**268**	**268**	**276**	**+8**

SUMMARY OF THE BUDGET REQUEST

The FY 2009 budget request of $131,091,000 and 276 FTE is an increase of $3,504,000 and 8 FTE over the FY 2008 Enacted level of $127,587,000 and 268 FTE.

Public Health Nursing $58.307 million (+$2.368 million) –

The Indian Health Service (IHS) Public Health Nursing (PHN) program is a community nursing program focused with the goals of promoting health and preventing disease and disability. The PHN health promotion and disease prevention focus is accomplished through primary prevention (education), secondary prevention (screening for disease), and tertiary prevention (reducing complications of disease) towards individuals, families, and community groups to improve health status. PHN services include: communicable disease - surveillance, immunizations and case management: maternal and child health care – prenatal/postpartum case management and education, newborn and child education and developmental screening, and case management of special needs children; chronic disease care and case management; health education and screening for at-risk diseases or health concerns, and school health screening.

Health Education $15.229 million (+$238 thousand) –

The Health Education (HE) program has identified the following areas of emphasis as the core basis for public health education in the IHS: community health, school health, worksite health promotion, and patient education. The HE 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.

Community Health Representatives $55.795 million (+$870 thousand) –

The CHR Program is primarily a Tribally-administered program under P.L. 93-638 as amended. The program was designed to bridge gaps between AI/AN persons and health care resources by integrating basic medical knowledge about health promotion/disease prevention and local community knowledge in specially trained indigenous community members.

Immunization AK $1.760 million (+$27 thousand) –

During the Tribal consultation process on the FY 2009 budget, the Tribes identified vaccine preventable diseases, vaccine performance, immunization consultation/education, research and liver disease prevention treatment and management as top health priorities. The Hepatitis B and Haemophilus Immunization Programs (Alaska) budget supports these priorities through direct patient care, surveillance and education AI/AN patients.

Preventive Health services contribute widely to the Tier 2 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 in by tracking immunization rates through specific immunization registries throughout the state of Alaska, such efforts contribute to the national immunization rates.

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

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$52,445,000	$55,939,000	$58,307,000	+$2,368,000
FTE	242	242	250	+8

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

FY 2009 Authorization.....Expired 2000

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

The Public Health Nursing's health promotion and disease prevention focus is accomplished through primary prevention (education), secondary prevention (screening for disease), and tertiary prevention (reducing complications of disease) focused health interventions towards individuals, families, and community groups to improve health status by early detection through screening and management of health issues. Public Health Nurses are members of the interdisciplinary health care team of the health care facility to improve the health care of the American Indian/Alaska Native (AI/AN) population served. The PHN is a major link for accessing health care services for many AI/ANs who live in rural and isolated communities.

PHN services include: communicable disease - surveillance, immunizations and case management: maternal and child health care – prenatal/postpartum case management and education, newborn and child education and developmental screening, and case management of special needs children; chronic disease care and case management; health education and primary prevention screenings for at- risk diseases or health concerns, and school health screenings. The AI/AN population experiences disproportionate rates of diabetes mellitus, cardiovascular disease, obesity, suicide, and unintentional injuries. The PHN program focuses on measurable clinical activities that address these health disparities, and activities that support IHS initiatives such as Chronic Disease, Health Promotion/Disease Prevention, Behavioral Health, in addition to the HHS Strategic Plan.

Specifically, the PHN outcome performance measure supports several elements of the **IHS Strategic Plan - Goals 1and 2: Build and Sustain Healthy Communities; Provide Accessible, Quality Health Care and the Secretary's 500 Day Plan of wellness and prevention activities** specifically supporting community-based approaches to address the health gap in the AI/AN population.

Forty-three percent of this budget request supports Tribal compacted and contracted PHN programs. Public Health Nursing's contributions to the agency and department goals are through funding distributed in the form of program awards for IHS and Tribal PHN programs. The 25 competitive awards issued in FY 2006 were continued in FY 2007 and emphasize Departmental and Agency goals of access to health care, Health Promotion/Disease Prevention (HP/DP) services. The program awards and grants through Public Health Nursing program are focused on improvements with immunization rates in the communities; screening, education and interventions in reducing cardiovascular disease; improvements in chronic disease management by targeted case management, patient and family education in the home; reducing childhood obesity and promotion of breastfeeding; maternal and child health improvements in prenatal case management and education, child health screening and obesity prevention, and general health promotion and disease prevention activities.

In FY 2006 a database was developed with the capability of capturing specific activities at the local level. This activity provides the ability for programs to track performance related clinical and quality improvement activities. Data improvements are evident in the output table in spite of an increasing vacancy rate for Public Health Nurses. Overall, the PHN program contributes towards 12 agency performance measures within Tier 1 & 2 Clinical and Preventive Services; six are highlighted in the corresponding output table: tobacco screening, domestic violence screening, depression screening, adult influenza vaccinations, and adult pneumococcal vaccinations. PHN activities also include home visits with focused interventions on the maternal and pediatric population such as: childhood obesity through breastfeeding promotion, screening for early identification of developmental problems, and parenting education.

A major challenge faced by the PHN program is the increasing vacancy rates over the past four years, there are fewer Public Health Nurses in the community, and is also reflected by the corresponding decrease in total PHN encounters. The program continues to make data quality improvements which contribute to the performance measures overall, particularly the screening measures.

In FY 2008 the PHN program will aggressively strive to exceed baseline activities established in FY 2007 by 5 percent, and focus on primary and secondary prevention activities, despite a likely increase in PHN vacancies, the program will assume vacancy rates will remain around 20 percent. In FY 2009, the program will attempt to maintain FY 2008 rates despite absorbing current services in FY 2009. These performance goals require the program to focus on:

- Sustained health promotion/ disease prevention services in the home and community settings.

- Maintain PHN services to individuals, family and community groups in light of additional program costs for pay, inflation, staffing of new facilities, and program increases as described.
- Targeting funds through program grants and competitive awards aimed at improving community health, disease prevention activities.
- The PHN competitive awards and grants funded for increased public health nursing interventions of health promotion and disease prevention as mentioned above in the local communities. These awardees and programs are reaching the community population to reduce morbidity through early screening and detection, risk reduction education, reduction of complications of chronic disease through home visiting, case management and patient and family education.

Public Health Nurses are members of the health care team and their interventions provide coordination of care and integrate services to the home and community. In addition, their work supports high quality community-based, culturally appropriate care to reduce disparities in access and health outcomes.

FUNDING HISTORY

Fiscal Year	Amount
2004	$42,580,000
2005	$45,015,000
2006	$49,453,000
2007	$52,445,000
2008 Enacted	$55,939,000

BUDGET REQUEST

The FY 2009 budget request for Public Health Nursing is $58,307,000; an increase of $2,368,000 over the FY 2008 Enacted level of $55,939,000. The total funding will provide:

- $33,289,000, or 57 percent, to Federal Public Health Nursing programs, including:

  +$1,482,000 and +13 FTE Staffing/Operating Cost Requirements for New and Expanding Facilities: These funds will support new staff and operating costs for the Phoenix Indian Medical Center, AZ SW Ambulatory Center and Lawton, OK Indian Hospital Expansion. Funding for new staffing for new/renovated facilities allows IHS to expand provision of health care in those areas where capacity has been expanded to address critical health care needs. Without additional funds to hire staff at these facilities, these facilities will function at a low level of efficiency and not provide for the planned expansion of services.

Facility	Amount	Federal FTE	Tribal Positions
PIMC SW Ambulatory Center, Phoenix, AZ	$750,000	7	0
Lawton Hospital Expansion, Lawton, OK	$732,000	6	0
Grand Total:	**$1,482,000**	**13**	**0**

- $25,018,000, or 43 percent, for Tribal Public Health Nursing programs under Self-Determination contracts and/or compacts.

PHN services provide care to 1.9 million AI/AN population throughout the 12 Areas where Federally and Tribal operated health care facilities are located. Both Federal and Tribal Public Health Nursing programs focuses on measurable clinical activities that address these health disparities, and activities that support IHS initiatives such as Chronic Disease, Health Promotion/Disease Prevention, Behavioral Health, in addition to the HHS Strategic Plan.

PHN activities support three goals of the HHS Strategic Plan:

Strategic Objective 2.1: Prevent the spread of infectious disease.
Strategic Objective 2.2: Protect the public against injuries and environmental threats.
Strategic Objective 3.3: Encourage the development of strong, healthy, and supportive communities.

The budget will provide PHN services to individuals, family, and community groups as well as competitive awards and grants aimed at improvements in community health and improved prevention efforts through targeted health improvement activities, screening and early detection, risk reduction education, reduction of complications of chronic disease through home visiting, case management and patient and family education.

In 2007 the data improvements are evident in the output table in spite of an increasing vacancy rate for Public Health Nurses. Overall, the PHN program contributes towards 12 agency performance measures; six are highlighted in the corresponding output table: tobacco screening, domestic violence screening, depression screening, adult influenza vaccinations, and adult pneumococcal vaccinations. PHN activities also include home visits to the population served (over 114,000 home visits), with a specific focus on the maternal and child health population, chronic disease and elder population. Emphasis for the pediatric population impacts childhood obesity through breastfeeding promotion, screening for early identification of developmental problems, and parenting education. High risk elders and tertiary prevention service for chronic disease is emphasized in the home settings.

The emphasis in FY 2009 is to maintain performance levels of FY 2008. In addition, data improvements to track outcomes longitudinally will be developed. Often, it is difficult to demonstrate public health prevention outcomes on a year by year basis. There will be emphasis to improve data analysis and evaluation to be able to demonstrate improved outcomes longitudinally.

Outcome

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective: By 2010, decrease YPLL by 20 percent over the 2002 level.									
23	**Public Health Nursing**[1]: Implement a data system capable of recording the nature of public health activities other than one on one patient care, with an emphasis on activities that serve groups or the entire community.	423,379	438,376	Data system	Data system	Baseline	427,700	449,085	449,085

[1]*Prior to FY 2006 this measure tracked the number of public health nursing services (primary and secondary treatment and preventive services) provided by public health nursing.*

The FY 2007 target, to establish a baseline of public health activities and link them to specific IHS clinical performance measure, was met. In 2007, PHN recorded 427,700 encounters that contributed toward twelve agency measures. Achievement of this measure demonstrates the utility of the data system that was developed to meet last year's target. In 2004, this measure captured the number of visits, which were trending upward but did not provide information about the specific purpose, which are now available. In 2008, the program has set an aggressive target to exceed baseline activities established in FY 2007 by 5 percent to 449,085. In FY 2009, the target is to maintain FY 2008 rates.

Output Table

(dollars in millions)

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.
				Target/ Est.	Actual	Target/ Est.	Actual		
	PHN Vacancy Rates	10%	17%		28%		20%	20%	20%
	Encounters	423,379	438,376		460,234		427,700	440,500	439,200
	Contributes to the following performance measures:								
	Tobacco Screening	8,720	10,358		13,101		36,408	38228	38228
	Domestic Violence Screening	306	1,368		1,973		2,672	2,805	2,805
	Depression Screening	380	369		1,108		1,824	1,915	1,915
	Pap smear or Follow-up	3,068	2,824		2,377		3,811	4,001	4,001
	Adult Influenza Vaccine	48,362	32,433		46,881		39,797	41,786	41,786
	Adult Pneumococcal Vaccine	5,856	6,546		7,040		7,438	7,809	7,809
	Appropriated Amount	$42,580	$45,015	$49,453		$52,445		$55,939	$58,307

Area Allocation – Public Heath Nursing

SERVICES	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate
Aberdeen	7,177,746	7,491,377	7,610,093
Alaska	3,463,619	3,614,962	3,672,248
Albuquerque	3,908,180	4,078,947	4,143,586
Bemidji	1,916,785	2,000,539	2,032,242
Billings	3,799,385	3,965,399	4,028,238
California	481,818	502,871	510,840
Nashville	671,220	700,549	711,651
Navajo	12,137,972	12,668,339	12,869,094
Oklahoma	7,929,637	9,478,074	10,360,279
Phoenix	5,805,037	6,058,688	6,904,706
Portland	2,701,839	2,819,895	2,864,582
Tucson	901,675	941,074	955,987
Headquarters	1,550,086	1,617,817	1,643,454
Undistributed Funds	0	0	0
Total, PHN	**52,445,000**	**55,938,530**	**58,307,000**

Grant / Program Awards -- Public Health Nursing Grantees

Area	Grantee Name	Project Title	2006&2007 Funded
Abq	First Nations Community Healthsource; NM	Well Child/ Increase Immunization Rates	$100,000
Ak	Southeast Alaska Regional Health Consortium; AK	Well Child/ Develop and EPSDT Program	$100,000
Bem	Huron Potowatomi, Inc; MI	HP/DP CVD Risk Reduction	$100,000
Bem	Leech Lake Reservation Tribal Council; MN	HP/DP Education and Screening Program	$100,000
Bil	Chippewa Cree Tribe; MT	Chronic Disease CVD Risk Reduction	$99,706
Ca	Indian Health Council, Inc; CA	Chronic Disease DM and CVD Risk Reduction	$100,000
Ca	Lake County Tribal Health Consortium; CA	Behavioral Health/Chronic Disease: Improving Disease Management	$100,000
Ca	San Diego American Indian Health Center; CA	MCH/ Increase access to care for Infants and Children	$100,000
Ca	United American Indian Involvement, Inc; CA	Well Child/ Establish an Immunization Program	$100,000
Ok	Cherokee Nation Of Oklahoma; OK	Chronic Disease/ Obesity Prevention	$100,000
Phx	Native American Community Health Center; AZ	MCH/ Access to care for PN Patients off reservation	$100,000
		TOTAL AWARDED	**$1,099,706**

Public Health Nursing Program Awards

Area	Service Units	Project Title	2006-2007 Awards
Abe	Rapid City Service Unit	Healthy Living Initiative	$91,000
Abe	Rosebud Service Unit	Promoting Breastfeeding	$13,000
Abe	Standing Rock Service Unit	Reducing obesity in children ages 6-18	$139,000
Abe	Wagner Service Unit	Smoking cessation program	$100,000
Abq	Santa Fe Service Unit	Health promotion and disease prevention in urban AI children	$100,000
Abq	Southern Colorado Ute Service Unit	Prevention of cardiovascular disease, breast cancer, obesity and diabetes	$74,000
Nav	Chinle Service Unit	Community Based Post-partum peer support group	$84,000
Nav	Fort Defiance Service Unit	Precious Child program: Teen parenting	$100,000
Ok	Clinton Service Unit	Obesity Prevention	$100,000
Ok	Oklahoma Area	MCH Initiative, Breastfeeding, Domestic Violence	$100,000
Ok	Wewoka Service Unit	HPDP obesity prevention	$97,000
Phx	Phoenix Service Unit	Immunization improvements	$20,000
Phx	Phoenix Service Unit	Prenatal care, increasing breastfeeding, obesity prevention, childhood immunizations, adult immunizations, CVD prevention, FAS prevention	$100,000
Phx	Phoenix Service Unit	HPDP childhood obesity	$101,000
		TOTAL AWARDED	**$1,219,000**

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

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$14,287,000	$14,991,000	$15,229,000	+238
FTE	21	21	21	0

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

FY 2009 Authorization.....Expired 2000

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS Health Education program has been in existence since 1955. The program continues to focus on the importance of educating our American Indian/Alaska Native (AI/AN) clients. The 22 Health Education program staff partner with other IHS disciplines and programs to ensure that the education of our clients continues to occur even at sites without a full-time health educator. Thus, 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 our Tribal partners. No other HHS Agency has the capability of tracking health and patient education at the patient level. 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 on education. As the Health Education Output Table demonstrates, we have maintained a steady 5 percent increase in the number of AI/AN clients that have participated in an educational encounter moving from 777,000 clients in FY 2004 receiving education to 1,924,457 at the end of FY 2007. Clearly this demonstrates the IHS commitment to improve health outcomes, increased health literacy and increased patient-provider communications.

The Health Education program maintains data tracking of two key program objectives – Tobacco Cessation and Cardiovascular disease. During the most recently completed Government Performance and Result Act (GPRA) data collection period, the Health Education program increased performance from the 12 percent baseline to 16 percent of the proportion of tobacco-using patients that receive tobacco cessation intervention; and increased the proportion of at-risk patients who have a comprehensive assessment for all CVD-related risk factors to 30 percent. It is anticipated that the CVD baseline will be

maintained at 30 percent in FY 2008 and in FY 2009. Rates for tobacco cessation will also be maintained at 16 percent through the end of FY 2009.

While not a GPRA Indicator, the IHS Health Education maintains IHS-wide statistics on educational encounters. Examples of educational statistical encounters reveal: the number of clients educated, which providers provided education, where the education took place, what information the patient was provided with, the amount of time spent providing this education, whether the patient understood the education provided, and 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 22 Health Education Program staff continues to:

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

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

- Develop and strengthen a standardized, nationwide patient and health education program as evidenced by the integration of the IHS Patient Education Protocols into all IHS software packages including the PCC, PCC+ and the Electronic Health Record; with the continued provision of ongoing training to IHS and Tribal staff on the documentation and coding of patient and health education. **This effort supports the HHS strategic goal to improve the quality of health care services as well as assisting IHS to meet Healthy People 2010 Objectives.**

- Increase a concentrated focus on the area of the HP2010 Focus Area: Health Communications:
  - Increase the proportion of AI/ANs with access to health information.
  - Improve the health literacy of AI/AN with inadequate or marginal literacy skills.
  - Increase the health information contained on www.ihs.gov ensuring that information disclosed is quality-assured and cultural appropriate for AI/AN clients.
  - Work to establish one Center for Excellence in Health Communication within IHS to enhance the capacity of staff that provides educational services to AI/AN clients by providing standardized professional education and training for staff and patient and family education in the clinical facilities as well as in the community.
  - Improve patient-provider communication skills.

FUNDING HISTORY

Fiscal Year	Amount
2004	$11,793,000
2005	$12,429,000
2006	$12,429,000
2007	$14,287,000
2008 Enacted	$14,991,000

BUDGET REQUEST

The FY 2009 budget request of $15,229,000 for Health Education supports IHS facilities, Indian Tribes and Tribal organizations to develop comprehensive health education programs for AI/AN and is an increase of $238,000 over the FY 2008 Enacted level of $14,991,000 and 22 FTE.

- Within the past 10 years, Health Education has been heavily compacted and contracted by Tribal health programs. $11,259,000 or approximately 74 percent of Health Education program funding will support compacted/ contracted Tribal Health Education programs.
- $3,970,000 will be distributed to 21 IHS Federally-Administered Health Education programs in the 12 IHS Areas. Including $650,000 which supports Headquarters Health Education activities.
- No new FTEs are anticipated for FY 2009.

The plans for FY 2009 are to advocate for moving Patient Education/Health Literacy forward as a GPRA Indicator to increase outputs on the importance of education. This increased attention to health/patient education will further enhance the Office of the Surgeon General's initiatives in the area of **Healthy People 2010: Health Communications Objective.**

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

The Health Education program increased performance from the 12 percent baseline to 16 percent of the proportion of tobacco-using patients that receive tobacco cessation intervention; and increased the proportion of at-risk patients who have a comprehensive assessment for all CVD-related risk factors to 30 percent. It is anticipated that the CVD baseline will be maintained at 30 percent in FY 2008 and in FY 2009. Rates for tobacco cessation will also be maintained at 16 percent through the end of FY 2009. The reduction of Tobacco use among AI/ANs will impact cardiovascular disease rates among AI/ANs. Health Education provides education to clients on CVD and Tobacco cessation; and, additionally provides training to staff on how to impact CVD and tobacco cessation.

Outcome Table

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: By 2010 decrease YPLL by 20 percent over the 2002 level.									
32	**Tobacco Cessation Intervention[1]:** Proportion of tobacco-using patients that receive tobacco cessation intervention. IHS-All	27%	34%	Baseline	12%	12%	16%	16%	16%
32	Tribally Operated Health Programs	28%	34%	Baseline	10%	10%	12%	12%	12%
Long-Term Objective 2: By 2010 decrease YPLL by 20 percent over the 2002 level.									
30	**CVD Comprehensive Assessment[2]:** Proportion of at risk patients who have a comprehensive assessment for all CVD-related risk factors**.** IHS-All	2 sites	43%	44%	48%	Baseline	30%	30%	30%
30	Tribally Operated Health Programs	N/A	N/A	N/A	N/A	Baseline	24%	24%	24%

[1]*In FY 2004 and FY 2005 this measure tracked the proportion of patients ages 5 and above who are screened for tobacco use.*
[2]*In FY 2005 and FY 2006, this measure tracked the proportion of patients ages 23 and older who receive blood cholesterol screening. Prior to FY 2005 measure was: Number of community-directed pilot cardiovascular disease prevention programs.*

Output Table

(dollars in millions)

Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Estimate	FY 2006 Actual	FY 2007 Estimate	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate
Clients served/provided with patient/health education services	777,377	845,159		1,767,855		1,924,457	1,734,900	1,703,300
Health Educator FTE	22	**22**		22		22	22	22
Appropriated Amount ($ Million)	$11.8	$12.4	$12.4		$14.3		$15.0	$15.2

Area Allocation

Health Education -- Allocation by Area

SERVICES	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate
Aberdeen	1,508,686	1,565,401	1,590,208
Alaska	1,815,070	1,883,302	1,913,147
Albuquerque	1,119,261	1,161,336	1,179,740
Bemidji	591,474	613,709	623,435
Billings	1,107,623	1,149,261	1,167,473
California	265,144	275,112	279,471
Nashville	556,954	577,891	587,049
Navajo	2,242,127	2,326,414	2,363,281
Oklahoma	2,178,053	2,427,279	2,465,745
Phoenix	1,723,166	1,787,944	1,816,278
Portland	902,358	936,280	951,117
Tucson	193,682	200,963	204,148
Headquarters	83,401	86,537	87,908
Undistributed Funds	0	0	0
Total, Health Education	**14,287,000**	**14,991,428**	**15,229,000**

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

COMMUNITY HEALTH REPRESENTATIVES

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$54,891,000	54,925,000	$55,795,000	+$870,000
FTE	5	5	5	0

Authorizing Legislation.....25 U.S.C. 13, Snyder Act; P.L. 83-568, Transfer Act 42 U.S.C. 2001; P.L. 94-437, Indian Health Care Improvement Act, as amended.

FY 2009 Authorization.....Expired 2000

Allocation Method..... Direct Federal, P.L. 93-638 Self-Determination Contracts, 1 Competitive Grants, and Self-Governance Compacts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Originally begun by the Office of Economic Opportunity in 1968, the Community Health Representatives (CHR) Program was transferred to the IHS at a time when IHS was looking for ways to support the Tribes in self-determination through the provision of health care. Under the concept of utilizing community members as health para-professionals to expand health services and initiate community change, CHRs serve tribal members and communities as charged by Congress to provide health care, health promotion and disease prevention services to Indian communities (Indian Health Care Improvement Act [IHCIA] as amended, Public Law 100-713, dated November 23, 1988). The IHCIA also mandated the Secretary to provide a quality training program, including continuing education needs for CHRs.

Funds are distributed to the Tribes through Area allocations. All but two of the 264 CHR programs are administered and operated by the Tribes through contracts/compacts under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA). Headquarters CHR shares are utilized primarily for 1) training and 2) data/software development through the Resource Patient and Management System's (RPMS) CHR Patient Care Component (PCC) data application.

Training is key in providing laypersons with health education needed to perform the wide variety of 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 all of the Tier 2 performance measures under Hospitals and Health Clinics.

Training enables CHRs to provide 16 categories of services. For FY 2007, direct ***Patient Care*** led in services provided at 19 percent; ***Case Management*** over 15 percent; ***Monitoring Patients*** nearly 15 percent; ***Other Patient Services*** over 13 percent; ***Case Finding/Screening*** nearly 13 percent; ***Transportation*** over 10 percent; and ***Health Education***, 8 percent (see patient services/activities in table below). Acquiring data in CHR PCC is challenged by underutilization and under-reporting. Focusing on training of CHRs on the proper use, data entry and export of CHR PCC data will support the Secretary's 500-Day Plan of adopting information technology in health care; contribute to statistics which prove program effectiveness; and improve coordination and communication between CHRs and clinicians regarding patient care.

A CHR Program performance target is to increase service hours of Chronic Disease services for CVD, Diabetes and Cancer provided by CHRs to support clinical and community-based initiatives such as the Health Promotion/Disease Prevention, Behavioral Health and Chronic Care Initiatives. These measures impact access to health care services, expand consumer choices and promote healthy behaviors. "High talk, low tech" pays dividends, as shown in recent studies on services provided by community health workers (CHWs) like CHRs for services like direct patient care and outreach, advocacy, education and screening services furnished by that are established as cost effective. For example, Beckham (2004) showed that CHW programs utilized for asthma management reduced total per capita costs by 41 percent and Emergency Department (ED) costs by 1568 percent. On Diabetes Management, Fedder (2003) showed that Medicaid costs were reduced an average of $2,245 per patient per year by utilizing CHWs.

The health and socio-economic services CHRs provide to their communities support the HHS goal to improve the economic and social well-being of individuals, families and communities.

Program accomplishments during FY 2007 include:

1) Meeting and surpassing the program performance goal to increase by 5 percent service hours provided for chronic disease services to support clinical and community-based initiatives;
2) Enhanced collaboration with various disciplines and offices within IHS on projects, including:
   - Diabetes Program to provide outreach, referral and monitoring services;
   - Nutrition Program in the development of a 3-day specialty course emphasizing motivational interviewing, emotional eating and support to parents;
   - Chronic Care Initiative (CCI) Leadership and Innovations in Planned Care (IPC) Pilot Sites;
   - Establishment/continued support of CHR Work Groups to advise on Medications, CHR PCC training, Curriculum, etc.
3) Enhanced collaboration within HHS:
   - Specialized HIV/AIDs training and community projects designed to increase awareness and enhance screening efforts in conjunction with the Minority Aids

Initiative in the Secretary's Office;

- A National Cancer Institute-funded project aimed at involving the CHRs more effectively as part of the care team for cancer prevention, screening, education and tobacco cessation as the community arm of an expanded care team and resulting in education modules for CHRs, patients and utilization of Health Information Technology (Cancer is the second highest health priority identified by tribal leaders for FY 2009);
- Implementation of NIH quarterly mailings of NIH health information focusing on improving the development and dissemination of health information with American Indian and Alaska Native communities.

4) The revision of the CHR curriculum to content which incorporates more certified nurse aide (CNA)-type training.

IHS and Tribal health facilities depend on CHRs to track down, contact and deliver critical patient health information to patients; educate and encourage them to make and follow up on appointments; and transport if necessary. CHRs directly impact patient access to and delivery of services. Programmatic activities contribute towards Tier 1 & 2 clinical performance measures.

FUNDING HISTORY

Fiscal Year	Amount
2004	$50,996,000
2005	$51,365,000
2006	$52,946,000
2007	$54,891,000
2008 Enacted	$54,925,000

BUDGET REQUEST

The FY 2009 budget request is $55,795,000; an increase of $870,000 over the FY 2008 Enacted level of $54,925,000. The total funding for Community Health Representatives will provide:

A. $55,405,658 (or 99.3%) for P.L. 93-638 Self-Determination contracts and compacts with Tribes for direct health care, health promotion and disease prevention services such as those described in the chart below to 1.9 million AI/AN population throughout 12 Areas in homes and other community-based settings.

B. $389,342 (or .0069%) is under direct Federal administration for training, information technology costs, special projects and national education meeting(s). These retained funds will also support the following plans in FY 2009, but not limited to:

- a formal program evaluation;
- assessment and dissemination of information related to CHR involvement and integration as part of the health care team in the Chronic Care Initiative and system improvement efforts which incorporate CHRs; and
- ongoing training efforts of CHRs;

Outputs Table

(dollars in millions)

Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Estimate	FY 2009 Estimate
			Estimate	Actual	Estimate	Actual		
Patient Services in Hours directed to Chronic Diseases (1), (2)	n/a	n/a		145,719		159,684	159,684	159936
# of contacts (patient services/activities) (3), (4)	n/a	n/a		816,723		925,980	925,980	940,610
Number of CHRs trained in basic, refresher, and first responder training (5)	55	136		232		235	884	892
Number of CHRs trained on CHR PCC (6)				718		673	1,570	
Appropriated Amount ($ Million)	$51.1	$51.4	$52.9		$54.9		$54.9	$55.8

[1]*84 of 264 CHR Programs report utilizing CHR PCC (the only way IHS Headquarters can track CHR data). A factor of 3 is utilized to estimate totals.*
[2]*The Performance Goal listed above represents a goal undertaken 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 drawn from the CHR PCC software application and related to IHS GPRA indicators.*
[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 identified 5-7 additional services that regularly went 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). Assuming a factor of only 2, the estimate of patient contacts/services reported for 2007 would be 1,851,960 rather than 925,980*
[4]*Without any type of program expansion for the entire program, estimate for FY 2008 services will remain the same.*
5)National educational meeting in 06 accounted for 703 persons trained

Key challenges affecting results – Tribes' support for CHR utilization of CHR PCC for reporting purposes and access CHRs have to RPMS. Access is challenged by security measures required of all contractors for needed patient health information.

Area Allocation – Community Health Representatives

SERVICES	FY 2007 Enacted	FY 2008 Enacted	FY 2009 Estimate
Aberdeen	6,960,563	6,964,823	7,075,196
Alaska	4,225,040	4,227,626	4,294,622
Albuquerque	3,188,243	3,190,194	3,240,750
Bemidji	4,475,421	4,478,160	4,549,127
Billings	4,104,237	4,106,749	4,171,830
California	1,866,731	1,867,873	1,897,474
Nashville	2,926,273	2,928,064	2,974,466
Navajo	6,603,977	6,608,019	6,712,738
Oklahoma	8,311,022	8,316,109	8,447,896
Phoenix	5,596,647	5,600,073	5,688,819
Portland	4,444,693	4,447,413	4,517,893
Tucson	1,805,119	1,806,224	1,834,848
Headquarters	383,034	383,268	389,342
Undistributed Funds	0	0	0
Total, CHR	**54,891,000**	**54,924,598**	**55,795,000**

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

HEPATITIS B AND HAEMOPHILUS IMMUNIZATION PROGRAMS (ALASKA)

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$1,681,000	$1,733,000	$1,760,000	+$27,000
FTE	0	0	0	0

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

FY 2008 Authorization .....Expired 2000

Allocation Method.....Tribal contracts; Tribal Shares; Grants

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Liver Disease and Hepatitis Program (Hepatitis B Program) was initiated in 1983 because of the need to prevent and monitor a large population of Alaska Natives with and susceptible to hepatitis B infection; it continues to provide this service in addition to evaluation of vaccine effectiveness and the medical management persons with hepatitis and liver disease. 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 provides resources, training and coordination to tribal facilities throughout Alaska. These programs are distinct programs of the Alaska Native Tribal Health Consortium which is based in Anchorage, Alaska.

Hepatitis B Program

Based on demonstrated high rates of disease, program activities include clinical care of chronic liver disease patients, consultation on immunization and hepatitis issues, follow-up of hepatitis B carriers, follow-up and new evaluation of hepatitis C infected persons, follow-up of persons with autoimmune liver disease, follow-up of large cohorts of infants, children and adults vaccinated with hepatitis A and B vaccine to determine duration of immunity and if booster doses will be needed in the future. In addition, the program implemented another program that diagnoses, evaluates and counsels patients with non-alcoholic fatty liver disease.

The program accomplishments are:

- The Liver Disease and Hepatitis 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 2006 and 2007, 63 and 60 percent of patients were screened for liver cancer at least once during the year and 50 have been started on antiviral therapy. It is estimated that 200-300 Alaska Natives may need antiviral therapy in the next 5 years.

- The program monitors Alaska Natives with hepatitis C infection for alpha-fetoprotein to detect liver cancer early and perform liver function tests to identify potential treatment candidates. 91 patients have been treated with 6 month to 1-year courses of antiviral therapy and an estimated 200 to 300 will need therapy in the next 5 years.
- The program actively screens for autoimmune hepatitis (AIH) primary biliary cirrhosis (PBC) and nonalcoholic fatty liver disease in the Alaska Native population. The program has determined the prevalence of AIH, to be 42.9/100,000 (highest of any ethnic group reported in the world) and PBC, will conduct studies to better understand and monitor the treatment of this disease. Due to the high rates of obesity and type-2 diabetes in Alaska Natives, the program has increased surveillance, screening, counseling and treatment of non-alcoholic fatty liver disease.
- The program is continuing studies on the immunogenicity, safety and long-term efficacy of hepatitis A and B vaccines in infants, children and adults with 1,050 patients enrolled. The results of many of these studies are published and have made a significant contribution to the literature.
- The program helped to establish and is upgrading a Molecular Biology Laboratory at the Alaska Native Medical Center, which, to our knowledge, is the only laboratory of this type to be in an IHS facility. Work conducted there has improved our understanding of hepatitis virus genotypes and disease outcomes and allowed us to closely monitor viral loads.
- Collaborating with CDC in Atlanta on a study of the prevalence of chronic liver disease in patients seen at the Alaska Native Medical Center. This study will help to illustrate the overall health impact and help us better address disease disparities.

Immunization (Hib) Program

The purpose of the Immunization Program is to maximize the prevention of vaccine-preventable disease through advocacy, training, resources, immunization tracking, coordination of vaccine delivery and research on vaccine-preventable disease. Statewide immunization records are audited quarterly to update and review of immunizations completed and/or needed. The patient (or their parent) and their provider are subsequently notified (via letter, phone call or other method) of immunization needs.

In addition, the Immunization Program has implemented routine rotavirus and human papillomavirus (HPV) vaccination and is working with the CDC Arctic Investigation Program and Tribal agencies to promote and monitor the impact of HPV vaccine in Alaska Native females.

The Liver Disease and Hepatitis Program (Hepatitis B Program) and the Immunization (Haemophilus Influenza) Program both provide consultation on immunization and liver

disease issues to Indian Health Service and Tribal providers throughout the US. Both programs conduct research and publish journal articles in peer-reviewed journals on topics related to vaccine-preventable disease, hepatitis, other liver diseases and health disparities in AI/ANs.

The program accomplishments are:

- Met IHS GPRA target objective of 78 percent for childhood immunizations in FY 2007, with 85 percent of 19-35 month old children fully immunized.
- Greatly exceeded the IHS GPRA target objective of 76 percent for pneumococcal (Pneumovax) immunization of elders in FY 2007 with 91 percent of elders immunized
- Alaska Area was below the IHS GPRA target objective of 59 percent for influenza immunization of elders in FY 2007 with an immunization rate of 53 percent.
- Elimination of vaccine-type pneumococcal cases among Alaska Natives <2 years old.
- 98 percent decrease in Hib disease with over 450 cases prevented by vaccine.
- Implemented routine rotavirus immunization in Alaska Native infants.
- Implemented audits of immunization rates in Alaska Native elders, and electronic report for auditing adolescent immunization rates.
- Initiated new quarterly reporting of adolescent vaccination rates.
- Obtained AAP funding for "Kusko Immunization Initiative" in the Yukon Kuskokwim Delta. This **initiative won a national award for innovation**.
- Completed enrollment in a study to evaluate the viral etiology of respiratory hospitalizations and implemented a study to address chronic lung disease and bronchiectasis in Alaska Native children; published a major article in JAMA on the emergence of replacement strains of pneumococcal infections in Alaska
- Published 4 articles in peer-reviewed journals and co-authored two Alaska Epidemiology Bulletins.

FUNDING HISTORY

Fiscal Year	Amount
2004	$1,561,000
2005	$1,572,000
2006	$1,621,000
2007	$1,681,000
2008 Enacted	$1,733,000

BUDGET REQUEST

The FY 2009 budget request is $1,760,000 and 0 FTE is an increase of $27,000 from the FY 2008 Enacted level of $1,733,000 and 0 FTE.

Hepatitis B and Haemophilus Immunization Programs (Alaska) +$27,000
The funding for Hepatitis B and Haemophilus Immunization Programs (Alaska) supports the Tribally-identified priorities (from the Tribal consultation process), such as vaccine preventable diseases, vaccine performance, immunization consultation/ education, research and liver disease prevention treatment and management as top health priorities. The Hepatitis B and Haemophilus Immunization Programs (Alaska) budget supports these priorities through direct patient care, surveillance and education to AI/AN patients.

Vaccination of the elderly against pneumococcal disease is one of the few medical interventions found to improve health and save on medical costs. This measure is included in the "One HHS" 10 Department-wide Management Objectives to attain a 10 percent relative increase by FY 2007. The FY 2007 Alaska Area elder's pneumococcal vaccination rate of 91 percent greatly exceeds the National GPRA objective of 76 percent for FY 2007.

The program supports **HHS Strategic Goal 2:** Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats, and specifically support **Strategic Objective 2.1:** Prevent the spread of infectious diseases.

Routine immunizations represent a cost-effective public health measure that significantly improves the health of children. The FY 2007 target for childhood vaccination was met and exceeded for Alaska Area, with the percentage of children ages 19-35 months receiving recommended vaccines at 85 percent.

The Hepatitis B Program provides regular screening of hepatitis B carriers for hepatocellular carcinoma (HCC) and active liver inflammation, with a goal to screen 50 percent twice a year and 70 percent at least once a year. A study of persons who presented with symptomatic HCC showed that alpha-fetoprotein (AFP) to be a useful marker to identify HCC at an early stage. Those with elevated AFP levels are evaluated for lesions and treated as needed. Those with elevated ALT or AST may have active hepatitis B and need antiviral treatment. We plan to continue our analysis of screening patterns to identify villages/regions where rates have fallen off and to develop interventions with a goal to maintain/improve screening rates.

Resources from IHS, National Institutes of Health, Center for Disease Control grants and other contracts support the programs for Alaska. There has been an increase of services provided through an expansion of clinical and other services provided. For example, IHS added a full day clinic (52/year) at Alaska Native Medical Center and two field clinics which increases patient loads and serves to increase diagnosis of liver disease in patients previously not screened/tested.

Output

(dollars in millions)

Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Estimate	FY 2006 Actual	FY 2007 Estimate	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate
Hepatitis Program (Visits = V and Screened = S)								
Hepatitis Patients **Targeted** for Screening	n/a	n/a	n/a	T=2538	T=2638	T=2621	T=2738	T=2738
Chronic Hepatitis B Patients **Screened**	n/a	n/a	n/a	S=745 T=1175	S=845 T=1275	S=690 T=1167	S=790 T=1267	S=790 T=1267
Chronic Hepatitis C Patients **Screened**	n/a	n/a	n/a	S=609 T=1076	S=709 T=1176	S=608 T=1139	S=708 T=1239	S=708 T=1239
Other Liver Disease Patients **Screened***	n/a	n/a	n/a	S=227 T=287	S=277 T=337	S=224 T=315	S=327 T=387	S=327 T=387
Number of Hepatitis A/B vaccinations**	n/a	n/a	n/a	5850	5800	4556	5000	5000
Immunization Program								
2010 Objective: Combined (4:3:1:3:3) Immunization Rates for AI/AN Children Aged 19-35 Months	72%	85%	85%	88%	88%	85%	80%	80%
2010 Objective: Influenza vaccination rates among adult patients aged >65 years	54%	59%	59%	56%	59%	57%	59%	59%
2010 Objective: Pneumococcal vaccination rates among adult patients aged 65 years and older	69%	69%	72%	89%	76%	91%	76%	76%
3-27 month old Alaska Native immunization rates reported:	4,900	5,000	5,000	4,800	5,100	5,100	5,200	5,200
19-35 month olds Imm Audited:	n/a	n/a	n/a	3300	2,900	3,577	3,100	3,100
11-17 year old Imm. audited	n/a	n/a	n/a	n/a	n/a	9,574	9,500	9,500
65+ year old Imm. audited	n/a	n/a	n/a	n/a	6,000	8,147	8,100	8,100
Appropriated Amount	$1.6	$1.6	$1.6		$1.7		$1.7	$1.8

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

*Other liver disease includes autoimmune hepatitis, primary biliary cirrhosis, and non-alcoholic fatty liver disease

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

Area Allocation

Immunization -- Allocation by Area

SERVICES	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate
Aberdeen	0	0	0
Alaska	1,681,000	1,732,544	1,760,000
Albuquerque	0	0	0
Bemidji	0	0	0
Billings	0	0	0
California	0	0	0
Nashville	0	0	0
Navajo	0	0	0
Oklahoma	0	0	0
Phoenix	0	0	0
Portland	0	0	0
Tucson	0	0	0
Headquarters	0	0	0
Undistributed Funds		0	0
Total, Immunization	**1,681,000**	**1,732,544**	**1,760,000**

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URBAN INDIAN HEALTH

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$33,691,000	$34,547,000	$0	+$34,547,000
FTE	7	7	0	-7

Authorizing Legislation ..... ……Title V, P.L. 94-437, The Indian Health Care Improvement Act, as amended.

FY 2009 Authorization .....Expired 2000

Allocation Method.....Contracts and grants awarded to Urban Indian Health Organizations.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Urban Indian Health Program (UIHP) is proposed for termination in FY 2009. Resources will be directed towards provision of health care services in Tribal communities on or near reservations.

The UIHP was established in 1976 to provide affordable accessible health care for the underserved urban AI/AN population. The IHS provided funding through contracts and grants with 34 urban Indian 501(c) (3) non-profit organizations to provide health care services in 41 sites throughout the U.S. Urban Indian Health Organizations (UIHO) defined their scope of work and services based upon the documented unmet needs of the urban AI/AN communities they served. UIHOs were governed by Boards of Directors of whom at least 51% are AI/AN.

UIHOs provided primary medical health care and public health case management wrap-around services for approximately 74,000 urban AI/ANs who did not have access to the resources offered on the reservation. Urban primary care clinics and case management programs provided high quality culturally accessible, affordable and accountable health services including ambulatory health care, health assessment, health promotion, disease prevention, child abuse prevention, immunizations, and behavioral health services. These services contributed to the IHS data reporting requirements such as the Diabetes Clinical Audit, and also supported both agency and departmental initiatives such as the Chronic Care Initiative and the HHS Strategic Plan.

The 34 UIHOs were categorized based upon the level of services they had the capacity to provide.

There were 21 Comprehensive Ambulatory Facilities. A comprehensive UIHO provided direct medical care to the population served for 40 or more hours per week. The range of services greatly varied among these programs that were defined as comprehensive. A few comprehensive programs had two or more full-time medical doctors, full-time pharmacist, provided lab and radiology services, and had on-site dental providers. At the opposite end of the spectrum, some comprehensive programs had a full-time medical provider on site, but did not offer dental, pharmacy, lab or radiology services. The designation of "comprehensive" is actually a relative term for a program which is not currently designed to be a truly comprehensive health program in the more commonly used sense of the word.

There were 6 Limited Ambulatory Facilities. A limited UIHO provided direct medical care to the population served for less than 40 hours per week. As with comprehensive programs, the services provided by programs defined as Limited varied. Some programs had medical providers on-site for 32 hours per week; other programs had a medical provider on-site for only 4 hours per week.

There were 7 Outreach and Referral Facilities. These UIHOs had counselors to provide counseling services in areas of mental health, substance abuse, health promotion/disease prevention education, immunizations, and cultural outreach and referral services under Memorandum of Understanding. Direct medical care services were not provided by these facilities because they did not have a medical doctor on-site.

The target audience or eligibility for Urban Indian Health Program Health Care Services is defined in the authorizing program legislation. An "Urban Indian" eligible for services, as codified at 25 U.S.C. § 1603(c), (f), (g), includes any individual who:

(1) Resides in an urban center, which is any community that has a sufficient urban Indian population with unmet health needs to warrant assistance under Title V, as determined by the Secretary of the Department of Health and Human Services ("HHS"); and who
(2) Meets one or more of the following criteria:
    (A) Irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including: (i) those tribes, bands, or groups terminated since 1940, and (ii) those recognized now or in the future by the State in which they reside; or
    (B) Is a descendant, in the 1st or 2nd degree, of any such member described in (A); or
    (C) Is an Eskimo or Aleut or other Alaska Native; or
    (D) Is the descendant of an Indian who was residing in the State of California on June 1, 1852, so long as the descendant is now living in said State; or[1]
    (E) Is considered by the Secretary of the Department of the Interior to be an Indian for any purpose; or
    (F) Is determined to be an Indian under regulations pertaining to the Urban Indian Health Program that are promulgated by the Secretary of HHS.

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[1]Eligibility of California Indians may be demonstrated by documentation that the individual:
(1) Holds trust interests in public domain, national forest, or Indian reservation allotments; or
(2) Is listed on the plans for distribution of assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), or is the descendant of such an individual.

Urban programs submitted a report on the amounts and purposes for which Title V funding was expended, including: a) the number of eligible Urban Indians to whom services were provided, and b) the number and type of services provided to those eligible Urban Indians. Information contained in the 2006 UCRR showed that the Urban Indian health programs served a population that was 54 percent American Indian. The remaining 46 percent included other minority groups, Medicare/Medicaid eligibles, and others with private insurance and those who paid on a sliding-fee scale. The actual percentage of each of these non-Indian groups is not available as this information is not gathered through the UCRR. Urban programs had policies requiring supporting documentation of the eligibility of a particular individual included on their reports which included: Certificate of Degree of Indian Blood (CDIB), BIA Form 4432, Tribal Membership Card, Tribal Correspondence, Birth Certificate(s) (state seal or certified copy) to establish descendancy (first or second degree), Family Documents (e.g., family bible), and Self-Certification.

In FY 2007, the UIHOs effectively implemented the HHS Priorities, the HHS Strategic Plan Goals and Objectives Fiscal Years 2007–2011, and the IHS Strategic Plan 2007–2011.

The 2007 GPRA reporting cycle (July 1, 2006 – June 30, 2007) was successful for the Urban Indian programs. Areas of greatest accomplishment included: (1) 100 percent of the urban programs reported GPRA – 34/34, and (2) 82 percent of the urban programs reported using 100 percent review of the appropriate data source – 28/34 (as opposed to sampling a smaller percentage of records)

Compared to IHS 2007 national results/targets, urban programs met 53 percent of the 2007 national targets – an impressive accomplishment given second year to report. Urban programs were at or above the IHS national rates with regard to achieving the quality standards for: Poor and Ideal Glycemic control for diabetic patients, Blood Pressure Control for diabetic patients, Nephropathy Assessment for diabetic patients, Cancer Screenings (Pap Smear and Mammography), and Depression Screening.

Implementation of the IHS Resource and Patient Management System (RPMS) in Urban Programs -- Ambitious targets and timeframes were established for implementing the IHS clinical information system, the Resource and Patient Management System (RPMS), in 21 urban programs. The primary objective was to integrate patient care and cost data in a single automated data processing system that collected and stored a core set of health and management data that cut across disciplines and facilities.

The FY 2008 target was to establish RPMS in 11 more urban programs. Urban program health professionals and staff were funded to attend RPMS training including: PIMS training, PCC data entry, patient registration, third party billing, behavioral health, diabetes, i-care, and site manager training. Nine IHS Area Offices' Office of Information Technology (OIT) were funded to: (1) procure and install circuits, hardware, and servers to support urban health programs, and (2) support IT personnel including the business office and health information management office costs in support of urban programs.

Urban programs established partnerships with the Veterans Health Administration. All urban programs had active partnerships with their local VA. They had agreements with the local VA that identified joint program initiatives and program services such as alcohol/substance abuse prevention and treatment, HP/DP, and mental health services.

FUNDING HISTORY

Fiscal Year	Amount
2004	$31,619,000
2005	$31,816,000
2006	$32,744,000
2007	$33,755,000
2008 Enacted	$34,547,000

BUDGET REQUEST

The FY 2009 budget request for Urban Indian Health is $0; a decrease of $34,547,000 over the FY 2008 Enacted level.

IHS resources have always been targeted to providing health care to communities on or near reservations. For many of these communities, health care from outside the IHS does not exist. Unlike Indian people living in isolated rural areas, urban Indians live near hospitals and health care providers, and they have access to programs such as Medicaid, and other Federal, State and local health care programs, on the same basis as all Americans. One important source of health care for all low income urban Americans is the 330 Community Health Centers program, administered by the Health Resources Services Administration. Funding increases for the Community Health Centers program may allow it to serve 1.5 million more urban Americans in CY 2009. Community Health Centers currently operate in all 34 cities served by the Urban Indian Health Programs and in hundreds of other cities where Indian people live.

Outcome

(data in millions)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: Percent decrease in YPLL by 2010.									
UIHP-5	Increase the number of sites utilizing an electronic reporting system	N/A	N/A	Baseline	9	+6	+9	+7	N/A
UIHP-E	Cost per service user in dollars per year.	557	776	601	737	767	1/2008	805	N/A

Output

(data and dollars in millions)

Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Estimate	FY 2006 Actual	FY 2007 Estimate	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate
Medical Encounters	195,016	**220,253**		218,314	222,680		227,134	0
Ancillary Encounters	184,962	**158,217**		206,001	210,121		214,323	0
Dental Encounters	43,605	**46,325**		51,371	52,398		53,446	0
Health Education Encounters	52,735	**53,003**		48,544	49,515		50,505	0
Nutrition Encounters	81,355	**77,346**		71,485	72,915		74,373	0
Behavioral Health Encounters	99,341	**126,703**		172,073	175,514		179,025	0
Other Encounters	148,768	**164,769**		195,356	199,263		203,248	0
Appropriated Amount ($ Million)	$31.6	$31.8	$32.7		$33.7		$34.5	$0

Grant Awards

Funding for the Urban Indian health programs for FY 2008 came from the FY 2008 appropriations for both the grants and contracts awarded to the programs. As such, these are a main part of the annual appropriation for the UIHP.

Urban Indian Health Program Contracts - RECURRING Funding from FY 2007-2009

	FY 2007	FY 2008	FY 2009 Est.
ABERDEEN			
Pierre, SD (SDUIH)	$486,266	$486,266	$0
Lincoln, NE (NUIHC)	605,526	605,526	0
TOTAL	**1,091,792**	**1,091,792**	**0**
ALBUQUERQUE			
Denver (DIHFS)	356,981	356,981	0
AIDC - Alb Indian Dental Center	518,710	518,710	0
Albuquerque (1st Nations)	884,957	884,957	0
TOTAL	**1,760,648**	**1,760,648**	**0**
BEMIDJI			
Minneapolis (IHBM)	1,476,787	1,476,787	0
Detroit (AIHFS of S.E. Michigan)	588,486	588,486	0
Green Bay, WI (UAIHC)	254,352	254,352	0
Milwaukee, WI (Ignace)	812,707	812,707	0
Chicago, IL (AIHSC)	336,736	336,736	0
Bemidji AO	0	0	0
TOTAL	**3,469,068**	**3,469,068**	**0**
BILLINGS			
Billings (IHBB)	421,880	421,880	0
Butte (NAIA)	245,811	245,811	0
Helena (HIA)	199,298	199,298	0
Great Falls (IFHC)	331,862	331,862	0
Missoula (MIC)	298,692	298,692	0
TOTAL	**1,497,543**	**1,497,543**	**0**
CALIFORNIA			
Bakersfield (CSV)	273,849	273,849	0
Oakland/Sfrancisco	754,134	754,134	0
Oakland - Frienship House ASA	0	0	0
Sacramento (SUIHP)	690,945	690,945	0
San Jose (IHC of SCV)	388,645	388,645	0
Santa Barbara (AIHSC)	371,680	371,680	0
San Diego (SDAIHC)	487,569	487,569	0
Los Angeles (UNAII)	1,123,482	1,123,482	0
Fresno (NAIC-SF)	340,362	340,362	0
CAO T&TA	0	0	0
TOTAL	**4,430,666**	**4,430,666**	**0**
NASHVILLE			
Baltimore (Lifelines)	0	0	0
New York (AICH)	375,566	375,566	0
Boston, MA (NAICB)	278,974	278,974	0
Nashville Area Office	0	0	0
TOTAL	**654,540**	**654,540**	**0**
NAVAJO			
Flagstaff, AZ (NACA)	392,761	392,761	0
TOTAL	**392,761**	**392,761**	**0**

OKLAHOMA			
Dallas (DITC)	1,005,411	1,005,411	0
Oklahoma City (OCIC)	0	0	0
Tulsa, OK (IHCRC)	0	0	0
Wichita, KS (HHC)	507,753	507,753	0
TOTAL	**1,513,164**	**1,513,164**	**0**
PHOENIX			
Reno, NV (NUI)	314,902	314,902	0
Phoenix (NACHC)	1,114,288	1,114,288	0
Salt Lake City, UT (IWC)	408,909	408,909	0
TOTAL	**1,838,099**	**1,838,099**	**0**
PORTLAND			
Seattle (SIHB)	3,417,126	3,417,126	0
Portland (NARA of the NW)	643,336	643,336	0
Spokane (N.A.T.I.V.E. Project)	515,116	515,116	0
TOTAL	**4,575,578**	**4,575,578**	**0**
TUCSON			
Tucson (TIC)	393,728	393,728	0
TOTAL	**393,728**	**393,728**	**0**
GRAND TOTAL, Contracts	**$21,617,587**	**$21,617,587**	

Urban Indian Health Program Grants - Recurring Funding from 2007-2009

	FY 2007	FY 2008	FY 2009 Est.
ABERDEEN			
Pierre, SD (SDUIH)	$210,368	$210,368	$0
Lincoln, NE (NUIHC)	179,110	179,110	0
TOTAL	**389,478**	**389,478**	**0**
ALBUQUERQUE			
Denver (DIHFS)	162,232	162,232	0
Albuquerque (1st Nations)	220,629	220,629	0
TOTAL	**382,861**	**382,861**	**0**
BEMIDJI			
Minneapolis (IHBM)	526,244	526,244	0
Detroit (AIHFS of S.E. Michigan)	188,574	188,574	0
Green Bay, WI (UAIHC)	135,289	135,289	0
Milwaukee, WI (Ignace)	172,651	172,651	0
Chicago, IL (AIHSC)	192,242	192,242	0
TOTAL	**1,215,000**	**1,215,000**	**0**
BILLINGS			
Billings (IHBB)	205,695	205,695	0
Butte (NAIA)	117,694	117,694	0
Helena (HIA)	127,480	127,480	0
Great Falls (IFHC)	164,244	164,244	0
Missoula (MIC)	153,958	153,958	0
TOTAL	**769,071**	**769,071**	**0**
CALIFORNIA			
Bakersfield (CSV)	137,550	137,550	0
Oakland/SFrancisco (NAIC-SF)	284,539	284,539	0
Sacramento (SUIHP)	191,114	191,114	0
San Jose (IHC of SCV)	184,700	184,700	0
Santa Barbara (AIHSC)	148,457	148,457	0
San Diego (SDAIHC)	176,525	176,525	0
Los Angeles (UNAII)	423,845	423,845	0
Fresno (NAIC-SF)	140,131	140,131	0
TOTAL	**1,686,861**	**1,686,861**	**0**
NASHVILLE			
New York (AICH)	167,171	167,171	0
Boston, MA (NAICB)	130,255	130,255	0
TOTAL	**297,426**	**297,426**	**0**
NAVAJO			
Flagstaff, AZ (NACA)	131,172	131,172	0
TOTAL	**131,172**	**131,172**	**0**
OKLAHOMA			
Dallas (DITC)	217,809	217,809	0
Oklahoma City (OCIC)	0	0	0
Tulsa, OK (IHCRC)	0	0	0
Wichita, KS (HHC)	146,712	146,712	0
TOTAL	**364,521**	**364,521**	**0**

PHOENIX			
Reno, NV (NUI)	176,531	176,531	0
Phoenix (NACHC)	437,139	437,139	0
Salt Lake City, UT (IWC)	195,145	195,145	0
TOTAL	**808,815**	**808,815**	**0**
PORTLAND			
Seattle (SIHB)	590,785	590,785	0
Portland (NARA of the NW)	252,355	252,355	0
Spokane (N.A.T.I.V.E. Project)	263,620	263,620	0
TOTAL	**1,106,760**	**1,106,760**	**0**
TUCSON			
Tucson (TIC)	202,721	202,721	0
TOTAL	**202,721**	**202,721**	**0**
GRAND TOTAL, Grants	**$7,354,686**	**$7,354,686**	**$0**

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

INDIAN HEALTH PROFESSIONS

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$31,375,000	$36,291,000	$21,866,000	-$14,425,000
FTE	14	14	14	0

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

FY 2008 Authorization.....Expired 2000

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

In 1976, Congress enacted the Indian Health Care Improvement Act (IHCIA) P.L. 94-437 that authorizes the Indian Health Service (IHS) Indian Health Professions (IHP) to manage the Scholarship Program, Loan Repayment Program and recruitment and retention activities for IHS. However, the first awards were not made until 1978, as Congress had not appropriated funds for the IHP program.

The purpose of the program is:

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

Scholarship Program – In FY 1979, the scholarship programs started with three programs. The Preparatory and Pre-Graduate Scholarship Programs, Section 103, prepares students to enter a health profession training program. The Preparatory Scholarship program provides financial assistance for AI/AN (federally or state-recognized) students who enroll in compensatory or preparatory courses leading to entry to health professional schools such as medical, nursing, pharmacy and others. The Pre-Graduate Scholarship Program provides financial support for AI/AN (federally or state-recognized) students who enroll in courses leading to a bachelor's degree in specific pre-

professional areas such as pre-medicine, pre-dentistry and others as needed by Indian health programs.

The third scholarship program, the Health Professions Scholarship Program, Section 104, provides AI/AN students, who are (federally recognized only), and enrolled in health professions or allied health professions programs. Students incur service obligations and payback requirements on acceptance of funding from this program. Priority is given to graduate students and junior- and senior-level students unless otherwise specified.

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

The IHS Scholarship program made 1,879 scholarship awards between FY 2004 and FY 2007 (an average of 470 awards per year). This process involved area scholarship coordinators seeking out potential scholars by sending marketing packets of information to schools and Tribes, reviewing thousands of applications annually, and assuring follow-up with schools and students to assure payments are processed for tuition and that students are receiving their stipend and are meeting their academic requirements.

Approximately 10 percent fewer scholarships are expected to be awarded in FY 2008 due to increased tuition costs. The FY 2009 request will allow a percentage of students in school (approximately 186 or 242 continuing students) to continue to be funded in their health professions program.

In FY 2007, after several challenges throughout the most recently completed fiscal year, the IHS Scholarship program accomplished the following:

- Completely redesigned the scholarship website including the development of an on-line scholarship application to be implemented in 2008.
- Worked with UFMS staff and contractor to assure timely payments to students.
- The number of new graduates serving at a site within 90 days of graduation **increased by 10 percent** (from 37 percent in FY 2006 to 47 percent in FY 2007).
- Developed baseline retention beyond service obligation figures for the scholarship program.
- To illustrate the effectiveness of the IHS Scholarship program, the IHS conducted a first-time retention review of IHS scholars by developing a baseline retention rate for scholars beyond the obligated service period. A sample survey of 500 IHS scholars showed an average retention period of 6.16 years per scholar compared to the 2.21 years of service.

Loan Repayment Program – Started in FY 1988, the IHS Loan Repayment Program (LRP) offers health care professionals the opportunity to ease qualified student loan debts and help IHS meet the staffing needs of Indian health programs. The program is open to health professionals who commit to working in health facilities serving AI/ AN for a minimum two-year service obligation.

In FY 2007 (the most recently completed fiscal year), the Loan Repayment Program:

- Developed and implemented a new loan repayment database application
- Completed redesign of the loan repayment website
- Developed baseline retention beyond service obligation figures for the loan repayment program
- Conducted a first-time retention review of IHS loan repayment recipients to develop a baseline retention rate for loan re-payers beyond the obligated service period. A sample survey of IHS 1,100 loan repayment recipients showed an average retention period of 3.81 years per loan re-payer compared to the 2.5 years of service obligation.

Recruitment and Retention – The IHS continues to support the IHS recruitment and retention efforts and development of health professionals in critical health professional shortage areas.

While most health professionals are recruited to work in full-time positions, some health professionals provided temporary service to IHS facilities through several mechanisms like direct employment into temporary positions, direct contracting with various facilities, working with contract locum tenens companies, and volunteering their services for various periods of time

The IHS utilizes full-time recruiters for physicians, nurses, and dentists. In addition, many health professional staff members assist in recruitment activities by visiting professional schools, attending professional meetings as IHS representatives, and acting as preceptors and mentors for health professions students who come to their facilities as part of their training.

- In FY 2007, the IHP supported the scholarship and loan repayment programs in several ways
  - Established and maintained websites that contains information regarding health professional needs at IHS, Tribal, and urban Indian health facilities;
  - Established internship arrangements between IHS facilities and health profession training programs;
- Attended health fairs at colleges;
- Attended high school career days;
- Sent direct mailings to student health professionals;
- Encouraged high school and college students to enter the health professions;

A challenge to not meeting the FY 2009 performance goals would be the affect on the IHS professions vacancy rates. Overall, the vacancy rates for most categories are similar to those from FY 2003, even though IHS has more positions to fill due to retirements and new facilities. While the dental vacancy rate remains critical, we have seen the most dramatic increase in the physician and nursing vacancy rates. The scholarship and loan repayment programs are unable to provide enough health care professionals to substantially reduce the vacancy rate, but they do continue to have a major impact on meeting the staffing needs of hard to fill sites.

Grant Programs -- The Indians into Medicine (INMED) program, Section 114, supported over 115 student participants in 2006-2007. The programs provided recruitment, training, educational and experiential opportunities for students.

The Indians into Psychology (INPSYCH) program, Section 217, supports the IHS Director's Behavioral Health initiative that increases mental health services to AI/AN people. Direct support through IHS Scholarships, Loan Repayments, Extern programs, recruitment activities, and the INPSYCH program placed 16 licensed clinical psychologists in Indian health program in 2005, 3 in 2006 and 6 in 2007.

The projected allocation for the Indian Health Professions program in FY 2009 is:

Section	Title	Amount	Expected Outcome
103	Health Professions Preparatory Scholarship	$59,876	2 continuing and unknown number of new contracts.
104	Health Professions Scholarship	$7,972,769	186 continuing and unknown number of new contracts
105	Extern Programs	$882,666	100 temporary clinical assignments
108	Loan Repayment Program	$10,795,953	407 contract extensions and unknown number of new contracts.
112	Quentin N. Burdick American Indians into Nursing Program	$1,030,255	4 grants
114	INMED Program	$674,481	2 grants
217	American Indians into Psychology Program	$450,000	2 grants
TOTAL		**$21,866,000**	

FUNDING HISTORY

Fiscal Year	Amount	Program Increase (non-add)
2004	$30,774,000	
2005	$30,392,000	
2006	$31,039,000	
2007	$31,039,000	
2008 Enacted	$36,291,000	$4,424,980 - Loan Repayment Program

BUDGET REQUEST

The FY 2009 budget request of $21,866,000 and 14 FTE is a decrease of $14,425,000, or 39.75 percent, from the FY 2008 Enacted level of $36,291,000 and 14 FTE. The funding will provide for:

Scholarship Program $8,032,645 (-$6,033,195) -- In FY 2009, the $14,065,840 scholarship budget from FY 2008 would be reduced to $8,032,645. Administrative costs are expected to be reduced to approximately $500,000 (down from $750,000 due to not needing to run a competitive review cycle for new scholarship awards) leaving $7,472,769 available for continuation scholarship awards. The IHS will prioritize

funding for current scholarship recipients who were funded in FY 2008 and those in health professions programs over those in preparatory programs. This prioritization is expected to result in the IHS Scholarship Program providing funding for 2 (one full-time and one part-time) Section 103 contracts in FY 2008 at a cost of $59,876 and approximately 186 Section 104 scholarship students at a cost of $7,412,893 (assumes the average cost of a scholarship in FY 2009 is $39,918).

Loan Repayment Program $10,795,953 (-$6,535,505) -- The LRP budget, Section 108, received $17,331,458 in FY 2008 and would be reduced to $10,795,953 for FY 2009. Administrative costs are expected to be $961,533 leaving approximately $9,834,420 available for continuation of current loan repayment contracts. IHS would give new awards after award extensions on 407 of the current loan repayment contracts (at an average cost of $24,163) are fulfilled to retain as many providers as possible currently serving at IHS and Tribal sites. Note: The Loan Repayment Program received an additional $5,000,000 line item appropriation in FY 2008 ($4,424,980 after the 1.56 percent rescission).

Externship Program $882,666 (-$431,578) -- The Extern program, Section 105, received $1,314,244 in FY 2008 and would be reduced to $882,666 in FY 2009 with approximately 100 summer externships (at an average cost of approximately $8,762). This budget provides for student externships for scholarship recipients to work at IHS and Tribal sites during nonacademic periods.

Quentin N. Burdick American Indians into Nursing Program $1,030,255 (-$679,712) -- The Nursing program, Section 112, received $1,709,967 in FY 2008 and would be reduced to $1,030,255 in FY 2009. This level of funding will fund 4 to 6 grants.

Indians Into Medicine $674,481 (-$444,990) -- The INMED program, Section 114, received $1,119,471 in FY 2008 and will receive $674,481 in FY 2009. This level of funding will fund 2 grants.

American Indians into Psychology Program $450,000 (-$300,000) -- The INPSYCH program, Section 217, received $750,000 in FY 2008 and will receive $450,000 in FY 2009. This level of funding will fund 2 to 3 grants.

In FY 2007, to meet the HHS Strategic Objective 2.3 to promote and encourage preventive health care, including mental health, lifelong healthy behaviors, and recovery, the IHS Scholarship program was able to support additional behavioral health professionals including psychiatrists, clinical psychologists, chemical dependency counselors and social worker's to help treat and reduce uncontrolled depression in individuals and communities and the secondary results of this disease (e.g., addictions, domestic and community violence, and suicide).

Outcomes and Outputs

The performance goal refers to placement of scholars within 90 days of completion of their health professions degree. Indian health programs are being provided the number/names of graduates in each discipline to assist the programs in the recruitment of health professionals for their health facilities.

The Scholarship Program is continually striving to improve program performance, as demonstrated by a 27 percent overall increase in the 90 day placement rate from FY 2004 to FY 2007. The performance target for FY 2009 will be a 60 percent placement rate within 90 days of graduation. Increased efficiency in placing health profession scholarship recipients can and will help improve the health care delivery system at I/T/U facilities, and the workload of health professional contributes towards the accomplishment of clinical and preventive health services. However, the challenge in the event of a decrease in the program allocation would result in fewer awards and funded positions to place obligated scholars in Indian health program facilities.

Outcome

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2010, increase the number of scholarship placements within 90 days of graduation to 50 percent									
42	**Scholarships**: Proportion of Health Professional Scholarship recipients **placed in** Indian health settings within 90 days of graduation.	20%	30%	32%	37%	42%	47%	52%	60%

Output

(dollars in millions)

Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Estimate	FY 2006 Actual	FY 2007 Estimate	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate
Number of Scholarships Awarded - Total	591	414	410	432	369	442	402	188
Section 103	108	30	30	61	65	77	54	0
Section 103P	122	83	80	99	57	64	40	2
Section 104	361	301	300	272	247	301	308	186
Number of Loan Repayments Awarded-Total (Section 108)	807	798	760	792	730	741	774	611
New Awards (2 Year Awards)	269	294	240	254	250	264	228*	0
Contract Extensions (1 Year Awards)	223	235	230	244	230	223	288	407
Continuation Awards (Funded in Previous Fiscal Year)	315	269	290	294	250	254	264	228
Number of Externs (Section 105)	206	201	210	244	210	161	150	100
Number of Grants Awarded –Indians into Nursing Program (Section 112)	6	6	6	6	6	6	6	4
Number of Grants Awarded –INMED Program (Section 114)	2	2	2	2	2	2	2	1
Number of Grants Awarded –Indians into Psychology Program (Section 217)	3	3	3	3	3	3	3	2
Appropriated Amount	$30.8	$30.4	$30.0		$31.0		$36.3	$21.9

* The $4,424,890 program increase for the Loan Repayment Program ($5 million less $575,110 rescission) in FY 2008 will allow for 116 new awards in FY 2008.

Area Allocation

The Indian Health Professions program funds are administered from Headquarters.

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Indian Health Service
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TRIBAL MANAGEMENT GRANT PROGRAM

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$2,438,000	$2,489,458	$2,529,000	+$39,542
FTE	0	0	0	0

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

FY 2009 Authorization.....Expired 2000

Allocation Method.....Discretionary competitive grants are awarded to Tribes and Tribal organizations annually.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Tribal Management grant funds have been made available to tribes since 1976, with the initial passage of the Indian Self-Determination and Education Assistance Act, (ISDEAA) P.L. 93-638 and as amended, August 18, 2000. A Tribal Management Grant (TMG) award provides a Tribe the opportunity to assess, plan, or improve its capacity to assume Programs, Services, Functions and Activities (PSFA) of the IHS if it so chooses.

The TMG Program is a national competitive grant program that awards grants annually to Federally-recognized Tribes and qualified Tribal Organizations. The TMG Program began shortly after passage of P.L. 93-638. Tribes and Tribal Organizations utilize TMG funding to enhance their management capabilities through such projects as conducting health program related feasibility studies; development of Tribal specific health plans; Tribal health program operation evaluation; the development or improvement of Tribal health management structures such as establishing Tribal health boards and improving Tribal financial management systems to assist them in assuming all or part of existing Indian Health Service (IHS) programs, services, functions, or activities. All of these activities improve the management capacity of Tribes to take on additional PSFA's provided by the IHS. The IHS distributes the total appropriated amount into two parts – grant awards and program operations.

There are approximately 224 Tribes that are currently Title I contractors and 322 Tribes that are Title V compactors of a total 561 Federally-recognized Tribes. The Title I Tribal contractors include a number of those Tribes directly served by federally-operated health service facilities that have made a decision to contract for funds to operate such IHS programs as alcohol and substance abuse, community health representative, emergency

medical service, and other support and ancillary programs. These Title I contractors, many of whom consider themselves as direct service tribes (DST) have chosen not to compact all PFSAs of the IHS. Other Title I Tribal contractors continue to pursue additional PSFAs as their capacity grows and may eventually transition to Title V compact status.

Tribes and Tribal organizations continually work to improve the quality of health care provided to their communities by achieving and maintaining not only Federal standards/regulatory requirements but also applicable health care accreditations. Specific outcomes as a result of feasibility studies and evaluation studies and management infrastructure grants are:

- The establishment of Tribal Health Boards which serve as health advisory committees to Tribal Councils.
- Training of Health Boards.
- Through Tribal health board initiatives and recommendations Tribal leaders are prepared to meet their communities' health needs.
- Tribal leaders also ensure compliance through implementation of policy and procedure manuals in key areas such as quality assurance, medical records, and information technology systems.

The TMG program provides an opportunity for Tribes to evaluate Federal programs and plan for the possibility of assuming operational control of a Federal program by contracting under the provisions of the ISDEAA. However, it must be recognized that the award of a self-determination contract or compact in and of itself should not be regarded as a measure of success of the TMG program. The Federal policy of self-determination recognizes the rights of Tribes to make a decision to contract to operate a Federal program or to decide to continue to have the Federal government administer a program on its behalf. This is the hallmark of a TMG award in that it provides a Tribe the opportunity to assess, plan, or improve its capacity to assume PSFA of the IHS if it so chooses. A Tribe then can make informed choices based upon the use of the TMG award to (1) build its capacity to take over PSFA of the IHS or (2) to improve the current capability to administer or manage those PSFA it is currently responsible for and not contract additional PSFA in order to eventually compact.

This grant program is highly competitive and over time has resulted in a greater focus from the TMG program office to provide training sessions to assist Tribes (including previous applicants not selected for funding) to prepare their grant proposals for a more competitive submission and environment.

With the conversion to electronic submission of grant applications on Grants.gov in 2005, the IHS anticipated that the tribal entities would be submitting fewer applications until knowledge of the electronic application process and experience in electronic submission increased to a comfortable level. The drop in numbers in the output table adequately reflects and captures the higher submission of paper applications in 2004 and 2005. In 2005, paper and electronic applications were accepted. In FY 2006, electronic submission was deemed mandatory by IHS. Training and technical assistance was

provided by IHS to meet this need. However, the decrease in submissions is evident in the output table for years FY 2006 and 2007. It is anticipated that as the comfort level and familiarity increase for electronic submission that the numbers will gradually increase.

Decreases in funding for this grant program could result in tribes applying for the smaller awards such as $50,000 planning grants, $50,000 evaluation grants, and $70,000 feasibility studies in lieu of the management structure development grants ($100,000 per year or up to $300,000 for 3 years) in the hope of a better opportunity for funding if they are requesting smaller dollar amounts. Addressing health disparities through planning and evaluation of assumed PSFAs as well as the study of how feasible it would be to take over additional PSFAs assists the Tribes but does not help to build the Tribal health program's management infrastructure.

The award amounts and number of grants awarded by the TMG program varies annually based on the type of grant applications received and determined fundable. Grants are awarded for single year or multi-year projects dependent upon the number, dollar amounts and type of fundable applications. New grant awards are awarded each year after the multi-year non-competing continuation award funds are set aside for the previous year's multi-year grants.

FUNDING HISTORY

Fiscal Year	Amount
2004	$2,376,000
2005	$2,343,000
2006	$2,394,000
2007	$2,438,000
2008 Enacted	$2,489,458

BUDGET REQUEST

The FY 2009 budget request for the TMG Program is $2,529,000; an increase of $39,542 over the FY 2008 Enacted level of $2,489,458. The total funding will provide funding for grant awards and administrative costs respectively for:

- Approximately 7 non-competing continuations
- Estimated 11-12 new awards depending on type
- Administrative cost coverage for administering the grant program and providing grant-writing and application submission training

- The TMG Program is intended to build management capacity of the Tribes in order that they may take additional PSFA of the Indian Health Service as deliverables under their existing P.L. 93-638 contracts. This contractual relationship results in additional outsourcing of federal functions for the provision of health services to eligible American Indian and Alaska Native people and is in compliance with the President's Management Agenda.

electronic health records conversion and recordkeeping and accreditation to meet the standards of either the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the Accreditation Association for Ambulatory Health Care (AAAHC) requirements as well as correction of deficiencies in their management and internal control and financial and accounting systems revealed by the single audit act – OMB A-133 Audits of States, Local Governments and Non-Profit Organizations. All applications must reflect a health focus. If the trend continues based on the projections of increased applications for feasibility studies, planning grants and evaluation grants in lieu of the management structure type, then there may be less funds available for the management structure applications.

Area Allocation

The Tribal Management Grant funds are administered from Headquarters.

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

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$63,631,000	$63,624,000	$62,632,000	-$992,000
FTE	356	356	349	-7

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

FY 2009 Authorization.....Expired 2000

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

The Headquarters operations are determined by statute and administrative requirements set forth by the Department of Health and Human Services, the Administration, the Congress, and field operations (12 Area Offices and 163 Service Units). Headquarters actively works with the Department to formulate and implement national health care priorities, goals, and objectives. The agency works with the Department to formulate a budget and necessary legislation. In addition, it responds to congressional inquiries, and interacts with other governmental entities to enhance and support health services for Indian people. The IHS Headquarters also formulates policy and distributes resources; provides general program direction and oversight for IHS Areas and Service Units; provides technical expertise to all components of the Indian health system, which includes IHS direct, Tribally operated programs, and urban Indian health programs (I/T/U); maintains national statistics; identifies trends; and projects future needs.
The 12 Area Offices distribute resources, monitor and evaluate the full range of comprehensive health care and community oriented public health programs, and provide technical support to IHS direct and Tribally-operated programs. They ensure the delivery of quality health care through the 163 Service Units and participate in the development and demonstration of alternative means and techniques of health services management and

delivery to promote the optimal provision of health services to Indian people through the Indian health system.

The budget funds Headquarters and 12 Area offices operations, and Tribal shares (as indicated by the table below).

	FY 2007 Enacted	FY 2008 Enacted	FY 2009 Estimate
Headquarters (56.5%)	$35,670,000	$35,666,000	$35,110,000
Title I Contracts (non-add)	*2,131,585*	*2,215,143*	*2,180,587*
Title V Compacts (non-add)	*5,488,464*	*5,703,612*	*5,614,636*
Area Offices (12) (43.5%)	27,961,000	27,958,000	27,522,000
Title I Contracts (non-add)	*800,873*	*832,267*	*819,284*
Title V Compacts (non-add)	*7,374,635*	*7,663,721*	*7,544,167*
BA	**$63,631,000**	**$63,624,000**	**$62,632,000**

The Direct Operations budget supports the leadership and overall management of the IHS to ensure effective support for the IHS mission. This includes oversight of financial, human, facilities, information and support resources and systems.
Performance measurement is built into all oversight measures, both in program delivery and administrative support systems.

Leadership and direction also includes specific focus on the PMA, the HHS Performance Objectives, and the Secretary's 500-Day Plan. The IHS will carry out and report on specific activities in 8 of the 10 government-wide objectives of the PMA.
The Department tracks the performance of all HHS Operating Divisions by the use of a Management Scorecard which reflects the PMA objectives. For FY 2009, IHS activities will continue in the following PMA and HHS Performance Objective areas:

- Strategic Management of Human Capital—performance contracts and workforce planning;
- Competitive Sourcing—Tribal self-determination;
- Improved Financial Performance—support the HHS Unified Financial Management System and continued audit improvements and fiscal monitoring;
- Expanding Electronic Government—support and implement current and planned e-Gov activities (e.g., e-grants, e-learning, e-travel, automated position hiring and classification, I procurement, migration to HHS mail, HSPD-12 access to information systems); and,
- Program Improvement Initiative (formerly Budget and Performance Integration)—GPRA and Program Assessment Rating Tool;
- Federal Real Property Asset Management--effectively managing the construction, monitoring and appropriate disposal of health care facilities;
- HHS Consolidated Acquisition System-Department-wide contract management system that will integrate the Unified Financial Management System.
- Health Information Quality and Transparency Initiative—ensure that Federal health care agencies adopt and promote measures that promote consumer access to health

care pricing and quality data, while implementing interoperable health information technology and standards.

Significant activities include the establishment of performance plans that cascade throughout the agency and provide for performance accountability at all levels of the agency. The Direct Operations budget also supports leadership and oversight for the accomplishment of the performance measures that are included in the IHS FY 2009 Annual Performance Plan. The measures address many of the administrative aspects of providing health care to AI/AN population and complies with the requirements of the GPRA and the *HealthyPeople 2010* goals of achieving equivalent and improved health status for all Americans over the next decade. In addition, management improvements will be guided by the President's Management Agenda (PMA), the Department's Performance Objectives, and the priorities of the Secretary of Health and Human Services (HHS). Headquarters, through this activity, will continue to develop and expand its crosscutting collaborations and partnerships with other Federal agencies and outside organizations to meet many performance measures and PMA objectives. A FY 2009 performance goal for Direct Operations is to continue the implementation of a human capital strategy to assist managers with succession planning activities. Twenty-seven percent of IHS employees will be eligible for retirement in 2011. Enhancing the IHS workforce's knowledge and skills in areas such as financial management, entrepreneurship and the application of regulations has been identified as critical to meet the IHS' current and future needs to fulfilling the mission of the IHS.

FUNDING HISTORY

Fiscal Year	Amount	
2004	$60,714,000	
2005	$61,649,000	
2006	$62,194,000	
2007	$63,631,000	
2008 Enacted	$63,624,000	

BUDGET REQUEST

The Direct Operations FY 2009 budget request of $62,632,000 and 349 FTE is a decrease of $992,000 and 7 FTE over the FY 2008 Enacted level of $63,624,000 and 356 FTE.

Area Allocation

Direct Operations -- Allocation by Area

SERVICES	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate
Aberdeen	2,615,791	2,615,493	2,574,723
Alaska	6,386,418	6,385,689	6,286,152
Albuquerque	1,444,412	1,444,248	1,421,735
Bemidji	2,238,633	2,238,378	2,203,487
Billings	2,491,074	2,490,790	2,451,964
California	2,351,997	2,351,729	2,315,071
Nashville	2,084,385	2,084,147	2,051,660
Navajo	3,646,461	3,646,045	3,589,212
Oklahoma	5,802,815	5,802,153	5,711,711
Phoenix	3,468,141	3,467,745	3,413,691
Portland	3,305,241	3,304,864	3,253,349
Tucson	745,457	745,372	733,754
Headquarters	27,050,174	27,047,088	26,625,489
Undistributed Funds	0	0	0
Total, Direct Operations	**63,631,000**	**63,623,741**	**62,632,000**

DEPARTMENT OF HEALTH & HUMAN SERVICES
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SELF GOVERNANCE

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$5,763,000	$5,836,000	$5,928,000	+$92,000
FTE	11	11	12	0

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

FY 2009 Authorization ..... Expired 2000

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

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. Through enactment of P.L. 102-573, the Indian Health Care Amendments of 1992, authority to fund the Tribal SGDPs was extended to IHS and the Office of Tribal Self-Governance (OTSG) was established. Through enactment of P.L. 106-260, the Tribal Self-Governance Amendments of 2000, permanent authority was given to Title V, Tribal Self-Governance. Since 1993, the IHS, in conjunction with Tribal representatives, has been engaged in a process to develop methodologies for identification of tribal shares for all Indian Tribes. Tribal shares are those funds historically held at the Headquarters and Area organizational levels of the IHS. Of the $1.805 billion under Tribal Health Administration, approximately $1.202 billion will be transferred to support 117 compacts and 138 funding agreements in FY 2009.

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

- Agency performance measure achievement through various Tribal pilot projects throughout the country which are funded through the Self Governance budget;
- Funding for ambulances to Indian tribes and tribal organizations;
- Funding to an Indian tribal organization to provide technical assistance, coordination of meeting dates, locations, etc. in development of a annual report to Congress;
- Funding of a pilot project to explore alternative methods for providing direct care services to individuals within a three State area;

- Funding of Interagency Agreement between IHS/VA to provide support and training to Community Health Representatives, first responders, modular curriculum development/online training, and specialty field training/support for suicide prevention and response.
- One program teaches what effects substance abuse has on the heart and body while another teaches about the devastating effects of driving under the influence of alcohol and other drugs.
- Best Practices projects which compiles and documents the successful outcomes of the Self-Governance Tribes, which included the following as examples:
  - A new treatment center – that established new patterns and a different self-image for the patient; a large component of treatment includes the integration of cultural identification;
  - An increase in the areas of health promotion activities – bike helmets, car seats, exercising/walking clubs, diabetic care, and encourage children to be physical active.
  - Construction of a new facility with funding from other agencies along with internal funds of tribe, and the tribe now has a full range of clinical services thanks to the flexibility of SG; and
  - New program that teaches patients to balance their nutrition and physical activity with focus on food choices, stress and motivation.

Therefore, SG does not directly control the assessment of these Tribal programs and services. It supports Tribal efforts to pursue their local goals through special programs, advocacy, technical assistance and administrative support.

FUNDING HISTORY

Fiscal Year	Amount
2004	$5,644,000
2005	$5,586,000
2006	$5,668,000
2007	$5,763,000
2008 Enacted	$5,836,000

BUDGET REQUEST

The FY 2009 budget request is $5,928,000 and 12 FTE; an increase of $92,000 over the FY 2008 Enacted level. The Self Governance budget will support the provision of technical assistance to approximately 384 federally recognized Indian tribes and tribal organizations compacted with the Indian Health Service (IHS); fund up to 24 Indian Tribes with Planning and Negotiation Cooperative Agreements; continue to fund the Government Performance and Results Act (GPRA) projects; and address tribal shares funding needs in IHS Areas and Headquarters for any Indian tribe(s) newly entering self-governance**.** The total funding for Self-Governance will provide:

- $2.3 million (or 39%) will be used for the operating budget of the OTSG: 12 FTEs - payroll costs, travel, supplies, rents/communications and contractual services;

reimbursements: travel cost (other than OTSG staff), TDY's to the OTSG; planning and negotiation cooperative agreements.

- $3.6 million (or 61%) for a reserve fund: for shortfalls - these funds were appropriated to fund shortfalls in compact funding in cases where there cannot be a direct transfer of funds from IHS to the Indian tribes to fund self-governance compacts without jeopardizing the support provided by IHS to other Indian tribes. Therefore, the **reserve funds** are used (1) to ensure that funding of tribal shares under Self-Governance compacting does not adversely impact non-Self-Governance Tribes. These funds are provided directly to the Self-Governance Tribes or to Area Offices and/or Headquarters programs and the OTSG so that Self-Governance Tribes may receive their full funding of tribal shares as provided for in P.L. 106-260; (2) for Self-Governance costs incurred as the result of special circumstances: severance pays, RIF costs, settlements and assessments costs; assistance with the purchase of ambulances; (3) to support special projects that enhance Self-Governance Activities: Government Performance Results Act (GPRA) Projects; development of a curriculum to be used for the training of future Agency Lead Negotiators (ALN) within the IHS; Self-Governance Communication Education project continued agreement; eligibility services project; EMS services; travel/logistics of Advisory committees, workgroups; PAMS project - information technology; other trainings.

The Self-Governance budget is currently addressing the following elements of the HHS and IHS Strategic Plans**:** Chapter 2, Goal 1, Objective 1.3.1; Chapter 3, Goal 2; and, Chapter 6; the IHS Strategic Plan: Goal 2, Objective 2.4; Goal 3, Objectives 3.1 – 3.2; and, the OMB Tribally Operated Heath Programs (TOHP) Program Assessment Rating Tool (PART) performance measures and follow-up actions.

The IHS has communicated the importance of health data and GPRA reporting to all Area Directors, Agency Lead Negotiators and Contract Proposal Liaison Officers. Beginning in FY 2007 this was a standard negotiation item to be discussed at all contract and compact negotiations. Although Tribes are not required to report health and GPRA data, the IHS has seen annual increases in the reporting of data associated with population served by TOHP. The OTSG will continue to raise this issue at subsequent negotiations as part of our ongoing negotiation objectives. For FY 2008, the OTSG will provide project funding to sustain a reporting rate of at least 76 percent of the population served by 2008. For FY 2009, it is highly likely that this target will decrease by 2 percent should Information Technology moneys be reprogrammed into other activities such as Maintenance and Improvements or staffing to maximize productivity with limited resources.

Government Performance Results Act (GPRA) Projects: The concept of the GPRA Projects was designed to improve and enhance existing Tribal data reporting to meet the quality, completeness and reliability requirements of GPRA, and/or enhance Tribal implementation/infrastructure capacity. In turn, Tribal increased efforts provide data collection information that supports the IHS annual budget and makes improvements in local Area programs by replicating best practices, and identifying barriers and solutions nationwide. Indian tribes receive RPMS training and assistance with data entry; record

labs for all patients, not just diabetics; increase awareness of the lack of adequate data from their contract health providers; improve efficiency of data entry staff by receiving reports and reviewing outputs; decrease the turnover of data entry staff; increase number of providers that participate in the project by increasing the accuracy of reporting; develop data quality teams that meet quarterly to improve GPRA measures and collaborate with Tribal Data Coordinators that provide technical assistance to improve GPRA reporting that directly responds to OMB TOHP PART follow-up management objectives and the annual output measure of increasing the percentage of Tribally-Operated Health Programs' clinical user population included in GPRA data.

Tribal Health Information Technology Infrastructure: The OTSG provides funding to tribes that improve health care quality, safety, cost, and value. In FY 2008, the OTGS will facilitate Tribally Operated Health Programs to increase the deployment of the IHS Electronic Health Record from 116 to 151 sites in the Indian health care system through informational sessions on Electronic Health Record at national conferences and during negotiations. Funding will support consolidation projects to bridge tribal-federal health data that further builds the Indian health information technology infrastructure. Funding will support deployment of RPMS software applications by providing technical assistance to tribes.

Training and Health Initiatives: The OTSG promotes and encourages preventative health care, including mental health, lifelong behaviors, and recovery.

- OTSG will provide funding to increase health care service availability and accessibility by expanding access to health screenings for American Indians and Alaska Natives. Such funding will address the proportion of eligible patients who have had appropriate colorectal cancer screening.
- OTSG will provide project funding to support the joint DOJ, SAMHSA, and IHS National Tribal Methamphetamine Trainings.
- OTSG will provide funding to emergency medical services response projects that increase tribal response to natural disasters and emergency preparedness.
- OTSG will provide funding to purchase emergency medical services training equipment for Tribally Operated Health Programs.
- OTSG will provide funding and technical assistance for regional training programs that promote self-governance and self-determination funding opportunities available to tribes, such as planning and negotiation cooperative agreements.

Outcome

(data in percentage and in 100,000)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2010, increase the number of OTSG funded projects									
TOHP-1	Increase percentage of TOHP clinical user population included in GPRA data	78%	74%	77%	77%	78%	76%	76%	74%
TOHP-E	TOHP: Maintain hospital admissions per 100,000 diabetics per year from long-term complications of diabetes	142.8	165.1	163.4	Sep/2008	161.8	Sep/2009	160.2	160.2

Output (data per unit)

Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Estimate	FY 2009 Estimate
			Estimate	Actual	Estimate	Actual		
Increase Program Training Projects	3	4	4	4	3	3	6	6
Increase Tribal Health Information Technology Infrastructure	8	10	7	6	8	7	10	10
Increase IHS Chronic Care initiatives at Tribal Site: Screening projects	n/a	n/a	n/a	n/a	n/a	n/a	3	3
Increase TOHP EHR deployment.	n/a	n/a	n/a	n/a	n/a	56	59	63
Appropriated Amount ($)	$1. 6M	$1. 5M	$1. 2M		$2. 3M		$2. 5M	$2. 5M

Area Allocation

SERVICES	FY 2007 Enacted	FY 2008 Enacted	FY 2009 Estimate
Aberdeen	0	0	0
Alaska	373,974	378,680	384,681
Albuquerque	0	0	0
Bemidji	73,762	74,690	75,874
Billings	258,203	261,452	265,596
California	13,908	14,083	14,306
Nashville	311,346	315,264	320,260
Navajo	0	0	0
Oklahoma	233,042	235,974	239,714
Phoenix	0	0	0
Portland	329,578	333,726	339,014
Tucson	0	0	0
Headquarters	4,169,187	4,221,653	4,288,555
Undistributed Funds	0	0	0
Total, Self-Governance	**5,763,000**	**5,835,523**	**5,928,000**

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CONTRACT SUPPORT COSTS

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$269,730,000	$267,398,000	$271,636,000	+$4,238,000
FTE	0	0	0	0

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

FY 2009 Authorization.....Expired 2000

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Self-Determination and Education Assistance Act (ISDEAA) allows Tribes to assume operation of Federal programs and to receive not less than the amount of direct program funding that the Secretary would have otherwise provided for the direct operation of the program (specifically, contract support costs were first identified in the 1988 amendments to the ISDEAA). In FY 2009, approximately $1.805 billion of the Agency's appropriation will be under Tribal Health Administration primarily through Title I and V of the ISDEAA. The ISDEAA also provides that there be added to the program amount, contract support costs. The CSC are defined in the ISDEAA as the reasonable costs for activities either not normally provided by the Secretary in his/her direct operation of the program, or were provided by the Secretary in support of the program from resources other than those under contract.

Specific elements of CSC include are:

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

The IHS has had a CSC policy in existence since 1992 that governs the administration and allocation of CSC. The policy was developed through extensive consultation and participation of Tribes. On April 6, 2007, the Director of IHS signed a revised CSC Policy, which is now established as a permanent Chapter within the IHS Manual (Part 6, Chapter 3, TN-2007-05), effective for the fiscal year (FY) 2007 through FY 2010 funding periods.

The revised policy modified the CSC allocation methodology associated with new or expanded awards under the ISDEAA, P.L. 93-638, as amended. Allocations will now be made at the average level of CSC funding paid to all existing P.L. 93-638 awards. The IHS CSC policy conforms to applicable OMB Circular A-87 and A-122 cost principles.

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

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

Throughout calendar year 2006, Tribally-operated health programs (TOHP) worked to address the follow-up recommendations from the findings of the performance assessment rating tool (PART). The CSC accounts for 16 percent of the total funding provided to TOHP, yet, is a key element of cost affecting the overall performance of TOHP. TOHP received a rating of Adequate on their PART assessment. Generally, this rating describes a program that needs to set more ambitious goals, achieve better results, improve accountability or strengthen its management practices. The PART assessment found that TOHPs maintain or improve the overall health of American Indians and Alaska Natives (AI/AN) each year, as measured by independent evaluations and clinical indicators like screening rates for medical conditions. Most notably, the programs have reduced Years of Productive Life Lost by 11 percent over the past decade. However, performance information is only available for programs that voluntarily report the data, or 77 percent of AI/ANs served in 2006. By law, the government cannot require Tribal programs to submit performance data. This restriction makes it difficult to identify deficiencies and assist Tribes in improving program performance. Tribes are also not required to inform the IHS of how much funding they receive from other sources, such as Medicare and Medicaid. As a result, it is difficult to determine the relationship between overall funding levels and program performance. The HHS (IHS & CMS) and Tribes are collaborating to address the follow up recommendations included in the FY 2007 and 2008 President's Budget.

Finally, in continuing to manage CSC funding, and in response to the March, 2005 Supreme Court decision in Cherokee Nation v. Leavitt[1], the IHS has issued additional guidance concerning any new or expanded contracts or compacts being entered into for

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

FY 2007. This guidance requires that Tribes and the IHS reach agreement concerning the unavailability of ISD/CSC funding and the obligation of the IHS to fund CSC pursuant to the appropriations "cap" on CSC. If there is not agreement on the part of the Tribe then the new or expanded program request will likely be declined. These principles need to be adhered to in instances where CSC funding may not be available in order for the IHS to enter into new contracts or compacts under the Indian Self-Determination and Education Assistance Act. If the Tribe and the IHS could not reach agreement, the proposal to contract for the new and expanded PFSA/PSFA would be declined.

FUNDING HISTORY

Fiscal Year	Amount
2004	$267,398,000
2005	$263,683,000
2006	$264,730,000
2007	$269,730,000
2008 Enacted	$267,398,000

BUDGET REQUEST

The FY 2009 budget request of $271,636,000 and 0 FTE is an increase of $4,238,000 over the FY 2008 Enacted level of $267,398,000 and 0 FTE. The total funding will provide:

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

Outputs

- The total number of Tribes/Tribal Organizations contracting or compacting is 336.
- 54 percent of IHS health care delivery is under Tribal Administration.

(dollars in millions)

Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Estimate	FY 2009 Estimate
			Estimate	Actual	Estimate	Actual		
Total Direct Program Contracted by Tribes	$1,180.7	$1,229.7	N/A	$1,261.9	$1,337.6	N/A	$1,417.9	$1,503.0
Final CSC Appropriated Amount ($ Thousands)	$267.4	$263.7	$264.7		$269.7		$267.4	$271.6

Area Allocation

Contract Support Costs -- Allocation by Area

SERVICES	FY 2007 Enacted	FY 2008 Enacted	FY 2009 Estimate
Aberdeen	$ 10,727,501	$ 10,634,773	$ 10,803,305
Alaska	87,769,463	87,010,792	88,389,671
Albuquerque	9,128,182	9,049,279	9,192,685
Bemidji	12,637,008	12,527,775	12,726,305
Billings	9,087,406	9,008,855	9,151,621
California	27,078,898	26,844,830	27,270,246
Nashville	16,689,930	16,545,664	16,807,866
Navajo	12,732,548	12,622,489	12,822,520
Oklahoma	34,303,945	34,007,425	34,546,348
Phoenix	14,422,476	14,297,809	14,524,390
Portland	33,741,603	33,449,944	33,980,032
Tucson	1,411,040	1,398,843	1,421,011
Headquarters	0	0	0
Undistributed Funds	0	0	0
Total, CSC	**$ 269,730,000**	**$ 267,398,478**	**$ 271,636,000**

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PUBLIC AND PRIVATE COLLECTIONS

	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate
Medicare:			
Federal	$119,882,000	$120,998,000	$120,998,000
Tribal [1]	6,986,000	6,986,000	6,986,000
Tribal [2]	34,085,000	34,085,000	34,085,000
Subtotal:	160,953,000	162,069,000	162,069,000
Medicaid:			
Federal	418,446,000	430,084,000	430,084,000
Tribal [1]	22,217,000	22,217,000	22,217,000
Tribal [2]	75,181,000	75,181,000	75,181,000
Subtotal:	515,844,000	527,482,000	527,482,000
Medicare/Medicaid Total:	676,797,000	689,551,000	689,551,000
Private Insurance	90,151,000	90,151,000	90,151,000
TOTAL:	**$766,948,000**	**$779,702,000**	**$779,702,000**
FTE	4,225	4,225	4,225

[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

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

Medicare/Medicaid -- The FY 2007 collections total includes adjustments that incorporate the CY 2007 rate increase. The FY 2008 and 2009 Medicare and Medicaid (M&M) budget estimate includes the 2007 rate increase. No rate adjustments can be made for CY 2008 or 2009 because these rates have not been set. A priority is being placed on establishing the 2008 M&M rates.

In FY 2008 and FY 2009, the IHS will continue to focus on strengthening business office policies and management practices, including internal controls, patient benefits coordination, provider documentation training, certified procedural coding training and electronic claims processing. Also, IHS will continue the development of modifications to its third party billing and accounts receivable software to improve effectiveness and to

ensure system integration with its business processes and compliance with HIPAA, National Provider ID and M&M regulations.

IHS will continue working with the Centers for Medicare and Medicaid Services (CMS) and the State Medicaid agencies to improve each program's capability to identify patients who are eligible to enroll in M&M programs. IHS will also continue to work with the CMS and the Tribes on third party coverage, claims processing, denials, training and documentation of services.

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

Private Third Party Collection -- The FY 2008 and 2009 private Insurance budget estimate will continue at the FY 2007 collection level. During FY 2008 and in FY 2009, IHS will continue its efforts to enhance each health facility's capability to identify patients who have private insurance coverage and improve claims processing, provider documentation and coding to increase private insurance billing and collections. Funds collected will be used by the local Service Units to improve services, including the purchase of medical supplies and equipment, and to improve local service unit business management practices. In addition, the IHS will continue to utilize private contractors to pursue collections on outstanding claims from private payers.

The IHS has had Congressional authority to bill Medicare and Medicaid since 1976.

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

(Dollars in Thousands)

Type of Obligation	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate
Personnel Benefits & Compensation	$311,650,000	$322,720,000	$322,722,000
Travel & Transportation	4,107,000	4,119,000	4,119,000
Transportation of Things	3,819,000	3,863,000	3,863,000
Comm./Util./Rent	10,227,000	10,218,000	10,218,000
Printing & Reproduction	375,000	377,000	377,000
Other Contractual Services	145,418,000	146,190,000	146,190,000
Supplies	103,006,000	102,244,000	102,244,000
Equipment	18,229,000	18,325,000	18,325,000
Land & Structures	24,221,000	24,552,000	24,552,000
Grants	6,042,000	7,173,000	7,173,000
Insurance / Indemnities	237,000	238,000	238,000
Interest/Dividends	67,000	111,000	111,000
Subtotal	628,479,000	641,233,000	641,233,000
Tribal Collections	$138,469,000	$138,469,000	$138,469,000
Total Collections	**$766,948,000**	**$779,702,000**	**$779,702,000**

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SPECIAL DIABETES PROGRAM FOR INDIANS

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$150,000,000	$150,000,000	$150,000,000	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.

FY 2009 Authorization ..... Expires FY 2009

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Congress established the initial Special Diabetes Program for Indians (SDPI) through the Balanced Budget Act of 1997. Support for the SDPI was augmented through the Consolidated Appropriations Act of 2001 and House Resolution 5738 of 2003. As a result, the SDPI now operates with a budget of $150 million per year (FY 2004-2008).

The IHS Division of Diabetes Treatment and Prevention (DDTP) provides leadership and programmatic administrative oversight to the *Special Diabetes Program for Indians* grant program. The mission of the IHS DDTP is to develop, document, and sustain a public health effort to prevent and control diabetes in American Indians and Alaska Natives (AI/ANs). This mission is accomplished by promoting collaborative strategies for the prevention of diabetes and its complications to over 1.9 million AI/ANs through its extensive diabetes network. The diabetes network consists of a national program office; Area Diabetes Consultants in each of the 12 IHS Areas; 19 Model Diabetes programs in 23 different IHS and Tribal sites, and 333 and 66 local IHS, Tribal and Urban Indian SDPI grant programs. The 66 SDPI grant programs, awarded in FY 2004, are comprised of 30 CVD risk reduction demonstration projects and 36 diabetes prevention demonstration projects.

This extensive diabetes network supports the *SDPI* grant programs by providing comprehensive diabetes surveillance, research translation, promotion of quality assurance and improvement activities, technical support, resource and “best practices” information, and develops and distributes American Indian specific diabetes education materials. This program also serves as the key IHS contact and source of information for outside organizations and agencies working on diabetes and disparities related to diabetes. Now

the most comprehensive rural system of care for diabetes in the U.S., the IHS combines both clinical and public health approaches to address the problem of diabetes and its complications.

Target Audience
The initial *Special Diabetes Program for Indians (SDPI)* appropriation was authorized by Congress in 1997 in response to alarming trends documenting a disproportionately high rate of type 2 diabetes in AI/AN communities. It came in the wake of increasing public concern about the human and economic costs of diabetes in the U.S. and the growing **prevalence** among the AI/AN population.

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

Diabetes **mortality** is more than 3 times (3.1) higher in the AI/AN population than in the general U.S. population (1999-2001). In 2003, of AI/ANs aged 35 years or older with diabetes, nearly 70 percent had hypertension. Hypertension in people with diabetes significantly increases their likelihood of developing diabetes complications.

Complications of diabetes lead to much higher incidence rates of blindness, vascular insufficiency leading to amputation, and End Stage Renal Disease (ESRD) than in the general U.S. population.

- In 2002, one in every four (24.8 percent) AI/AN elders over age 65 years had coronary heart disease (or one of every five of those aged 55 and older).

There has been some good news recently. Since 1997, the incidence of ESRD has declined among the American Indian and Alaska Native population with diabetes, particularly among adults over age 45 years (a 29% decrease was seen in those aged 45-64 years and a 13 percent decrease in those aged 65 years and older). This improvement was seen despite the continued rise in diabetes prevalence in the same time period, and may be due to the reduction in risk factors and improvements in diabetes care practices in Indian communities as shown by our yearly IHS Diabetes Care and Outcomes Audit.

Distribution Method
In the Balanced Budget Act of 1997, Congress established the SDPI to "establish grants for the prevention and treatment services" to address the growing problem of diabetes in AI/ANs." The entities eligible to receive these grants included IHS programs, tribes and tribal organizations, and urban Indian organizations.

The IHS distributed this funding to over 300 such entities according to legislative intent through a process that included a formal tribal consultation, development of a formula for distribution of the funds to eligible entities, and a formal grant application and administrative process. These programs were allowed to use this funding to design and carry out interventions that will best address the problem of diabetes in individual communities. Depending on community needs, these programs incorporate a wide range of proven diabetes treatment and prevention strategies, such as patient education, quality

diabetes care services, as well as physical activity, nutrition and weight loss activities. $1 million was also set-aside for the CDC Native Diabetes Wellness Program (formerly known as the National Diabetes Prevention Center).

Special Diabetes Program for Indians

CATEGORY	(Dollars in Millions)
Original Diabetes Grants – now called Community-directed Diabetes Programs (297 Tribal and IHS grants plus 36 urban grants = 333 grants in FY 1998) Includes administrative funds to HQ, Areas, Tribal Leaders Diabetes Committee, and evaluation support contracts, etc.	$108.9
Urban Indian Health Program community-directed diabetes programs (36 grants)	7.5
Demonstration Projects (66 grants) Includes administrative funds 1) to support the limited dissemination activities, 2) to HQ, 3) to Coordinating Center which will also support the limited dissemination activities, 4) to support contracts, etc.	27.4
Funds to strengthen the Data Infrastructure of IHS	5.2
Native Diabetes Wellness Center (CDC)	1.0
TOTAL:	**$150,000**

Strategy

The *SDPI* has brought Tribes together over these past 10 years, working toward a common purpose and sharing information and lessons learned along the way. The IHS has shown through its public health evaluation activities that these programs have been very successful in improving diabetes care and outcomes, as well as the start of primary prevention efforts, on reservations and in urban clinics.

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

Our evaluation of *SDPI* and diabetes clinical measures suggests that population-level diabetes-related health is better among our AI/AN patients since the implementation of *SDPI*. The greatest benefit for AI/AN with diabetes has likely been in the reduction in microvascular complications due to improvement in hyperglycemia. Further reducing microvascular and macrovascular complications will require continued efforts to improve glucose, blood pressure and cholesterol values. However, the greatest long-term benefit will most likely be from the diabetes primary prevention activities now becoming commonplace in AI/AN communities.

Demonstration Projects

In FY 2004 the IHS, in response to Congressional direction, developed and implemented a SDPI competitive Demonstration Project. The focus of the competitive Demonstration Project is on: 1) primary prevention of type 2 diabetes in those adults at risk for developing diabetes and 2) reduction of cardiovascular risk in AI/AN adults diagnosed

with type 2 diabetes. Sixty-six grants were awarded and this 5-year project was launched in November 2004. These Demonstration Projects were not designed to conduct new research. Rather, they were designed to translate findings from scientific studies into the "real world settings" of AI/AN communities and their health care systems.

When the rigorous evaluation of the SDPI Demonstration Projects in complete, the IHS DDTP will better understand how best to implement the successful interventions in the diverse settings of AI/AN communities.

Strengthening the Diabetes Data Infrastructure

The IHS has used administrative funding from the *Special Diabetes Program for Indians* to strengthen the diabetes data infrastructure of the Indian health system by improving diabetes surveillance and evaluation capabilities. These funds also support the development and implementation of the IHS Electronic Health Record, the electronic patient and data management system used in many Indian health facilities. As a result of these data infrastructure improvements, the Indian health system has been better able to identify and track American Indians and Alaska Natives with diabetes. This improvement in diabetes surveillance will allow for the measurement of the long-term outcomes of age-specific prevalence of diabetes and of CVD in people with diagnosed diabetes.

Technical assistance, provider networks, clinical monitoring and grant evaluation activities at the Headquarters and Area office levels have also been strengthened. In addition, support for the Area Diabetes consultants, who serve a crucial role in coordinating these functions at the Area level, was made stronger. SDPI funding for the past 10 years has served to build and enhance a much needed infrastructure within local IHS and Tribal administrations that enables continued development of diabetes programs to address treatment and prevention of diabetes, as well as obesity and other chronic diseases.

Milestones accomplished and challenges faced during current year

The SDPI provides funding for diabetes treatment and prevention services in 399 Tribal, IHS and urban Indian Health programs. Yearly SDPI grantee assessments are conducted within the yearly SDPI Progress Report. These assessments have shown significant improvements in care and community services provided over time when compared to the baseline SDPI assessment in 1997, as evidenced by:

- Improved Elements of Diabetes Care:
  - 68% more grant programs have diabetes teams – health professionals who work together to provide diabetes care
  - 36% more grant programs have diabetes clinics that offer special medical appointments for people with diabetes
  - 65% more grant programs use a diabetes registry to keep track of people with diabetes in their communities
- Promoting Healthy Lifestyles:
  - 57% more grant programs offer nutrition services for adults
  - 38% more grant programs have access to a registered dietitian

    - 72% more grant programs offer community walking and running programs
    - 53% more grant programs have a physical activity specialist
- Addressing the threat of childhood obesity and diabetes:
    - 76% more grant programs have type 2 diabetes prevention programs for youth
    - 29% more grant programs offer nutrition services for children and youth
    - 69% more grant programs have community-based physical activity programs
    - 52% more grant programs have safe environments for physical activity
- Efforts to Support Behavior Change:
    - 71% more grant programs offer organized diabetes education activities
    - 56% more grant programs offer culturally-appropriate diabetes education
    - 55% more grant programs work with social service programs
    - Greater availability of depression screening and a variety of therapies to help patients cope with stress and depression.
- Weight Management Activities.
    - 65% more grant programs offer adult weight management programs
    - 64% more grant programs offer weight management programs for children and youth.

American Indian and Alaska Native communities have used SDPI funds to make quality diabetes practices common place in local health facilities.

- Key Clinical Outcome Measures Have Improved:
    - The mean long-term blood sugar control level (A1C) overall decreased 13% from A1C=9.00% (1996) to A1C=7.82% (2007).
    - The incidence of ESRD among AI/AN has declined for the entire diabetic population:
        - 29% decrease in those aged 45-64 years
        - 13% decrease in those aged 65 years and older
    - The mean LDL cholesterol level decreased 17% from 118 mg/dl (1996) to 96 mg/dl (2007).

Building Programs Based on Best Practices. There are 18 Best Practice Models. The best practice models have been used by applicants to identify strengths in diabetes resources and services in their communities, find gaps in diabetes services or programs, establish program priorities, find best practice models that could be applied within their own communities, and to begin a work plan to develop their own local best practice models.

Tribal Consultation. The Tribal Leaders Diabetes Committee, established in 1998, continues to meet several times each year at the direction of the IHS Director to review information on the progress of the *SDPI* activities and to provide general recommendations to the IHS.

Strengthen IHS Data infrastructure. SDPI funds support the development and implementation of the IHS Electronic Health Record and, as a result, the Indian Health system has been better able to identify and track AIAN with diabetes as a result of improvement.

Grant Program Evaluation. The CDC's *Framework for Public Health Evaluation*, provides a framework for ongoing analysis of the *SDPI* Community-directed grant programs. In addition, the IHS is conducting a comprehensive evaluation of the *SDPI* Targeted Demonstration Projects to answer questions on program effectiveness and outcomes based on solid, statistically accurate, and timely data. Preliminary analyses reveal:

Diabetes Prevention Demonstration Project: As of June 30, 2007, 36 programs have recruited 1643 participants with prediabetes to receive education to promote weight loss through increased physical activity and reducing fat grams and calories in their diets with a modified version of the 16-session Diabetes Prevention Program Curriculum. Of these participants, 825 completed both the baseline and follow-up assessments of whether key clinical characteristics had improved after completing the 16-session Diabetes Prevention Program curriculum. Preliminary descriptive results for the first year of the project reveal that the participants achieved a 4.2 percent average reduction in weight and BMI from baseline to follow up assessment. Average waist circumference measurements decreased by 3.7 percent and fasting blood glucose results decreased by 3.9 percent from baseline to follow-up. Other clinical indicators showed similar improvements. The percent of participants who met the program goal of more than 150 minutes per week of physical activity increased from 23 percent at baseline to 57 percent at follow up.

Healthy Heart Demonstration Project: As of June 30, 2007, 30 programs have recruited 1486 participants with diabetes to participate in an intensive, clinic-based case management approach to reduce their risk factors for cardiovascular disease. Short term and intermediate outcome measures include change in reported physical activity, weight, BMI, waist/hip circumference, blood pressure, cholesterol and A1C tests. The evaluation also includes measurement of psycho-social, behavioral and programmatic factors that may influence an individual participant's success in the program. Baseline characteristics in year 1 include a mean BMI of 36.6, mean A1C of 7.6 percent, and mean blood pressure and cholesterol levels already within goal range. Comorbid conditions were common, including self-reported high blood pressure (66.4%), back pain (44.4%), depression (26.3%), arthritis (24.8%) and heart disease (18.4%). Preliminary annual assessment results in a portion of these participants reveal improvements in some short term and intermediate outcome measures.

Tribal Management of Local Grant Programs. Eighty-one percent of the *SDPI* Community-directed Diabetes Programs are Tribal programs.

Collaborations and Partnerships. The IHS has developed and built upon collaborations and partnerships with federal and private organizations as a result of the *SDPI*. These include:

- Joslin Vision Network (JVN) Tele-ophthalmology Project.
- NIDDK/CDC/TLDC/Tribal College collaboration
- National Congress of American Indians and Native American Boys and Girls Clubs.
- Head Start Bureau.
- Committee on Native American Child Health (CONACH).

- American Diabetes Association.
- American Indian Higher Education Consortium.
- CDC's State Diabetes Control Programs.
- National Diabetes Education Program (NDEP)

Challenges
In its entire history, the IHS had never been faced with creating and managing such a large grant program. In response to this challenge, 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.

Despite the progress made, significant diabetes-related challenges remain in AI/AN communities such as:

- Significant number of vacancies for professional health care positions hinder staffing of programs especially in rural areas
- Finding adequate space to set-up programs and conduct program activities
- Being located in remote areas making access to clinical services a significant challenge
- Additional needs for training and technical assistance for
  - Grant writing and planning
  - Assessment and planning at the community level
  - Grant program management and leadership skills
  - Grant program evaluation – statistics, data analysis and research on program impacts and outcomes

FUNDING HISTORY

Fiscal Year	Amount
2004	$150,000,000
2005	$150,000,000
2006	$150,000,000
2007	$150,000,000
2008	$150,000,000

BUDGET REQUEST

The IHS Special Diabetes Program for Indians FY 2009 budget request is $150,000,000 and 0 FTE. This is maintenance of the FY 2008 level of $150,000,000 and 0 FTE.

These dollars are being requested for transformation of the 333 Community-directed diabetes programs and dissemination into other Tribal communities of what has been learned from the 66 Demonstration Project sites for prevention of diabetes and prevention of cardiovascular disease for adults (FY04-08).

National Tribal consultation has been conducted regularly throughout the course of this program, and has significantly influenced the activities conducted. Recent Tribal consultation has identified diabetes as a top priority for Tribes. As such, IHS proposes to implement a limited educational and skills-based approach to develop and implement programs at new sites. Beginning in FY 2009, the IHS will deliver this new information to all IHS, Tribal and urban sites via multi-media outlets based on evidenced-based interventions from the Demonstration Projects implemented in FY 2004 and completed in FY 2008. In FY 2009, the program will take steps to transform the operation and administration of Community-Directed and Demonstration Project grants to increase efficiencies and ensure the long-term effectiveness of programs.

Over the past 10 years, American Indian and Alaska Native communities have used *SDPI* funding to make quality diabetes practices commonplace in local Indian health care facilities.

- **Key clinical outcome measures**—such as blood sugar control, blood lipid levels, and kidney function—**have improved** among American Indians and Alaska Natives with diabetes each year since the *SDPI* was created.
- These improvements not only enhance the quality of life of people with diabetes, but also help the Indian health system achieve cost-effectiveness, realize cost savings, and reduce the cost burden of diabetes for all of society.
- In addition to these successes in clinical outcomes, the *SDPI* helped create diabetes treatment and prevention programs where none existed before, as well as enhance programs that were already in place. These programs employ **successful, proven strategies to address key areas of diabetes treatment and prevention** across the entire life span—including clinical care, type 2 diabetes and youth, nutrition, physical activity, weight management, and behavior change.

To continue building on this success, the IHS Division of Diabetes proposes to apply the experience and expertise gained during the past 10 years to achieve excellence in diabetes treatment and prevention in American Indian and Alaska Native adults, children, and youth by: (1) applying the findings from the Demonstration Projects throughout the Indian health system; (2) transforming the Community-Directed Diabetes Programs and Demonstration Projects; and (3) continuing to rely on the IHS Division of Diabetes Treatment and Prevention's successful strategy of using effective, evidence-based diabetes treatment and prevention strategies.

The *Special Diabetes Program for Indians* is a true collaboration between the Tribes and the agency, one that has demonstrated positive outcomes and a proven track record that continues to show steady improvements, quantitatively and qualitatively, from year to year.

GPRA/Output Table

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2009, improve the diabetes prevention and treatment services to the AI/AN population. By 2010, reduce the number of Years of Potential Life Lost (YPLL) due to diabetes.									
	Diabetes: A1c Measured[1]: Proportion of patients who have had an A1c test. IHS-All	77%	78%	N/A	79%	N/A	79%	N/A	N/A
	Tribally Operated Health Programs	74%	76%	N/A	77%	N/A	77%	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]	16/17%	18/15%	18/15%	18/16%	18/15%	19/16%	19/16%	19/17%
1	Tribally Operated Health Programs	15%	12%	12%	13%	12%	13%	13%	14%
Long-Term Objective 1: By 2010, increase the percentage of patients with diagnosed diabetes with ideal glycemic control to 40 percent..									
2	**Diabetes: Ideal Glycemic Control:** Proportion of patients with diagnosed diabetes with ideal glycemic control (A1c <7.0). IHS-All[2]	34/27%	36/30%	36/32%	37/31%	37/32%	38/31%	38/31%	38/29%
2	Tribally Operated Health Programs	28%	33%	33%	33%	33%	33%	33%	31%
Long-Term Objective 1: By 2010, increase to 50 percent the proportion of patients with diagnosed diabetes with ideal blood pressure control.									
3	**Diabetes: Blood Pressure Control:** Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<130/80). IHS-All[2]	34/35%	36/37%	36/37%	38/37%	38/37%	38/39%	38/39%	38/37%
3	Tribally Operated Health Programs	33%	36%	36%	37%	37%	38%	38%	36%

Long-Term Objective 1: By 2010, increase to 70 percent the proportion of patients with diagnosed diabetes who have been assessed for dyslipidemia (LDL cholesterol).									
4	**Diabetes: Dyslipidemia Assessment:** Proportion of patients with diagnosed diabetes assessed for dyslipidemia (LDL cholesterol). IHS-All[2]	69/53%	70/53%	72/56%	73/60%	76/60%	74/61%	74/61%	74/58%
4	Tribally Operated Health Programs	52%	48%	49%	58%	58%	58%	58%	55%

[1]*There is no measure or goal; this information is provided for context.*
[2]*First figure in results column is Diabetes audit data; second is CRS.*

Program Specific Output

(data and dollars in millions)

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target/ Est.	FY 2009 Target/ Est.
				Target / Est.	Actual	Target / Est.	Actual		
	Proportion of SDPI yearly grantee assessments completed*	95	93	90	87	87	Pending	90	90
	Proportion of SDPI grantees using at least one of the 18 Diabetes Best Practices**	NA	NA	NA	NA	NA	NA	50	52
	Proportion of patients with diagnosed diabetes assessed for DM education# provided (yearly audit).	64	63	58	61	60	61	61	61
	Appropriated Amount	$150.0	$150.0	$150.0		$150.0		$150.0	$150.0

* Denominator reflects grantees and subgrantees; number of SDPI grantees changes each year
** This is a new measure for 2008. Baseline will be established.
#Many new programs participated in the audit assessment in 2006 so the expected target was lowered in 2006.

FY 2006 SDPI Annual Funding Amounts

SDPI Community-Directed Grant Programs by State and FY 2006 Annual Funding Amount			
State	**State Name**	**Total Number of SDPI Grant Programs**	**Financial Assistance Award FY 2006**
AK	Alaska	25	$8,963,599
AL	Alabama	1	$186,868
AZ	Arizona	32	$26,359,794
CA	California	45	$8,307,826
CO	Colorado	3	$728,212
CT	Connecticut	3	$283,935
FL	Florida	2	$411,650
IA	Iowa	2	$518,266
ID	Idaho	4	$759,471
IL	Illinois	1	$226,282
KS	Kansas	7	$695,810
LA	Louisiana	4	$307,903
MA	Massachusetts	1	$142,066
ME	Maine	5	$429,697
MI	Michigan	13	$2,172,877
MN	Minnesota	13	$3,401,552
MS	Mississippi	2	$1,350,679
MT	Montana	19	$5,582,611
NC	North Carolina	2	$1,143,625
ND	North Dakota	7	$2,643,997
NE	Nebraska	4	$1,326,504
NM	New Mexico	32	$6,938,491
NV	Nevada	19	$3,260,720
NY	New York	4	$1,159,580
OK	Oklahoma	41	$18,387,863
OR	Oregon	15	$2,134,513
RI	Rhode Island	1	$114,858
SC	South Carolina	1	$120,669
SD	South Dakota	14	$5,439,117
TN	Tennessee	3	$84,609
TX	Texas	4	$589,207
UT	Utah	8	$1,444,740
WA	Washington	34	$3,541,903
WI	Wisconsin	14	$2,949,032
WY	Wyoming	4	$747,878
	TOTAL	**390 (includes sub-grantees)**	**$112,856,404**

SDPI Grant Demonstration Projects by State and FY 2006 Annual Funding			
	State	**Total Number of SDPI Demonstration Programs**	**Total FY 2006 Financial Assistance Award**
AK	Alaska	5	$1,767,100
AZ	Arizona	6	$2,309,800
CA	California	8	$2,740,000
ID	Idaho	1	$324,300
KS	Kansas	1	$397,100
MI	Missouri	1	$324,300
MN	Minnesota	5	$1,694,300
MS	Mississippi	1	$397,100
MT	Montana	4	$1,370,000
ND	North Dakota	1	$324,300
NE	Nebraska	1	$324,300
NM	New Mexico	7	$2,488,500
NY	New York	2	$648,600
OK	Oklahoma	7	$2,634,100
OR	Oregon	2	$794,200
SD	South Dakota	4	$1,370,000
UT	Utah	1	$397,100
WA	Washington	6	$2,018,600
WI	Wisconsin	3	$972,900
	Total	**66**	**$23,296,600**

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

FACILITIES

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$361,226,000	$374,646,000	$353,329,000	-$21,317,000
M&I	*54,668,000*	*52,889,000*	*52,889,000*	*000*
Sanitation	*94,003,000*	*94,253,000*	*94,253,000*	*000*
HCFC	*25,664,000*	*36,584,000*	*15,800,000*	*-20,784,000*
FEHS	*$165,272,000*	*$169,638,000*	*$169,105,000*	*-$533,000*
Equipment	*21,619,000*	*21,282,000*	*21,282,000*	*000*
Quarters [1]	*6,288,000*	*6,288,000*	*6,288,000*	*000*
FTE	**1,261**	**1,261**	**1,259**	**-2**

[1] 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 Authority.

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, Sanitation Facilities Construction, and Health Care Facilities Construction. The program support activity is Facilities and Environmental Health Support. Medical Equipment and Staff Quarters are also separate activities.

The FY 2009 budget request of $353,329,000 and 1,259 FTE is decrease of $21,317,000 below the FY 2008 Enacted level of $374,646,000 and 1,261 FTE.

Maintenance & Improvement (+$0) – Specific objectives include:

- Providing routine maintenance and repairs for facilities;
- Achieving compliance with buildings and grounds accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations or other applicable accreditation bodies;
- Providing improvements to facilities for enhanced patient care;
- Ensuring that health care facilities meet building codes and standards; and
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., energy conservation, seismic, environmental, handicapped accessibility, and security.

Sanitation Facilities Construction (+$0) – Types of sanitation facilities projects:

- 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 (-$20,784,000) -

- The FY 2009 request continues construction of the Barrow, Alaska hospital project.

Facilities and Environmental Health Support (-$533,000) -

- Funds personnel who provide facilities and environmental health services throughout the Indian Health Service at the Area, District, and Service Unit levels, and operating costs associated with provision of those services and activities.
- Divided into sub-activities to align with project and equipment accounts.

Equipment (+$0) – provides for:

- routine replacement medical equipment to over 1,600 Federally and Tribally-operated health care facilities,
- new medical equipment in tribally-constructed health care facilities, and
- TRANSAM which is surplus Department of Defense medical equipment and ambulance programs.

Quarters (+$0) – rents collected to be used for:

- operation, management, and general maintenance of quarters, including temporary maintenance personnel services, security guard services, and
- 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

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$54,668,000	$52,889,000	$52,889,000	$0
FTE	0	0	0	0

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

FY 2009 Authorization.....Expired 2000

Allocation Method.....Direct Federal, P.L. 93-638 Self Determination contract and Self-Governance compact programs for Maintenance and Improvement (M&I) routine and project funds is formula based; environmental compliance funds are competitively allocated to Federal and tribal health care facilities; and demolition funds are competitively allocated to Federal facilities.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The budget request of $52,889,000 for Maintenance and Improvement (M&I) supports the maintenance and improvement of IHS and Tribal health care facilities which are used to deliver health care services. The HHS and IHS are committed to sustaining the real property necessary to meet the mission and goals of the IHS. This request also moves towards a strategy of improving the condition of IHS health care facilities to condition standards set by HHS.

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

Annual health care space supported with M&I funds:

FY	Supported Space (Square Meters)
2003	973,083
2004	999,405
2005	1,003,689
2006	1,054,888
2007	1,112,112

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

The accreditation of facilities demonstrates the high level of quality of services being provided to American Indian and Alaska Native communities. In 2007, all IHS and Tribally-operated hospitals were accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or certified by the Centers for Medicare and Medicaid Services (CMS). Also, most large clinics and many smaller clinics were accredited by JCAHO or the Accreditation Association for Ambulatory Health Care, and most youth regional treatment facilities were either accredited by JCAHO or the Commission on Accreditation of Rehabilitation Facilities.

An essential component of these accreditation standards is a viable and proactive maintenance and repair operation with adequate funding levels. Facilities Engineering Program Plans (FEPPs) establish annual M&I workload targets and help determine the most prudent use of available resources. FEPPs are prepared by IHS Area Offices, service units, and Tribal programs to identify, delineate, and plan facilities related activities and projects to be accomplished during the upcoming fiscal year with M&I funds. Funds in the M&I line item account are used primarily to maintain and improve health care facilities and are identified for allocation as routine maintenance and project funds. Staff quarters operation, maintenance, and improvement costs are primarily funded with rent collections called Quarters Return (QR) funds. M&I funds may be used in conjunction with QR funds at locations with few quarters or where QR funds are insufficient to ensure appropriate quarters maintenance. New Executive Orders on asset management and environmental management related to facilities will affect the cost of facilities operations.

Status of Facilities

The physical condition of IHS-owned and many Tribally-owned facilities is evaluated through annual general surveys conducted by local facility personnel and IHS Area 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 Backlog of Essential Maintenance, Alterations, and Repair (BEMAR) database. The identified BEMAR for IHS and reporting Tribal facilities as of October 2007 was $371,930,000. The following table summarizes the BEMAR by category:

personnel costs for the following activities in IHS and Tribally-owned health care facilities: emergency repairs, preventive maintenance activities, maintenance supplies and materials, building service equipment replacement, upkeep activities, training, and local projects. These funds support facilities activities that are generally classified as those needed for 'sustainment' of the existing facilities. Approximately $41 million, identified as M&I routine maintenance, was provided to the IHS Area Offices and Tribes in FY 2007 for daily maintenance activities and local projects to maintain the current state of health care facilities. 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. The current IHS investment strategy fully funds sustainment to maintain the facilities in their current condition.

M&I Project Funds - IHS Area Office Facilities Engineers develop priority lists of larger projects to reduce the BEMAR. Although Tribes with Tribally-owned facilities may take their individual shares of the M&I project pool funds, for those Tribes located in Areas with a Federal facility inventory, M&I project pool funds may be restricted for Federal facilities to ensure that Federal stewardship responsibilities are maintained. Generally M&I projects in this category require levels of expertise, which may not be available at the local facility. Such projects accomplish major repairs and improvements of primary mechanical, electrical, and other building systems as well as public law compliance and program-related alterations. Program-related alteration projects include changes to existing facilities for more efficient utilization, for new patient care equipment, and to accommodate new treatment methodologies. Approximately $10 million, identified as M&I project, was provided to the IHS Area Offices and Tribes for projects in FY 2007 to reduce the BEMAR deficiencies and to improve healthcare facilities to meet changing healthcare delivery needs. The Healthcare Financial Management Association published the findings of a study that found that in the commercial (non-government) healthcare sector, hospitals spend an average of approximately five percent of a facility's value each year on restoration and modernization to maintain a reasonable backlog of maintenance and repair.

Environmental Compliance Funds - The IHS places a high priority on the implementation of the Greening the Government Executive Orders and meeting Federal, State, and local legal/regulatory environmental requirements, including allocating funding to address findings and recommendations from environmental audits. Many IHS and Tribal facilities were constructed before the existence of current environmental laws and regulations. Since IHS is required to comply with current Federal, State, and local environmental regulations, the use of environmental assessments to identify and evaluate potential environmental hazards is important. These assessments form the basis of the IHS facilities environmental remediation activities. The IHS has currently identified approximately $17 million in environmental compliance tasks and included them in the BEMAR database. Tribally-owned health care facilities receive assessments upon request by a Tribe.

Demolition Funds - The IHS has a number of Federally-owned buildings that are vacant, excess, or obsolete which are no longer needed. The number currently is estimated at over 100 buildings. Many of these buildings are safety and security hazards. Demolition of some of these buildings, in concert with transferring others, reduces hazards and liability.

FUNDING HISTORY

Fiscal Year	Amount
2004	$48,860,980
2005	$49,203,808
2006	$51,633,011
2007	$54,688,000
2008 Enacted	$52,889,000

BUDGET REQUEST

The FY 2009 budget request of $52,889,000 is the same as the FY 2008 Enacted level. There are no FTE associated with this program.

This level of funding will assist the IHS in meeting the real property asset management requirements and goals as outlined in the Executive Order 13327, *Federal Real Property Asset Management*; Executive Order 13423, *Strengthen Federal Environmental, Energy, and Transportation Management*; and the President's Management Agenda with the end product of improving the condition of existing facilities by eliminating the maintenance and repair backlog, demolition of excess buildings, and thereby raising the Condition Index. The requested funding will also aid in improving the efficiency of IHS and tribal facilities and addressing the most frequently cited area for improvement, which is the physical plant safety and efficiency. The average age of IHS health care facilities is greater than 33 years.

The total funding for M&I will provide:

- Approximately $45 million as M&I routine maintenance.
- Approximately $4 million identified as M&I project provided to the IHS Area Offices and Tribes for projects to reduce the BEMAR deficiencies and to improve healthcare facilities' CI to meet changing healthcare delivery needs.
- Approximately $3 million for environmental compliance projects and approximately $500,000 for demolition projects.

The funding allocated as M&I routine maintenance and M&I projects will aid the IHS to achieve the Department of Health and Human Services two performance goals:
first to fully fund sustainment. i.e., sustain the condition of existing real property to prevent deterioration; and second to provide a strategy to increase the Condition Index (CI) of each facility to 90 or greater.

Outcomes

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: Improvement to facility condition index[1]**.**									
1	Achieve CI of 90 for all constructed assets by 2016.	79	80	86.4	83 [2]	86.8	87 [2]	87.2	87.6

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

[2] The average CI for Government-owned facilities and selected Tribally-owned facilities that choose to maintain their deficiencies within our database system.

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

SANITATION FACILITIES CONSTRUCTION

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$94,003,000	$94,253,000	$94,253,000	$0
FTE	195	195	191	-4

Authorizing Legislation..... 25 U.S.C. 13 Snyder Act, P.L. 85-568, Transfer Act, 42 U.S.C. 2001, P.L. 86-121, Indian Sanitation Facilities Act; and Title III of P.L. 94-437, Indian Health Care Improvement Act, as amended.

FY 2009 Authorization .....Expired 2000

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Sanitation Facilities Construction (SFC) is an integral component of the IHS disease prevention activity. 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. The IHS physicians and health professionals credit many of these health status improvements to IHS' provision of water supplies, sewage disposal facilities, development of solid waste sites, and provision of technical assistance to Indian water and sewer utility organizations.

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

Sanitation facilities projects are carried out cooperatively with the tribes who are to be served by the facilities. Tribal involvement has been the keystone of the Sanitation Facilities Program since its inception in FY 1959. Projects start with a Tribal Project Proposal and are funded through execution of an agreement between the Tribe and IHS.

In these agreements the Tribes agree to assume ownership responsibilities, including operation and maintenance.

SFC projects can be managed by the IHS directly (Direct Service) or they can be managed by Tribes that elect to use Title I or Title V authorization under P.L. 93-638, the Indian Self-Determination and Education Assistance Act. The overall SFC goals, eligibility criteria, and project funding priorities remain the same, regardless of the delivery methods chosen by a Tribe.

The Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L. 94-437) directed the IHS to identify the universe of Indian sanitation facilities needs for existing Indian homes. As of the end of FY 2007, the list of all documented projects totaled over $2.3 billion with those projects considered economically feasible totaling $1.1 billion. As of the end of FY 2007, there were over 213,000 AI/AN homes in need of sanitation facilities, including over 36,000 AI/AN homes without potable water.

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

With completion of all projects approved through FY 2007, over 300,000 AI/AN homes will have been provided sanitation facilities since 1960. Experience shows that 60 to 70 percent of the actual construction is performed by Indian Tribes/firms.

The SFC program is a contributing factor in accomplishing the goals of the IHS Strategic Plan including: Goal 1: Build and Sustain Healthy Communities: Objective 1.2) Develop public health infrastructure with Tribes to sustain and support AI/AN communities. The SFC Program also supports the HHS Strategic Objective(s) 2.1: Preventing the spread of infectious diseases, 2.2: Protecting the public against injuries and environmental threats, and 2.4 Preparing for and responding to natural and man-made disasters. SFC projects provide resources for building and sustaining healthy communities through disease prevention; achieving parity in access by attempting to increase the number of AI/AN homes with potable water to 94 percent by 2015; providing compassionate quality health care through the provision of sanitation; and embracing innovation through prevention activities and increased partnerships with other federal agencies, states and tribes. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts, as well as being a major factor in the quality of life of Indian people.

In FY 2007, the IHS provided service to 21,819 homes, which slightly missed the performance target: to provide sanitation facilities projects to serve 23,000 AI/AN new or like-new and existing homes with water, sewage disposal, and/or solid waste water

facilities. The impact of construction inflation reduced the number of homes that could be served for the provided funding. The SFC program has exceeded all Government Performance and Results Act (GPRA), IHS, Departmental and PART performance measures, with exception of the 2007 performance measure noted.

In FY 2007, of the $94,003,000 appropriated for sanitation facilities, $46,503,000 was used to address the backlog of existing homes. This included funding to serve solid waste needs (included in the solid waste funding was approximately $492,000 to clean up open dumps identified by an interagency task force, the members of which included the Bureau of Indian Affairs, the Environmental Protection Agency (EPA), the Department of Agriculture and others). The remainder of the FY 2007 appropriation was used to provide $45,000,000 for sanitation facilities for new/like-new Indian homes and $1,000,000 for special projects, and emergency projects.

In cooperation with the Office of Management and Budget (OMB) a Common Measure was developed in 2002 with the Rural Utility Service (RUS), the Bureau of Reclamation (BOR), the EPA, and the IHS to allow direct comparisons between rural water programs within the federal government. The Common Measures agreed upon were the number of connections and the population served per million dollars of total project cost. It was recognized that BOR and IHS are direct service programs to a specific population, and EPA and RUS are grant/loan programs that can leverage funding with both of these programs mostly providing strictly upgraded services. SFC has leveraged its project funds yearly gaining up to 100 percent in matching projects contributions from other federal (EPA, RUS), state, tribal, and local entities. The IHS compared favorably in the OMB common measure of direct comparisons between federal rural water programs by servicing more than seven times the number of homes per dollar of funding than comparative programs.

An efficiency measure based on the average project duration is evaluating SFC expertise in advancing project discipline. For Sanitation Facilities Construction projects completed during Calendar 2011 and the years thereafter, the average project duration from the execution of the Project Memorandum of Agreement (MOA) to the Construction Completion date as tracked by the Sanitation Facilities Project Data System shall be at 4 years or less. Project duration or the average length of time to complete project construction from the time the project is funded is a measure of actual performance since project schedule is under a project manager's control. This time length has been slowly increasing from 2.5 years in 1993 to nearly 4 years at the end of 2005 or about 12.5 percent per year increase. It is expected that the project duration will increase to at least 4.3 years prior to returning to 4 years.

Based on the FY 2007 data, 11% of AI/AN homes are without a safe and reliable water supply. The marginal cost analysis for the SFC Program recommendations validated the existing IHS strategic goal and PART goal for the SFC Program to increase the number of AI/AN homes with potable water to 94 percent by 2015. The Tribes through tribal consultation, other federal agencies through the Johannesburg MOU, and EPA within their strategic plan are all committed to SFC long term strategic goal. The marginal cost

estimates related the level of SFC funding to the percent of AI/AN homes with potable water for a 10-year period.

FUNDING HISTORY

Fiscal Year	Amount
2004	$93,015,000
2005	$91,767,000
2006	$94,003,000
2007	$94,253,000
2008 Enacted	$94,253,000

BUDGET REQUEST

The FY 2009 budget request of $94,253,000 is the same as the FY 2008 enacted level of $94,253,000. 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 preventative 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) $1,000,000 will be reserved at IHS Headquarters for special projects and for distribution to the Areas as needed to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situations that require immediate attention to minimize potential threats to public health. Emergency and special funds remaining at the end of the fiscal year will be distributed to the Areas to address the Sanitation Deficiency System (SDS) priority list of needs.

2) Approximately, $48,000,000 of the total FY 2009 SFC appropriation will be reserved to serve new and like-new homes. Some of these funds may also be used for sanitation facilities for the individual homes of the disabled or sick with a physician referral indicating an immediate medical need for adequate sanitation facilities in their home. As needed, amounts to serve new and like-new homes will be established by Headquarters after reviewing Area requests. Priority will be given to projects intended to provide sanitation facilities for the first time to homes in categories B, C, and D (new homes and homes receiving major renovation bringing the homes up to like new condition) under the BIA Housing Improvement Program (HIP). (NOTE: Homes in BIA/HIP Category A are considered existing homes. Category A homes needing service will be included in the SDS.)

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

3) Approximately, $49,000,000 of the amount appropriated in FY 2009 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 homes without water supply or sewer facilities, or without both. Up to $5,000,000 will be used for projects to clean up and replace open dumps on Indian lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994.

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

A marginal cost analysis for the SFC Program was requested by the OMB in conjunction with OMB A-11, Section 221, Budget and Performance Integration. The development of a marginal cost analysis also served as a milestone on the DHHS' President's Management Agenda score card for the third quarter of FY 2005. The OMB approved the analysis and its findings in June of 2006. The recommendations validated the existing IHS strategic goal and PART goal for the SFC Program. The marginal cost estimates related the level of SFC funding to the percent of AI/AN homes with potable water for a ten year period. According to the marginal cost curves the SFC funding request may result in a slight decrease in the percent of AI/AN homes that have access to safe drinking water and enhance the challenge of reaching the long term strategic goal.

Outcomes -- Table of Performance measures

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective: Increase the percentage of American Indian/Alaska Native (AI/AN) homes with sanitation facilities to 90 percent by 2010.									
35 SFC-1	**Sanitation Improvement**: Number of new or like-new and existing AI/AN homes provided with sanitation facilities.	24,928	24,072	22,000	24,090	23,000	21,819	21,800	21,375
35A SFC-2	Percent of existing homes served by the program at Deficiency Level 4 or above as defined by 25 USC 1632.	N/A	38%	20%	35%	35%	45%	35%	35%
SFC-E	Track average project duration from the Project Memorandum of Agreement execution to construction completion.	N/A	3.8 yrs	4.1 yrs	3.6 yrs	3.9 yrs	Apr/2008	4.0 yrs	4.1 yrs

capital improvement program, funded through this budget activity, is authorized to construct health care facilities and staff quarters, renovate/construct Youth Regional Treatment Centers for substance abuse, Joint Venture Construction Projects, provide construction funding for Tribal small ambulatory care facilities projects, replace/provide new dental units, and to assist non-IHS funded renovation projects.

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

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

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

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

improvements for planning and construction of IHS staff housing. The IHS began reviewing the need for quarters at each location where new or replacement health care facilities were being planned.

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

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

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

Recent Accomplishments - In Fiscal Year 2007, three new health facilities were completed within 100% scope, budget, and schedule in the following communities:

- Clinton, Oklahoma (Replaced a 1930's facility)
- Sisseton, South Dakota (Replaced a 1930's facility)
- Wadsworth, Nevada (No previous healthcare facility)

The efficiency measure for the IHS Health Care Facility Construction program for FY 2007 was to complete construction of two health care facilities. This measure was accomplished with the completion of the Clinton and Sisseton facilities. The Wadsworth facility was scheduled for completion in October of 2008 but was completed in August of 2007. The FY 2008 and FY 2009 targets for this measure are to complete one construction project during each time period. Targets were reduced because one project was completed ahead of schedule and one project was delayed due to 638 Tribal contract negotiations.

These new health facilities were designed to serve 11,000 Native American and Alaskan Natives. This represents an increase of 35% in access to health care in the subject communities.

A new Youth Regional Treatment Center (YRTC) in Wadsworth, Nevada will provide inpatient substance abuse and alcohol treatment to eligible American Indian and Alaska Native youth.

The new facilities are built at a much higher standard of energy efficiency reducing the energy consumption per square meter and exceeding the new 2006 energy standards. The new buildings are 30 to 50% more energy efficient than the buildings they replaced.

In addition, the program awarded one Joint Venture construction project, and selected two Tribal projects, Ada and Little Axe, Oklahoma, through a FY 2007 competitive application process.

Continued funding for the health care facility projects will meet the strategic objectives for HHS and IHS. The HHS Strategic Objectives, 1.2 and 1.3, and the IHS Strategic Objectives, 1 and 2 cannot be realized without replacing small and antiquated facilities with appropriately sized facilities, adequate staffing, and state-of-the-art equipment. Sufficient resources, facilities, and equipment together with a culturally competent, highly skilled work force are fundamental to achieving health care access and health status parity with the U.S. general population. The ability to affect health status in any community involves increase access to quality healthcare.

Funding History

Fiscal Year	Amount
2004	$94,555,000
2005	$88,597,000
2006	$37,779,000
2007	$25,664,000
2008 Enacted	$36,584,000

Based on the funding level from FY 2004 through FY 2008, $282,000,000 will be expended on construction projects, which results in a positive economic impact. Per the Economic Development Administration, Department of Commerce criteria, approximately 7,400 new jobs can be attributed to these funds. 3,200 of these jobs are directly involved in the construction of health care facilities. Experience with health facilities construction contracts indicates that approximately one fourth of the construction labor force is Native American. This equates to approximately 800 total jobs over the stated years, or 160 jobs annually, are provided to the residents of the Indian reservations helping to reduce the unemployment rate in the US.

BUDGET REQUEST

The FY 2009 budget request is $15,800,000; a decrease of $20,784,000 below the FY 2008 Enacted level. The request will provide resources to for the following project:

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: Increase proportion of patients with diagnosed diabetes with ideal blood sugar control (A1c<7) within 7 years of opening a new facility, achieving a 10 percent increase by 2010. Reduce the YPLL rate within 7 years of opening a new facility, achieving a 10 percent decrease by 2010.									
HCFC-1	**Diabetes: Ideal Glycemic Control:** Proportion of patients with diagnosed diabetes with ideal glycemic control.	N/A	32/47	32	30/58	30	33/73	33	32
		N/A	N/A	6	42/23	44	43/34	43	42
		N/A	N/A	33	29/16	30	32/30	32	31
		15	N/A	Exempt	N/A	15	38/24	38	37
		N/A	24	Exempt	N/A	24	23/28	23	23
		21	N/A	Exempt	N/A	21	41/35	41	40
HCFC-2	**Pap Smear Rates:** Proportion of eligible women who have had a Pap screen within the previous three years.	N/A	65/41	65	62/43	62	61/47	61	60
		N/A	N/A	32	36/25	37	38/24	38	37
		N/A	N/A	58	55/14	56	56/15	56	55
		58	N/A	Exempt	N/A	58	60/2	60	59
		N/A	61	Exempt	N/A	61	61/10	61	60
		73	N/A	Exempt	N/A	73	72/17	72	71
HCFC-3	**Mammogram Rates:** Proportion of eligible women who have had mammography screening within the previous two years.	N/A	41/52	41	44/60	44	48/77	48	47
		N/A	N/A	44	47/33	48	49/33	49	48
		N/A	N/A	32	22/28	23	38/38	38	37
		43	N/A	Exempt	N/A	43	82/8	82	80
		N/A	30	Exempt	N/A	30	28/21	28	27
		66	N/A	Exempt	N/A	66	62/17	62	61
HCFC-4	**Alcohol Screening (FAS Prevention}:** Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients.	N/A	3/39	4	35/39	35	33/39	33	33
		N/A	N/A	5	29/11	30	69/12	69	69
		N/A	N/A	50	18/9	19	40/11	40	40
		0	N/A	Exempt	N/A	1	60/4	60	60
		N/A	9	Exempt	N/A	9	40/9	40	40
		6	N/A	Exempt	N/A	6	67/14	67	67
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	79/12	Baseline	98	98	93	93	92
		N/A	N/A	Baseline	100	100	85	85	84
		N/A	N/A	Baseline	94	95	74	74	73
		26	N/A	Exempt	N/A	26	86	86	85
		N/A	88	Exempt	N/A	Baseline	84/13	84	83
		66	N/A	Exempt	N/A	Baseline	95	95	94
HCFC-6	**Influenza vaccination rates among adult patients aged 65 years and older.**	N/A	65/66	65	67/74	67	62/95	62	61
		N/A	N/A	46	60/23	61	64/26	64	63
		N/A	N/A	49	58/18	59	68/18	68	67
		41	N/A	Exempt	N/A	41	72/-6	72	71
		N/A	69	Exempt	N/A	69	68/17	68	67
		93	N/A	Exempt	N/A	93	91/24	91	90

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: Increase proportion of patients with diagnosed diabetes with ideal blood sugar control (A1c<7) within 7 years of opening a new facility, achieving a 10 percent increase by 2010. Reduce the YPLL rate within 7 years of opening a new facility, achieving a 10 percent decrease by 2010.									
HCFC-7	**Pneumococcal vaccination rates among adult patients aged 65 years and older.**	N/A	67/66	70	77/74	77	81/95	81	80
		N/A	N/A	24	55/23	56	78/26	78	77
		N/A	N/A	53	52/18	53	75/18	75	74
		42	N/A	Exempt	N/A	42	87/-6	87	86
		N/A	83	Exempt	N/A	83	84/17	84	83
		90	N/A	Exempt	N/A	90	97/24	97	96
HCFC-8	**Tobacco Cessation Intervention[2,3]:** Proportion of tobacco-using patients that receive tobacco cessation intervention.	N/A	4/38	Baseline	1	3	1	1	1
		N/A	N/A	Baseline	3	5	9	9	9
		N/A	N/A	Baseline	13	15	14	14	14
		12	N/A	Exempt	N/A	Baseline	40	40	40
		N/A	6	Exempt	N/A	Baseline	1	1	1
		16	N/A	Exempt	N/A	Baseline	14	14	14

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 increased 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.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target	Out-Year Target
Long-Term Objective 1: Increase proportion of patients with diagnosed diabetes with ideal blood sugar control (A1c<7) within 7 years of opening a new facility, achieving a 10 percent increase by 2010. Reduce the YPLL rate within 7 years of opening a new facility, achieving a 10 percent decrease by 2010.										
HCFC-9	Percent reduction of the YPLL rate within 7 years of opening the new facility[1].	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Jan/2010 -10%
HCFC-10	Percent increase in the proportion of diagnosed diabetics demonstrating ideal blood sugar control within 7 years of opening the new facility[1].	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Oct/2010 10%

The group of measures above outline clinical performance and access to care for eight clinical performance topics and include: diabetes Glycemic control, cancer screening (breast and cervical), Alcohol screening to prevent Fetal Alcohol Syndrome, Tobacco Cessation and immunizations (childhood and adult). Overall trends for these measures show moderate improvement but variations across facilities and across measures were noted. High cost measures such as Glycemic control, cancer screenings, and tobacco

cessation can be attributed to the varied results across measures. In addition, increases in access to care (i.e. service population) have been observed for all measures and are not unique to one individual facility. Due to the inflation of the service population, clinical results can have an artificial appearance of declining performance. With that said, over inflation of the denominator (or increase in the service population) can dilute the true performance result (i.e. the overall number of patients being served has increased). All in all, the biggest attribute noted for these performance measures are the vast gains in access to quality healthcare across all topic areas outlined above.

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Request	FY 2009 +/- FY 2008
BA	$165,272,000	$169,638,000	$169,105,000	-$533,000
FS	*87,528,000*	*90,424,000*	*91,156,000*	*+732,000*
EHS	*63,408,000*	*64,576,000*	*63,545,000*	*-1,031,000*
OEHE	*14,336,000*	*14,638,000*	*14,404,000*	*-234,000*
FTE	**1,066**	**1,066**	**1,068**	**+2**

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

FY 2009 Authorization .....Expired 2000

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

SUMMARY OF REQUEST

The Indian Health Facilities programs, managed throughout including at IHS Headquarters by the OEHE and also carried out by Area, Field, and Service unit staff, provide an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs both directly and indirectly support all of the IHS facilities performance measures.

Services are delivered directly by Federal or Tribal employees or contractors. In addition to staffing costs, funds appropriated for this activity are used to pay for utilities in IHS health care facilities, certain non-medical supplies and personal property, and biomedical equipment repair.

The OEHE Headquarters staff, facilities and environmental health-related programs in IHS Area Offices**, area staff and District Offices, provide support for a diverse range of projects and activities.** Area facilities and environmental health personnel include architects, engineers, environmental health officers, real property and staff quarters management specialists, biomedical technicians, facilities planners, injury prevention specialists, institutional environmental health officers, construction inspectors, utility operations consultants, draftspersons, and land surveyors.

The Budget requests $169 million to provide support for the following activities:

Facilities Support (FS): (+732,000)

- Provides funding for staff, management, operation, and maintenance of real property and building systems, medical equipment technical support, and planning and construction management for new and replacement facilities projects.

Environmental Health Support (EHS): (-$1,031)

- Provide funding for engineers, environmental health officers, environmental health technicians, engineering aides, injury prevention specialists, and institutional environmental health officers.

Office of Environmental Health and Engineering (OEHE): (-$234,000)

- Provides funding 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, Congress, Tribes, and other Federal agencies.

FUNDING HISTORY

Fiscal Year	Amount	Program Increase (non-add)
2004	$137,803,000	
2005	$141,669,000	
2006	$150,709,000	
2007	$165,272,000	$1,000,000 Injury Prevention Program
2008 Enacted	$169,638,000	

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT
FACILITIES SUPPORT

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$ 87,528,000	$90,424,000	$91,156,000	+$732,000
FTE	571	571	575	+4

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

FY 2009 Authorization.....Expired 2000

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The personnel paid from this account operate and maintain health care facilities and staff quarters. Staff functions supported by this sub-activity include management, operation, and maintenance of real property and building systems, medical equipment technical support, and planning and construction management for new and replacement facilities 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. Lease costs however are funded from the Service appropriations.

The IHS is committed to ensuring that health care is provided in functional and safe structures. Because many IHS facilities are located in isolated and remote environments far from urban centers, the IHS also builds and maintains residential quarters at those locations to house non-local health care personnel.

The IHS owns approximately 904,000 square meters of facilities (buildings and structures) and 742 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. The average age of our health care facilities is 33 years.

In addition to Federally-owned space, the IHS manages direct leased and GSA assigned space. The table below shows the space occupied by IHS and Tribal Health Care Programs.

Space Occupied by IHS and Tribal Health Care Programs - FY 2007				
Type of Facility	Federally Owned	Direct Federal Lease	GSA Assigned	Tribal *
Hospitals and Health Centers	441,000 M^2	78,000 M^2	-0-	269,000 M^2
Staff Quarters	288,000 M^2	0 M^2	-0-	306 M^2
Other	175,000 M^2	35,000 M^2	62,000 M^2	289,000 M^2
Total	904,000 M^2	113,000 M^2	62,000 M^2	558,000 M^2

(FY 2007 end of year)

* Tribal Space listed for Hospitals and Health Centers includes all eligible supported space at locations where direct medical services are provided under P.L. 93-638 contracts in non-IHS owned buildings. Staffing and operations costs (including lease costs) are funded from the Services appropriation.

Four principal staff functions are funded at the Area and Service unit levels through the Facilities Support sub-activity.

- **Facilities Engineering** -- Area and Service unit facilities engineers and staff are responsible for ensuring that IHS building systems are operated properly, facilities and grounds are maintained adequately, utilities are managed appropriately, environmental compliance requirements are met, and buildings are safe. The need for maintenance and improvement projects is determined at the Area level and identified in Area Facilities Engineering Plans.

- **Clinical Engineering --** The IHS has highly sophisticated medical equipment in its inventory. Skilled and specialized personnel are employed to maintain and service that equipment because the lives of patients and level of patient care depend on accurate calibration and safe operation. Clinical engineers and technicians perform this critically important function. Larger IHS facilities have clinical engineering personnel on-site, but most IHS and Tribal facilities depend on Area, district, or service unit-based clinical engineers and technicians who travel to several facility locations to repair and maintain biomedical equipment.

- **Realty Management** -- Area Realty Management Officers provide technical and management assistance for realty activities associated with direct-leased, GSA-assigned, and IHS-owned (and to some degree Tribally-owned) space. The program includes facility and land acquisitions and disposals, licensing/easement processing, use-permit issuance, quarters management and rent-setting activities, lease administration, and budget functions. The program also helps Tribes and Tribal organizations acquire, administer, and/or manage excess Federally-owned and Tribally-leased real property.

- **Facilities Planning and Construction** -- Some IHS Areas have facilities planning and construction-monitoring components that assist in the planning and construction management of new and replacement health care facility and staff quarters projects.

The need for new facilities is determined by applying the IHS Health Facilities Construction and Quarters Construction Priority System methodologies. Area staffs develop initial proposals for new and replacement facilities, prepare Program Justification Documents, Program of Requirements Documents, and Project Summary Documents for projects. While construction is underway, Area facilities management staff may be supplemented with construction management personnel to oversee Federal interests in the construction of new and replacement facilities.

In addition, the functions of these facility and realty positions support new real property asset management requirements as required by Executive Order 13327, *"Real Property Asset Management*"; Executive Order 13423, *"Strengthen Federal Environmental, Energy, and Transportation Management"*; the President's Real Property Management Agenda Initiative; and HHS Program Management objectives. These management actions are to ensure management accountability, to ensure the efficient and economic use, to recognize the importance, and to respond to the current condition of Federal real property.

The IHS places a high priority on the implementation of the Greening the Government Executive Orders and meeting Federal, State, and local legal/regulatory environmental requirements, including allocating funding to address findings and recommendations from environmental audits. The costs associated with implementation of these requirements compete against other Facilities Support requirements within the existing budget levels. Starting in FY 2004, a national effort was initiated to execute a new cycle of environmental assessments with emphasis on direct building and grounds related deficiencies with sufficient data to initiate projects to address pending environmental deficiencies. The IHS then annually sets aside Maintenance and Improvement funds in the amounts of approximately $3 million for environmental compliance projects and approximately $500,000 for demolition projects.

In conjunction with improved management practices, energy conservation measures, and projects, IHS reduced the energy related utility consumption for IHS managed facilities from 2,190,000 BTU/SM in 2003 to 1,923,000 BTU/SM in 2007. These efforts help stem the growth in the cost of utilities, which is primarily due to space increases and inflation. IHS will continue all of these functions in FY 2009. However, this will only partially address the overall impact of expected increases in energy cost. During the period FY 2002 through FY 2007, total utility costs have increased 41 percent from $15.5 million to $21.9 million and total utility costs per GSM increased 40 percent from $25/GSM to $35/GSM. The IHS continues to aggressively investigate options to reduce energy costs through energy-savings performance contracts, utility energy-efficiency service contracts, and other contractual platforms for achieving conservation goals.

FY	Cost	BTU/SM	Cost/GSM
2003	15,500,000	2,190,000	$ 25
2004	14,800,000	2,150,000	$ 25
2005	18,500,000	1,930,000	$ 30
2006	21,800,000	1,797,000	$ 33
2007	21,900,000	1,923,000	$ 35

FUNDING HISTORY

Fiscal Year	Amount
2004	$ 70,472,741
2005	$ 73,843,675
2006	$ 79,970,547
2007	$ 87,528,000
2008 Enacted	$ 90,424,000

BUDGET REQUEST

The FY 2009 budget request of $91,156,000 and 575 FTE is an increase of $732,000 over the FY 2008 Enacted level of $90,424,000. This request will fund the costs of personnel and operation costs for Facilities Support at the Service unit and Area levels[1].

This request will facilitate the IHS progress towards the real property asset management requirements and goals as outlined in the Executive Order 13327, *"Federal Real Property Asset Management"*; Executive Order 13423, *"Strengthen Federal Environmental, Energy, and Transportation Management"*; the President's Management Agenda; and the Agency's Real Property Asset Management Plan.

This level of funding will provide:

Area Offices, service units and certain Tribal health care entities with funding for staff, utilities, program supplies and equipment to maintain the health care buildings and grounds, and to service approximately $320,000,000 worth of medical equipment. Facilities supported include hospitals, health centers, staff quarters, health stations and school health clinics, and youth regional treatment centers.

Staffing and operating funding at new facilities to allow IHS to expand provision of health care in those areas where existing capacity is most overextended.

Facilities	Amount	Federal FTE	Tribal Positions
PIMC SW Clinic	$935,000	6	
Lawton Indian Hospital	$1,241,000	7	
Grand Total:	**$2,176,000**	**13**	

Outcomes and Outputs

There are no performance targets for this sub-activity.

1/ Costs for these functions performed by P.L. 93-638 contractors at non-Federally-owned or previously Federally-owned facilities are funded from the Services appropriation.

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT
ENVIRONMENTAL HEALTH SUPPORT

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$63,408,000	$64,576,000	$63,545,000	-$1,031,000
FTE	415	415	415	0

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

FY 2009 Authorization.....Expired 2000

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The program provides funding for IHS Area, District and Service Unit environmental health staffs which include engineers, environmental health officers, environmental health technicians, engineering aides, injury prevention specialists, and institutional environmental health officers. AI/AN's face hazards in their environment that contribute to their health status, including: communities in remote/isolated locations that expose residents to severe climatic conditions, hazardous geography, and extreme isolation; increased exposure to disease carrying insects and rodents; limited availability of housing and extensive use of sub-standard housing; unsanitary methods of sewage and garbage disposal; and unsafe water supply.

Division of Sanitation Facilities Construction (SFC) staff manages and provides professional engineering services to construct over 400 sanitation projects annually at a total cost of over $190 million. 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, assisting Tribes where the Tribes provide construction management, and assisting Tribes with operation and maintenance of constructed facilities. In accordance with the Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L. 94-437) the SFC staff annually updates its inventory of sanitation facilities deficiencies for existing Indian homes. This is carried out with extensive consultation with Tribes. The SCF 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. Consistent with the 1994 Congressional earmark for "… tribal training on the operation and maintenance of sanitation facilities," $1,000,000 of these support funds will be used to provide for continued operation and maintenance training. The SFC staff provides technical assistance, training and guidance to Indian families and communities regarding the operation and maintenance of essential water supply and sewage disposal facilities.

To accomplish its goals, the **Division of Environmental Health Services (DEHS)** is a consultative public health advisor to Tribes. The DEHS staff lead in the assessment and identification of environmental hazards and risk factors facing Tribal groups and partner with Tribal groups in the development of sound public health strategies to prevent or mitigate environmental hazards. Strategies employed by DEHS staff include: maintaining surveillance of disease and injury incidence in communities; investigation of disease and injury incidents; identifying environmental hazards in community facilities and institutions such as food service establishments, Head Start Centers, community water supply systems, and health care facilities; and providing training, technical assistance and project funding to develop the capacity of Tribal governments to address their environmental health issues. The DEHS is administered through the following three program emphasis areas:

- **General Environmental Health** staff are the lead environmental health professionals providing environmental health services to Tribes in issues of water quality, waste disposal, hazardous materials management, food sanitation, community injury prevention, institutional environmental health, vector control, occupational safety and health and other environmental health issues.

  Staff and Tribal partners use the Web-based Environmental Health Reporting System (WebEHRS) to collect community and facility environmental health data. The WebEHRS data is used for surveillance of environmental factors, monitoring community environmental health conditions, and addressing community public health priorities. Data provided by WebEHRS is used by environmental health staff to monitor workload and prioritize environmental health conditions in communities with Tribal governments. Expansion of the capacity of WebEHRS to track activities, projects, and priorities for Tribal and federal environmental health programs is a performance measure for the IHS.

- **Injury Prevention Program** staff take the lead in developing public health strategies to reduce the burden of injury experienced by AI/AN. AI/ANs die from injuries and poisonings at a rate 2.6 times the U.S. All Races rate. Treatment of injuries (hospitalizations and ambulatory cases) cost an estimated $350,000,000 per year in direct health care costs to IHS, Tribes, and Contract care facilities. The IHS Injury Prevention Program has developed effective strategies and initiatives to reduce the burden of injury experienced by AI/AN, including: surveillance of community-based

injuries; development of targeted prevention programs based on surveillance data; developing community coalitions to address their injury issues; developing the capacity of community coalition members through injury prevention practitioners training; funding competitively awarded cooperative to develop Tribal injury prevention infrastructure; and evaluation program initiatives. In FY 2007, 31 Tribal projects continued best practices in community-based IHS Tribal Injury Prevention Cooperative Agreements to develop Tribal infrastructure. The program awards consisted of 22 five-year programs and 9 three-year projects. There were no new awards in FY 2006 – FY 2008. The next award cycle is expected to be in FY 2009 after the 9 three-year projects have been completed and re-announced.

- The **Institutional Environmental Health** (IEH) program is comprised of staff with specialized skills to quantify, evaluate, and respond to unique environmental and safety hazards found in health care, educational, childcare, correctional, and industrial facilities.

  IEH program staff are knowledgeable of and provide support in the following disciplines: infection control, industrial hygiene, radiation protection, hazardous materials and waste, safety management, ergonomics, fire/life safety, emergency management, public health preparedness, security, and environmental compliance. Also, IEH program staffs perform evaluations and management system reviews of IHS and Tribal health care facilities seeking accreditation and/or certification. Maintaining accreditation ensures that IHS continues to have access to third party funding.

  The Institutional Environmental Health Program utilizes a web-based occupational health incident reporting system called "WebCident" in IHS healthcare facilities. WebCident is used to report injuries, illnesses, hazardous conditions, security, and property-related incidents experienced by visitors, patients, and others, as appropriate. WebCident is used to prepare required Occupational Safety and Health Administration logs, identify, document and track hazardous conditions, report trends to assist with the development of targeted prevention strategies. DEHS continues to support the expansion of WebCident to all IHS and Tribal health care facilities and refine the program from feedback provided by users. Data developed through WebCident will be used to reduce occupational injuries/illnesses and associated workers' compensation claims, and reduce/eliminate hazards to employees, patients, visitors, and others.

TRIBAL HEALTH PROGRAMS

The IHS Area, District and Service unit environmental health personnel also train Tribal employees to provide environmental health services, under contract with IHS wherever a Tribe desires, provided that funds are available and other considerations make such arrangement practicable. As a result of training provided by IHS, Tribal environmental health personnel are better prepared to provide higher levels of service to the Indian people and to support the provision of direct patient care services. For example, some

Tribes have chosen to contract for the provision of the full range of environmental health services as typically provided by the IHS direct delivery program.

Area, District and Service unit environmental health personnel work with Tribes/Tribal organizations to encourage maximum participation in planning health services delivery programs. Also, they provide technical assistance to the Tribal officials who carry out administrative/management responsibilities associated with operation of federally supported programs. Their support of self-determination for Tribal organizations will continue. However, the extent to which there is participation in the self-determination process depends on, and is determined by, the individual Tribes/Tribal organizations.

BUDGET REQUEST

The FY 2009 budget request of $63,545,000 and 415 FTE is a decrease of $1,031,000 below the FY 2008 Enacted level of $64,576,000. The request funds the costs of personnel who accomplish environmental health services, injury prevention activities, and sanitation facilities construction activities, at the IHS Area, District, and Service unit levels and pays operating costs associated with provision of those services and activities.

Environmental Health Services staff will utilize WebEHRS to identify environmental health risk factors. Multiple interventions will be implemented in FY 2009 to address each identified risk factor.

OUTCOMES

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2010 decrease YPLL by 20 percent over the 2002 level.									
27	**Injury Intervention**: Number of community-based injury prevention programs[1].	37	37	Implement Web System	Web System Implemented	3 projects per Area	3 projects/12 Areas	Survey	1 Pilot/Area
Long-Term Objective 2: Provide quality health information for decision making to patients, providers and communities through improved information systems.									
34	**Environmental Surveillance:** Number of environmental health programs with automated web-based environmental health surveillance data collection system (webEHRS)[2].	15	12	18	20	29	32	Baseline[3]	3 interventions/Area

[1]*Measure will reflect number of projects per area starting in FY 2007. In FY 2008 measure changes to Injury Intervention (Motor Vehicle Injuries): Occupant protection restraint use.*
[2]*In FY 2008 measure changes to Environmental Surveillance: Identify and address environmental risk factors in communities.*
[3]*Developmental measure in FY 2008.*

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

FACILITIES AND ENVIRONMENTAL HEALTH SUPPORT
OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$ 14,336,000	$14,638,000	$14,404,000	-$234,000
FTE	80	80	78	-2

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

FY 2009 Authorization.....Expired 2000

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Office of Environmental Health and Engineering Support activity provides personnel, contracts, contractors, and operating costs for the Office of Environmental Health and Engineering (OEHE) Headquarters. Headquarters personnel have management responsibility for IHS facilities and environmental health programs, provide direct technical services and support to Area personnel, and perform critical management functions. Headquarters management activities includes national policy development and implementation, budget formulation, project review and approval, congressional report preparation, quality assurance (internal control reviews, Federal Managers Financial Integrity Act activities and other oversight), technical assistance (consultation and training), long range planning, meetings (with the Department of Health and Human Services, Members of Congress and their representatives, Tribes, and other Federal agencies), and recruitment and retention. Typical direct support functions performed by OEHE personnel who serve as project officers for health care facilities construction projects are: reviewing and/or writing technical justification documents, participating in design reviews and site surveys, conducting onsite inspections, and monitoring project funding status, etc.

In addition, these positions support new real property asset management requirements as required by Executive Order 13327, Real Property Asset Management; the President's Real Property Management Agenda Initiative; and HHS Program Management objectives. These actions are to ensure management accountability, to ensuring the

efficient and economic use, recognizing the importance of the assets, and responding to the current condition of Federal real property.

In FY 2007, OEHE Support funded personnel 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, Program of Requirements, announcement and selection 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. The coordination effort of a decentralized management structure throughout the IHS is complex. Health care delivery decisions are made locally and infrastructure needs are community based to avoid inappropriate decisions to be made from a distance which may adversely affect Indian communities.

BUDGET REQUEST

The FY 2009 budget request of $14,404,000 and 78 FTE is a decrease of $234,000 from the FY 2008 Enacted Level of $14,638,000.

OEHE collects and reports the 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 the President's Management Agenda on Real Property Asset Management and the mission of the IHS. Targets and measurements are documented in the HHS Real Property Asset Management Plan.

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

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$21,619,000	$21,282,000	$21,282,000	$0
FTE	0	0	0	0

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

FY 2009 Authorization.....Expired 2000

Allocation Method.....Direct Federal, and P.L. 93-638 Self Determination contracts and Self-Governance compacts for replacement medical equipment that is formula based; Equipment funds for tribally-constructed health care facilities are competitively allocated; and TRANSAM and ambulance purchase programs are Federally managed.

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

This sub-activity supports maintenance, replacement, and the purchase of new biomedical equipment at IHS and Tribal health care facilities.

The IHS and Tribal health programs manage laboratory, x-ray, and biomedical equipment valued at approximately $320 million. Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment to assure the best possible health outcomes. The average life expectancy for today's medical device is approximately six years depending on the intensity of use, maintenance, and technical advances. In FY 2007, the medical equipment program distributed over $15 million to IHS and tribal health programs to purchase new medical equipment, including replacement of existing equipment used in diagnosing and treatment of illnesses. Allocation of medical equipment funds is formula based.

Annual health care space supported with replacement medical equipment funds:

FY	Supported Space (Square Meters)
2003	989,185
2004	1,048,932
2005	1,051,075
2006	1,098,403
2007	1,155,452

This budget activity also funds equipment for replacement clinics built by Tribes using other funding sources. These equipment funds are competitively allocated where tribes and tribal organizations are invited to apply for these equipment funds during the annual application period.

Tribally-constructed health care facilities supported annually with equipment funds:

FY	Project Awards
2003	23
2004	49
2005	31
2006	27
2007	32

Using these funds, 32 awards - see table below - were made to tribal organizations that funded and constructed clinics or clinic additions. Tribes plan on spending in excess of $267 million in construction projects using non-IHS funding sources to access these equipment funds. As a result, approximately 253,000 individual patients will be treated with updated medical equipment in these tribally-funded construction projects.

Boise Fort Health Center	Gila River Health Corp	Native Village of Tuntutuliak
Bristol Bay Health Corporation (6)	Iowa Tribe of Oklahoma	Paiute Tribe
Cherokee Nation (2)	Kaltag Health Corporation	Seminole Tribe of Florida
Chickasaw Nation (2)	Leach Lake	Southcentral Foundation
Chugachmiut	Makah Tribal Council	Southern Indian Health Council
Citizen Potawatomi Nation	Munising Tribal Health Center	Yakama Nation
Confederated Tribes of Siletz	Muskogee (Creek) Nation	Yukon Kuskokwim Health Corp
Cow Creek Band of Umpqua	Native Village of Kakona	
Osage Nation of Pawhuska Health Center	Shingle Springs Rancheria Tribal Health Program	

Note - Some larger programs with multiple facilities applied for and were awarded more than one award due to multiple construction projects.

The program funds are used to acquire new and like-new excess medical equipment for the Department of Defense (DoD) or other sources through the TRANSAM (i.e., Transfer of DoD Excess Medical and Other Supplies to Native Americans or TRANSAM) program and to procure ambulances for IHS and tribal emergency medical services programs. In 2006 under the TRANSAM program, the IHS acquired and distributed approximately $2.1 million in medical assets obtained from military and VA excess property channels. Several ambulances were also purchased and provided to either replace older ambulances or augment existing tribally-operated emergency medical services. These programs are Federally managed.

Such program activities support HHS strategic objective(s) 2.4: Prepare for and respond to natural and man-made disasters; 1.3: Improve health care quality, safety, cost and

value. These activities also support IHS strategic goal 2: providing accessible, quality health care.

FUNDING HISTORY

Fiscal Year	Amount
2004	$ 17,080,905
2005	$ 17,336,756
2006	$ 20,947,214
2007	$ 21,619,214
2008 Enacted	$ 21,282,000

BUDGET REQUEST

The FY 2009 budget request of $21,282,000 is the same as the FY 2008 Enacted level. This total funding will provide:

- $15 million for routine replacement medical equipment to over 1,600 Federally and Tribally-operated health care facilities,
- $5 million for new medical equipment in tribally-constructed health care facilities, and
- $1 million for the TRANSAM and ambulance programs.

Outcomes and Outputs

There are no performance targets for this sub-activity.

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

PERSONNEL QUARTERS/QUARTERS RETURN FUNDS

	FY 2007 Actual	FY 2008 Enacted	FY 2009 Estimate	FY 2009 +/- FY 2008
BA	$6,288,000	$6,288,000	$6,288,000	$0
FTE	0	0	0	0

Authorizing Legislation ..... Public Law 98-473, as amended

FY 2009 Authorization ..... Indefinite

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 distributed and used at the locality in which they are collected

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Quarters Return funds will support the operation, management, and general maintenance of personnel quarters at IHS health care facilities.

Staff quarters' operation, maintenance, and improvement costs are funded with Quarters Return (QR) funds. An estimated $6,288,000 in QR funds will be collected from tenants of quarters during FY 2009. These funds will be used for the operation, management, and general maintenance of quarters, including temporary maintenance personnel services, security guard services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (stoves, water heaters, furnaces, etc.). In certain situations, M&I funds may be used, in conjunction with QR funds, to ensure adequate quarters maintenance; e.g., locations with few quarters where QR funds are not enough to pay for all required maintenance costs.

FUNDING HISTORY

Fiscal Year	Amount
2004	$ 5,900,000
2005	$ 6,200,000
2006	$ 6,288,000
2007	$ 6,288,000
2008 Enacted	$ 6,288,000

BUDGET REQUEST

The FY 2009 budget request of $6,288,000 is the same as the FY 2008 Enacted level.

FY 2009 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2008 Enacted	FY 2009 Estimate	FY 08 +/- FY 2009
DIRECT OBLIGATIONS			
Personnel Compensation:			
Full-Time Permanent(11.0)……	396,595	407,118	10,523
Other than Full-Time Permanent(11.3)……	29,086	29,818	732
Other Personnel Comp.(11.5)……	41,706	43,091	1,385
Military Personnel Comp (11.7)……	97,936	101,714	3,778
Special Personal Services Payments (11.8)……	152	152	0
Subtotal, Personnel Compensation……	565,475	581,893	16,418
Civilian Personnel Benefits(12.1)……	127,634	131,241	3,607
Military Personnel Benefits (12.2)	44,125	45,602	1,477
Benefits to Former Personnel(13.0)……	8,151	8,154	3
Subtotal, Pay Costs……	**745,385**	**766,890**	**21,505**
Travel(21.0)……	39,313	38,950	(363)
Transportation of Things(22.0)……	11,885	11,704	(181)
Rental Payments to GSA(23.1)……	8,081	7,940	(141)
Rental Payments to Others(23.2)……	1,771	1,745	(26)
Communications, Utilities and Miscellaneous Charges(23.3……	33,257	32,670	(587)
Printing and Reproduction(24.0)……	729	702	(27)
Other Contractual Services:			
Advisory and Assistance Services(25.1)……	22,332	12,336	(9,996)
Other Services(25.2)……	177,502	179,100	1,598
Purchases from Govt. Accts.(25.3)……	63,301	72,324	9,023
Operation and Maintenance of Facilities(25.4)..	3,764	3,591	(173)
Research and Development Contracts(25.5)…..	0	0	0
Medical Care(25.6)……	266,056	270,089	4,033
Operation and Maintenance of Equipment(25.7)	6,888	7,408	520
Subsistence and Support of Persons(25.8)……	2,103	219	(1,884)
Subtotal, Other Contractual Current……..	**541,946**	**545,067**	**3,121**
Supplies and Materials(26.0)……	105,650	106,028	378
Equipment (31.0)……	23,874	23,166	(708)
Land & Structures (32.0)……	5,756	5,101	(655)
Investments & Loans (33.0)……	0	0	0
Grants, Subsidies, & Contributions (41.0)……	1,826,137	1,783,627	(42,510)
Insurance Claims & Indemnities (42.0)……	2,216	1,112	(1,104)
Interest & Dividends (43.0)……	179	160	(19)
Subtotal Non-Pay Costs……	**2,600,794**	**2,557,972**	**(42,822)**
Total, Direct Obligations……	**3,346,179**	**3,324,862**	**(21,317)**

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

Object Class	2008 Estimate	2009 Estimate	Increase or Decrease
Personnel Compensation:			
Full-Time Permanent (11.0)	396,595	407,118	10,523
Other than Full-Time Permanent (11.3)	29,086	29,818	732
Other Personnel Comp. (11.5)	41,706	43,091	1,385
Military Personnel Comp. (11.7)	97,936	101,714	3,778
Special Personnel Services Payments (11.8)	152	152	0
Subtotal, Personnel Compensation	565,475	581,893	16,418
Civilian Personnel Benefits (12.1)	127,634	131,241	3,607
Millitary Personnel Benefits (12.2)	44,125	45,602	1,477
Benefits to Former Personnel (13.0)	8,151	8,154	3
Total, Pay Costs	**745,385**	**766,890**	**21,505**
Travel (21.0)	15,838	15,188	(650)
Transportation of Things (22.0)	11,885	11,704	(181)
Rental Payments to Others (23.2)	1,771	1,745	(26)
Communications, Utilities & Misc. Charges (23.3)	33,257	32,670	(587)
Printing and Reproduction (24.0)	729	702	(27)
Other Contractual Services:			
Advisory and Assistance Services (25.1)	22,332	12,336	(9,996)
Other Services (25.2)	177,502	179,100	1,598
Purchases from Govt. Accts. (25.3)	63,301	72,324	9,023
Operation and Maintenance of Facilities (25.4)	3,764	3,591	(173)
Operation and Maintenance of Equipment (25.7)	6,888	7,408	520
Subsistance and Support of Persons (25.8)	2,103	219	(1,884)
Subtotal, Other Contractual	275,890	274,978	(912)
Supplies and Materials (26.0)	105,650	106,028	378
Total, Non-Pay Costs	**445,020**	**443,015**	**(2,005)**
Total Salaries & Expenses	1,190,405	1,209,905	19,500
Direct FTE	9,533	9,562	29

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

	FY 2007 Actual	FY 2008 Estimate	FY 2009 Estimate
Headquarters			
Office of the Director	29	29	29
Office of Tribal Self-Governance	10	10	10
Office of Tribal Programs	9	9	9
Office of Urban Indian Health Programs	2	2	2
Office of Clinical and Preventive Services	87	87	87
Office of Information Technology	6	6	6
Office of Public Health Support	38	38	38
Office of Resource Access and Partnerships	13	13	12
Office of Finance and Accounting	27	27	24
Office of Management Services	109	109	105
Office of Environmental Health and Engineering	75	75	73
Sub-Total, Headquarters	405	405	395
Area Offices			
Aberdeen Area Office	1,859	1,859	1,855
Alaska Area Office	657	657	655
Albuquerque Area Office	1,012	1,012	1,009
Bemidji Area Office	441	441	440
Billings Area Office	873	873	870
California Area Office	91	91	90
Nashville Area Office	191	191	189
Navajo Area Office	4,342	4,342	4,321
Oklahoma City Area Office	1,769	1,772	1,852
Phoenix Area Office	2,492	2,521	2,520
Portland Area Office	547	547	545
Tucson Area Office	391	391	390
Sub-Total, Area Offices	14,665	14,697	14,736
TOTAL FTES	15,070	15,102	15,131

Average GS Grade

2004.....	8.1
2005.....	8.2
2006.....	8.2

INDIAN HEALTH SERVICE
DETAIL OF PERMANENT POSITIONS

	2007 Actual	2008 Estimate	2009 Estimate
ES-5	2	2	2
ES-4	3	3	3
ES-3	4	4	4
ES-2	5	5	5
ES-1	7	7	7
Subtotal	21	21	21
Total - ES Salaries	$3,438,284	$3,513,926	$3,619,344
GS/GM-15	424	424	424
GS/GM-14	408	408	408
GS/GM-13	363	364	365
GS-12	796	798	800
GS-11	1,257	1,260	1,264
GS-10	543	544	546
GS-9	1,216	1,222	1,226
GS-8	249	250	250
GS-7	941	946	948
GS-6	1,090	1,093	1,096
GS-5	1,968	1,974	1,980
GS-4	1,076	1,079	1,082
GS-3	209	210	210
GS-2	34	34	34
GS-1	1	1	1
Subtotal	10,575	10,607	10,636
Total - GS Salaries	$512,890,462	$525,834,180	$543,113,696
Assistant Surgeon General CO-08	4	4	4
Assistant Surgeon General CO-07	5	5	5
Director Grade CO-06	468	468	468
Senior Grade CO-05	577	577	577
Full Grade CO-04	551	551	551
Senior Assistant Grade CO-03	387	387	387
Assistant Grade CO-02	108	108	108
Junior Grade CO-01	18	18	18
Subtotal	2,118	2,118	2,118
Total - CO Salaries	$237,448,734	$242,672,606	$249,952,784
Ungraded	1,256	1,256	1,260
Total - Ungraded Salaries	$24,604,658	$25,145,961	$25,900,340

Average ES level	ES-02
Average ES salary	$163,728
Average GS grade	8.2
Average GS salary	$51,879

Indian Health Service
Programs Proposed for Elimination

The following table shows the single IHS program proposed for elimination in the President's 2009 Budget request. Termination purpose is to redirect funds to provision of health care services on or near reservations and for health programs that have a demonstrated record of success or that hold significant promise for increasing accountability and improving health outcomes. Following the table is a brief summary of the program and the rationale for its elimination.

Program	FY 2008 Funding (in millions)
Urban Indian Health Programs	$34.5

Rationale:

The Urban Indian Health Program budget is eliminated in the FY 2009 President's Budget request to IHS funds focus on providing health care on or near Indian reservations. The 2006 Program Assessment Rating Tool (PART) evaluation of this program found the beneficiaries of these programs have access to other sources of health care in the urban areas where they reside.

Special Requirements
Indian Health Service

Unified Financial Management System

Unified Financial Management System Operations and Maintenance (UFMS O & M) UFMS has now been fully deployed. The Program Support Center, through the Service and Supply Fund, manages the ongoing Operations and Maintenance (O & M) activities for UFMS. The scope of O & M services includes post deployment support and ongoing business and technical operations services, as well as an upgrade of Oracle software from version 11.5.9 to version 12.0. The Indian Health Service will use $10,695,196 for these O&M costs in FY 2009.

HHS Consolidated Acquisition System

The HHS Consolidated Acquisition System (HCAS) initiative is a Department-wide contract management system that will integrate with the Unified Financial Management System (UFMS). The applications within the HCAS are Compusearch PRISM and a portion of the Oracle Compusearch Interface (OCI). PRISM is a federal contract management system that streamlines the procurement process. PRISM automates contract writing, simplified acquisitions, electronic approvals and routing, pre-award tracking, contract monitoring, post award tracking, contract closeout and reporting. The Indian Health Service will use $1,718,379 to support the completion of HCAS implementation in FY 2009.

Special Requirements
HHS Enterprise Information Technology Fund-PMA e-Gov Initiatives
FY 2009

IHS Allocation Statement:

The **IHS** will contribute **$892,500** of its FY 2009 budget to support Department enterprise information technology initiatives as well as the President's Management Agenda (PMA) Expanding E-Government initiatives. Operating Division contributions are combined to create an Enterprise Information Technology (EIT) Fund that finances both the specific HHS information technology initiatives identified through the HHS Information Technology Capital Planning and Investment Control process and the PMA initiatives. These HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability. The HHS Department initiatives also position the Department to have a consolidated approach, ready to join in PMA initiatives.

Of the amount specified above, **$223,877** is allocated to support the President's Management Agenda Expanding E-Government initiatives for FY 2009. This amount supports the PMA E-Government initiatives of as follows:

PMA e-Gov Initiative	FY 2009 Allocation
Business Gateway	$5,600
E-Authentication	$0
E-Rulemaking	$0
E-Travel	$0
Grants.Gov	$15,814
Integrated Acquisition	$0
Geospatial LOB	$0
Federal Health Architecture LoB	$111,422
Human Resources LoB	$32,015
Grants Management LoB	$1,656
Financial Management LoB	$3,691
Budget Formulation & Execution LoB	$2,455
IT Infrastructure LoB	$0
Integrated Acquisition – Loans and Grants	$19,359
Disaster Assistance Improvement Plan	$31,866
TOTAL	**$223,877**

Prospective benefits from these initiatives are:

Business Gateway: Provides cross-agency access to government information including: forms; compliance assistance resources; and, tools, in a single access point. The site offers businesses various capabilities including: "issues based" search and organized

agency links to answer business questions; links to help resources regarding which regulations businesses need to comply with and how to comply; online single access to government forms; and, streamlined submission processes that reduce the regulatory paperwork burdens. HHS' participation in this initiative provides HHS with an effective communication means to provide its regulations, policies, and forms applicable to the business community in a business-facing, single access point.

Grants.gov: Allows HHS to publish grant funding opportunities and application packages online while allowing the grant community (state, local and tribal governments, education and research organizations, non-profit organization, public housing agencies and individuals) to search for opportunities, download application forms, complete applications locally, and electronically submit applications using common forms, processes and systems. In FY 2007, HHS posted over 1,000 packages and received 108,436 application submissions – more than doubling 52,088 received in FY 2007 with NIH substantially increasing its applications submissions from 47,254 to 89,439 submissions.

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.

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital. HHS has been selected as a Center of Excellence and will be leveraging its HR investments to provide services to other Federal agencies.

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. An HHS agency, Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally, NIH is an internally HHS-designated Center of Excellence and has applied to be a GMLOB consortia lead. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business –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.

Integrated Acquisition Environment for Loans and Grants: Managed by GSA, all agencies participating in the posting and/or awarding of Loans and Grants are required by the Federal Funding Accountability and Transparency Act (FFATA) to disclose award information on a publicly accessible website. Cross-government cooperation with the Office of Management and Budget's Integrated Acquisition Environment initiative in determining unique identifiers for Loans & Grants transactions furthers the agency in complying with the Transparency Act, which enhances transparency of federal program performance information, funding, and Loans & Grants solicitation.

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. The DAIP program office, during its first year of operation, will quantify and report on the benefits and cost savings or cost reductions for each member agency.

Department of Health & Human Services
Indian Health Service
Number of Service Units and Facilities
Operated by IHS and Tribes, October 1, 2006

Type of Facility	TOTAL	IHS	TRIBAL			
		Total	Total	Title I [a]	Title V [b]	Other [c]
Service Units [d]	**163**	57	106			
Hospitals [d]	**46**	31	15	1	14	0
Ambulatory [d]	**633**	83	550	205	336	9
Health Centers	304	50	254	122	132	0
School Health Centers	20	2	18	15	3	0
Health Stations	143	31	112	60	52	0
Alaska Village Clinics	166	0	166	8	149	9

[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

[d] Classified "IHS" if any Federally owned and operated facility present in Service Unit. Classified "Tribal" if a funding agreement exists (Title I, Title V, Other, or any combination of these) to fund the facility's operations and it is principally controlled by a Tribal government or designated entity through operation and ownership.

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2006 Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**37,138**	**21,143**	**58,281**
Aberdeen	5,093		5,093
Alaska		11,394	11,394
Albuquerque	2,111		2,111
Bemidji	538		538
Billings	2,516		2,516
California			*
Nashville		1,296	1,296
Navajo	13,583	3,147	16,730
Oklahoma	5,942	4,750	10,692
Phoenix	6,606	556	7,162
Portland			*
Tucson	749		749

* No impatient facilities in FY 2006

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	**4,597,480**	**5,576,089**	**10,173,569**
Aberdeen	711,394	88,337	799,731
Alaska	**	1,494,122	1,494,122
Albuquerque	431,217	81,883	513,100
Bemidji	238,931	605,386	844,317
Billings	496,381	114,582	610,963
California	**	504,225	504,225
Nashville	5,500	361,245	366,745
Navajo	1,017,484	228,186	1,245,670
Oklahoma	700,096	1,303,544	2,003,640
Phoenix	661,893	292,482	954,375
Portland	238,820	450,520	689,340
Tucson	95,764	51,577	147,341

** No IHS facilities in FY 2006

INDIAN HEALTH SERVICE
Immunization Expenditures 1/

	FY 2007 Estimate	FY 2008 Estimate	FY 2009 Estimate	Increase or Decrease
Infants and Children	$11,582,447	$12,068,910	$12,575,804	+$506,894
Adults	$1,603,729	1,671,086	1,741,272	+70,186
HPV vaccine (Non-add)		8,857,800 2/	8,857,800 2/	+8,857,800
Total:	$13,186,176	$13,739,996	$14,317,076	+$577,080

1/The immunization estimates do not include the Hepatitis B and Haemophilus Immunization program (Alaska) budget line item
2/HPV expenditure estimates is a newly licensed vaccine that does not include medical inflation

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 two target populations; infants and children (3 to 27 months of age) and adults (≥65 years of age).

By combining these two groups, an estimate of $10,540,043 was calculated for the IHS immunization expenditures in FY 2004 with inflation costs added into the equation:

FY 2005 Estimated Costs = FY 2004 cost times 3.7 percent
FY 2006 Estimated Costs = FY 2005 cost times 3.3 percent
FY 2007 Estimated Costs = FY 2006 cost times 4.0 percent
FY 2008 Estimated Costs = FY 2007 cost times 4.2 percent
FY 2009 Estimated Costs = FY 2008 cost times 4.2 percent

For FY 2008, **$8,587,800** was added for the newly licensed adult vaccine for Human Papilloma Virus (HPV) for females 19 – 26 years costs. The total cost does not include inflation, which may affect future estimated costs. The methodology was calculated based on the following assumptions:

1. 20 percent coverage of the 19 – 26 year old female user population (~23,855)
2. Cost of a 3 dose series of the vaccine at $360.00

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

1. Individuals outside these target groups are regular recipients of immunizations (e.g., HBg 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 are no performance measures available for the cost of monitoring (e.g., immunization registries)
3. 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 2009

	Budget Authority (in Millions)		
	2007 Final	**2008 Enacted**	**2009 Request**
Drug Resources by Function			
Prevention	15.061	$22.368	$15.388
Treatment	138.066	$155.776	$146.600
Total Drug Resources by Function	**153.127**	**178.144**	**161.988**
Drug Resources by Decision Unit			
Alcohol and Substance Abuse	148.226	$173.243	$161.988
Urban Indian Health Program	$4.901	$4.901	$0.000
Total Drug Resources by Decision Unit	**153.127**	**$178.144**	**$161.988**

Drug Resources Personnel Summary			
Total FTEs (direct only)	162	195	196
Drug Resources as a Percent of Budget			
Agency Budget	$ 4,103.333	$ 4,282.169	$ 4,260.852
Drug Resources Percentage	3.73%	4.16%	3.80%

Indian Health Service
Indian Self Determination

Indian Health Service Philosophy -- The Indian Health Service (IHS) has implemented the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, as amended, in the spirit by which the Congress recognized the special legal relationship and the obligation of the United States to American Indian and Alaska Native peoples. In keeping with the concept of tribal sovereignty, the ISDEAA, as amended, builds upon IHS policy that maximizes opportunities for tribes to exercise their right to manage and operate IHS health programs, or portions thereof, under Title I and Title V, as well as those tribes who choose their health services to be provided directly by the IHS. The IHS recognized that tribal decisions to contract/compact or not to contract/compact are equal expressions of self-determination.

Title I Contracts and Title V Self-Governance Compacts -- The IHS contracts/compacts with tribes and tribal organizations (T/TO) pursuant to the authority provided under Title I and Title V of the ISDEAA, as amended. This Act allows T/TO to enter into contracts/compacts with the Government to plan, conduct, and administer programs that are authorized under Section 102 of the Act. The IHS has been contracting with T/TO pursuant to the authority of P.L. 93-638 since its passage in 1975. Today, the IHS currently administers self-determination contracts under Title I and compacts authorized under Title V valued at more than $1.8 billion. The IHS currently administers contracts and Annual Funding Agreements (AFA) with 236 tribes or tribal organizations pursuant to Title I of the ISDEAA. Title V provides authorization to sign self-governance compacts for a specific number of tribes who meet certain criteria. One Hundred Seventeen compacts and 138 funding agreements have been negotiated to date with 322 tribes.

IHS and Tribally-Operated Service Unit and Medical Facilities -- The total dollars administered under ISDEAA contracts and compacts have nearly doubled in recent years and the scope of services managed and provided by tribal programs has also expanded greatly. Tribes have historically assumed control of community services first and then expanded into medical care. For example, the Community Health Representatives program and community-based components of the alcohol programs have been almost 100 percent tribally operated. Tribally operated hospitals have now started to rise, and over 20 percent of the hospitals funded by IHS are managed by tribes. This trend is expanding their scope and is also reflected in the increasing number of ambulatory medical facilities now managed by tribes.

Self-Determination Implementation: Contract Support Cost Funding -- Because the rate of T/TO entering into self-determination contracts and compacts has been steadily increasing, the demand for contract support cost (CSC) funding to support T/TO in their contracting/compacting has also increased. The CSC funding is authorized pursuant to Section 106(a)(2) of the ISDEAA. This funding has been used by T/TO to develop strong, stable tribal governments that have in turn enabled them to professionally manage

their contracts/compacts and the corresponding services to their communities. Additionally, through the funding of CSC, the IHS has helped in the development of T/TO who are maturing and now achieving greater levels of self-sufficiency in all areas.

The primary growth in CSC since 2003 can be attributed to the need to maintain the current level of services. Additional increased needs for CSC is attributed to the increased contracting and compacting by T/TO under both Title I and V of the ISDEAA. The Agency has taken steps to ensure that funding provided is allowable, allocable, reasonable, and necessary and has recently adopted standards for the review and approval of CSC. This has proven beneficial in maintaining consistency in the determination of tribal CSC requirements. The T/TO are continuing to support an appropriate share of administrative streamlining. The IHS has provided administrative shares of its budget to T/TO associated with their contracting and compacting activities since 1995.

Indian Health Service
Self Governance Funded Compacts FY 2007

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Alabama	**$3,178,000**	**$248,000**	**$127,000**	**$638,000**	**$4,191,000**
Poarch Band of Creek Indians	$3,178,000	$248,000	$127,000	$638,000	$4,191,000
Alaska	**$352,867,000**	**$28,320,000**	**$21,267,000**	**$64,493,000**	**$466,947,000**
Alaska Native Tribal Health Consortium	$95,025,000	$17,737,000	$3,502,000	$5,229,000	$121,493,000
Aleutian/Pribilof Islands Association, Inc.	$2,830,000	$674,000	$259,000	$523,000	$4,286,000
Arctic Slope Native Association	$7,391,000	$63,000	$932,000	$2,366,000	$10,752,000
Bristol Bay Area Health Corporation	$19,834,000	$859,000	$1,646,000	$5,454,000	$27,793,000
Chugachmiut	$3,679,000	$93,000	$209,000	$1,131,000	$5,112,000
Copper River Native Association	$1,878,000	$33,000	$159,000	$487,000	$2,557,000
Council of Athabascan Tribal Government	$1,727,000	$11,000	$61,000	$838,000	$2,637,000
Eastern Aleutian Tribes, Inc.	$2,894,000	$23,000	$140,000	$772,000	$3,829,000
Kenalitze Indian Tribe	$1,510,000	$9,000	$40,000	$411,000	$1,970,000
Ketchikan Indian Corporation	$4,670,000	$133,000	$752,000	$1,620,000	$7,175,000
Kodiak Area Native Association	$5,805,000	$90,000	$331,000	$1,135,000	$7,361,000
Maniilaq Association	$24,932,000	$953,000	$2,087,000	$7,639,000	$35,611,000
Metlakatla Indian Community	$5,528,000	$880,000	$373,000	$599,000	$7,380,000
Mount Sanford Tribal Consortium	$697,000	$1,000	$47,000	$174,000	$919,000
Native Village of Eklutna	$159,000	$2,000	$4,000	$19,000	$184,000
Norton Sound Health Corporation	$18,463,000	$757,000	$1,472,000	$4,026,000	$24,718,000
Seldovia Village Tribe	$840,000	$35,000	$29,000	$268,000	$1,172,000
Southcentral Foundation	$53,349,000	$1,833,000	$2,868,000	$11,339,000	$69,389,000
Southeast Alaska Regional Health Corporation	$33,632,000	$1,454,000	$2,371,000	$5,684,000	$43,141,000
Tanana Chiefs Conference	$27,194,000	$670,000	$1,300,000	$3,407,000	$32,571,000
Yakutat Tlingit Tribe	$288,000	$8,000	$23,000	$72,000	$391,000
Yukon-Kuskokwim Health Corporation	$40,542,000	$2,002,000	$2,662,000	$11,300,000	$56,506,000
Arizona	**$20,688,000**	**$3,245,000**	**$1,254,000**	**$3,044,000**	**$28,231,000**
Gila River Indian Community	$20,688,000	$3,245,000	$1,254,000	$3,044,000	$28,231,000
California	**$40,068,000**	**$1,727,000**	**$1,802,000**	**$10,670,000**	**$54,267,000**
Consolidated Tribal Health Project, Inc.	$3,124,000	$182,000	$81,000	$885,000	$4,272,000
Hoopa Valley Tribe	$4,239,000	$237,000	$192,000	$944,000	$5,612,000
Indian Health Council, Inc.	$6,669,000	$379,000	$217,000	$1,556,000	$8,821,000
Karuk Tribe of California	$2,322,000	$210,000	$70,000	$1,025,000	$3,627,000
Northern Valley Indian Health, Inc.	$1,866,000	$172,000	$53,000	$538,000	$2,629,000
Redding Rancheria	$5,220,000	$105,000	$432,000	$1,629,000	$7,386,000
Riverside-San Bernardino County Indian Health, I	$15,495,000	$345,000	$654,000	$3,787,000	$20,281,000
Susanville Indian Rancheria	$1,133,000	$97,000	$103,000	$306,000	$1,639,000
Connecticut	**$1,963,000**	**$13,000**	**$0**	**$31,000**	**$2,007,000**
Mohegan Tribe of Indians of Connecticut	$1,963,000	$13,000	$0	$31,000	$2,007,000
Florida	**$6,393,000**	**$355,000**	**$214,000**	**$1,069,000**	**$8,031,000**
Seminole Tribe of Florida	$6,393,000	$355,000	$214,000	$1,069,000	$8,031,000
Kansas	**$1,956,000**	**$14,000**	**$5,000**	**$235,000**	**$2,210,000**
Prairie Band of Potawatomi Nation	$1,956,000	$14,000	$5,000	$235,000	$2,210,000
Idaho	**$12,136,000**	**$818,000**	**$877,000**	**$1,647,000**	**$15,478,000**
Coeur D'Alene Tribe	$4,671,000	$251,000	$508,000	$889,000	$6,319,000
Kootenai Tribe of Idaho	$512,000	$24,000	$54,000	$59,000	$649,000
Nez Perce Tribe	$6,953,000	$543,000	$315,000	$699,000	$8,510,000
Louisana	**$982,000**	**$136,000**	**$83,000**	**$121,000**	**$1,322,000**
Chitimacha Tribe of Louisana	$982,000	$136,000	$83,000	$121,000	$1,322,000
Maine	**$2,932,000**	**$227,000**	**$128,000**	**$526,000**	**$3,813,000**
Penobscot Indian Nation	$2,932,000	$227,000	$128,000	$526,000	$3,813,000
Massachusetts	**$589,000**	**$42,000**	**$163,000**	**$220,000**	**$1,014,000**
Wampanoag Tribe of Gay Head	$589,000	$42,000	$163,000	$220,000	$1,014,000
Michigan	**$15,776,000**	**$1,174,000**	**$716,000**	**$1,700,000**	**$19,366,000**
Grand Traverse Band of Ottawa and Chippewa Inc	$2,355,000	$283,000	$50,000	$422,000	$3,110,000
Keweenaw Bay Indian Community	$2,529,000	$216,000	$92,000	$385,000	$3,222,000
Sault Ste. Marie Tribe of Chippewa Indians	$10,892,000	$675,000	$574,000	$893,000	$13,034,000
Minnesota	**$13,190,000**	**$1,184,000**	**$404,000**	**$1,036,000**	**$15,814,000**
Bois Forte Band of Chippewa Indians	$2,106,000	$222,000	$59,000	$302,000	$2,689,000
Fond du Lac Band of Lake Superior Chippewa	$6,953,000	$473,000	$276,000	$435,000	$8,137,000
Mille Lacs Band of Ojibwe	$3,242,000	$448,000	$56,000	$227,000	$3,973,000
Shakopee Mdewakanton Sioux Community	$889,000	$41,000	$13,000	$72,000	$1,015,000
Mississippi	**$13,967,000**	**$963,000**	**$945,000**	**$1,784,000**	**$17,659,000**
Mississippi Band of Choctaw Indians	$13,967,000	$963,000	$945,000	$1,784,000	$17,659,000
Montana	**$16,112,000**	**$1,335,000**	**$1,460,000**	**$3,405,000**	**$22,312,000**
Chippewa Cree Tribe of the Rocky Boy's Reservat	$8,245,000	$688,000	$875,000	$1,799,000	$11,607,000
Confederated Salish and Kootenai Tribes of Flathe	$7,867,000	$647,000	$585,000	$1,606,000	$10,705,000

Nevada	**$16,285,000**	**$1,024,000**	**$1,140,000**	**$3,008,000**	**$21,457,000**
Duck Valley Shoshone-Paiute Tribe	$6,010,000	$606,000	$585,000	$1,398,000	$8,599,000
Duckwater Shoshone Tribe	$933,000	$81,000	$149,000	$561,000	$1,724,000
Ely Shoshone Tribe	$1,079,000	$33,000	$47,000	$263,000	$1,422,000
Las Vegas Paiute Tribe	$2,532,000	$96,000	$101,000	$254,000	$2,983,000
Washoe Tribe of Nevada and California	$4,094,000	$141,000	$181,000	$261,000	$4,677,000
Yerington Paiute Tribe of Nevada	$1,637,000	$67,000	$77,000	$271,000	$2,052,000
New York	**$6,298,000**	**$289,000**	**$192,000**	**$471,000**	**$7,250,000**
St. Regis Mohawk Tribe	$6,298,000	$289,000	$192,000	$471,000	$7,250,000
North Carolina	**$17,312,000**	**$1,497,000**	**$826,000**	**$3,006,000**	**$22,641,000**
Eastern Band of Cherokee Indians	$17,312,000	$1,497,000	$826,000	$3,006,000	$22,641,000
Oklahoma	**$198,026,000**	**$11,091,000**	**$8,273,000**	**$23,618,000**	**$241,008,000**
Absentee Shawnee Tribe of Oklahoma	$5,119,000	$132,000	$611,000	$556,000	$6,418,000
Cherokee Nation	$45,335,000	$1,634,000	$1,246,000	$4,525,000	$52,740,000
Chickasaw Nation	$37,338,000	$2,214,000	$1,671,000	$6,110,000	$47,333,000
Choctaw Nation of Oklahoma	$48,579,000	$4,580,000	$2,526,000	$5,208,000	$60,893,000
Citizen Potawatomi Nation	$7,538,000	$396,000	$610,000	$1,385,000	$9,929,000
Kaw Nation	$977,000	$69,000	$152,000	$194,000	$1,392,000
Kickapoo Tribe of Oklahoma	$4,517,000	$72,000	$113,000	$858,000	$5,560,000
Modoc Tribe of Oklahoma	$47,000	$0	$4,000	$35,000	$86,000
Muscogee (Creek) Nation	$33,484,000	$1,717,000	$979,000	$2,928,000	$39,108,000
Northeastern Tribal Health System	$5,997,000	$66,000	$112,000	$756,000	$6,931,000
Ponca Tribe of Oklahoma	$2,887,000	$75,000	$122,000	$392,000	$3,476,000
Sac and Fox Nation	$4,845,000	$84,000	$98,000	$420,000	$5,447,000
Wyandotte Nation	$1,363,000	$52,000	$29,000	$251,000	$1,695,000
Oregon	**$19,090,000**	**$922,000**	**$1,832,000**	**$6,093,000**	**$27,937,000**
Coquille Indian Tribe	$1,608,000	$65,000	$175,000	$708,000	$2,556,000
Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians of Oregon	$1,434,000	$60,000	$167,000	$374,000	$2,035,000
Confederated Tribes of Grand Ronde	$4,702,000	$229,000	$398,000	$2,384,000	$7,713,000
Confederated Tribes of Siletz Indians of Oregon	$6,098,000	$162,000	$549,000	$1,254,000	$8,063,000
Confederated Tribes of the Umatilla Reservation	$5,248,000	$406,000	$543,000	$1,373,000	$7,570,000
Washington	**$36,763,000**	**$2,634,000**	**$2,077,000**	**$8,855,000**	**$50,329,000**
Jamestown S'Klallam Indian Tribe	$796,000	$41,000	$66,000	$267,000	$1,170,000
Kalispel Tribe of Indians	$765,000	$73,000	$18,000	$60,000	$916,000
Lower Elwha Klallam Tribe	$1,500,000	$103,000	$74,000	$293,000	$1,970,000
Lummi Indian Nation	$6,279,000	$553,000	$189,000	$1,407,000	$8,428,000
Makah Indian Tribe	$3,162,000	$261,000	$265,000	$221,000	$3,909,000
Muckleshoot Indian Tribe	$3,551,000	$161,000	$152,000	$0	$3,864,000
Nisqually Indian Tribe	$1,703,000	$80,000	$89,000	$495,000	$2,367,000
Port Gamble S'Klallam Tribe	$1,677,000	$147,000	$105,000	$457,000	$2,386,000
Quinault Indian Nation	$4,349,000	$338,000	$166,000	$1,724,000	$6,577,000
Shoalwater Bay Indian Tribe	$1,601,000	$64,000	$214,000	$638,000	$2,517,000
Skokomish Indian Tribe	$1,672,000	$70,000	$88,000	$350,000	$2,180,000
Squaxin Island Indian Tribe	$2,274,000	$221,000	$150,000	$905,000	$3,550,000
Suquamish Tribe	$1,271,000	$57,000	$114,000	$496,000	$1,938,000
Swinomish Indian Tribal Community	$2,080,000	$126,000	$134,000	$651,000	$2,991,000
Tulalip Tribes of Washington	$4,083,000	$339,000	$253,000	$891,000	$5,566,000
Wisconsin	**$10,903,000**	**$927,000**	**$263,000**	**$721,000**	**$12,814,000**
Forest County Potawatomi Community	$1,316,000	$145,000	$17,000	$73,000	$1,551,000
Oneida Tribe of Indians of Wisconsin	$9,587,000	$782,000	$246,000	$648,000	$11,263,000
Grand Total	**$807,474,000**	**$58,185,000**	**$44,048,000**	**$136,391,000**	**$1,046,098,000**

Indian Health Service
FY 2007 Self-Governance Funding Agreements
by Area

Area	Tribal User Population	Program Tribal Shares	Area Tribal Shares	Headqtrs Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	TOTAL
Alaska	$117,492	$357,127,000	$12,310,000	$11,750,000	$21,267,000	$64,493,000	**$466,947,000**
Aberdeen	0	152,000	128,000	0	0	0	**280,000**
Bemidji	25,387	36,331,000	4,797,000	1,745,000	1,382,000	3,458,000	**47,713,000**
Billings	15,096	14,768,000	1,818,000	861,000	1,460,000	3,405,000	**22,312,000**
California	25,839	37,001,000	2,895,000	1,899,000	1,802,000	10,670,000	**54,267,000**
Nashville	27,658	49,877,000	5,490,000	2,017,000	2,678,000	7,866,000	**67,928,000**
Oklahoma	237,023	192,956,000	8,513,000	9,619,000	8,279,000	23,852,000	**243,219,000**
Phoenix	21,120	38,235,000	1,555,000	1,453,000	2,394,000	6,051,000	**49,688,000**
Portland	39,676	63,957,000	5,087,000	3,318,000	4,786,000	16,596,000	**93,744,000**
Total, IHS	**$509,291**	**$790,404,000**	**$42,593,000**	**$32,662,000**	**$44,048,000**	**$136,391,000**	**$1,046,098,000**

Indian Health Service
Self-Governance
Fund Status Report --- FY 2007 Expenditure

30-Sep-07

	Date	Vendor / Description	Obligation	Adjustment	Balance
1	10/1/05	Beginning Balance			$5,667,374
2	10/1/06	Congressional Increases/Decreases		95,626	5,763,000
3	10/1/06	Federal Pay Costs	0	20,403	5,783,403
4	1/1/07	Less Recission Iraq Bill		(20,000)	5,763,403
5	Recurring OTSG Office expenses, salary, travel, etc.		1,169,922		4,593,481
6	10/1/05	Salish&Kootenai FA Neg 1995 User Pop	13,221		4,580,260
7	3/23/06	Choctaw 1995 Base Budget	21,058		4,559,202
8	10/3/06	Jamestown S'Klallam 1997 HQ TSA adj.	1,584		4,557,618
9	10/1/06	Mississipp Choctaw 1997 HQ TSA adj.	7,688		4,549,930
10	10/1/06	Penobscot 1997 HQ TSA adj	12,680		4,537,250
11	10/1/06	Kalispel TSA 2nd yr	9,613		4,527,637
12	11/29/06	PAO reimb Mike Wood TDY to OTSG	3,404		4,524,233
13	1/4/07	BEM reimb Linda Bedeau Trvl Tech wkgp	1,767		4,522,466
14	1/11/07	CAO reimb D. Heffington TDY to OTSG	13,909		4,508,557
15	1/26/07	TSGAC (Lummi) trvl/logistics/meetings	95,000		4,413,557
16	1/26/07	SGCE cont. agmt Lummi Tribe passthru	150,000		4,263,557
17	12/21/05	GPRA Pilot Proj ANTHC	249,000		4,014,557
18	12/21/05	GPRA Pilot Proj USET	249,000		3,765,557
19	12/21/05	GPRA Pilot Proj Rocky Boy	42,000		3,723,557
20	12/21/05	GPRA Pilot Proj Kaw	42,000		3,681,557
21	12/21/05	GPRA Pilot Proj Mississippi Choctaw	42,000		3,639,557
22	1/31/07	Planning Award Grand Portage Bem	50,000		3,589,557
23	1/31/07	Planning Award Pueble Santo Domingo Alb	50,000		3,539,557
24	1/26/07	PAO - Jamestown Tech wkgp logistics	70,000		3,469,557
25	3/6/07	Annual Report to Congress ANTHC-AK	125,000		3,344,557
26	4/5/07	PKW PCS transfer/pay cost	170,000		3,174,557
27	4/20/07	OIT Project with OTSG	71,000		3,103,557
28	4/1/07	Transfer Inflation funds to Office budget	15,482		3,088,075
29	4/23/07	Forest County Pilot Project	72,000		3,016,075
30	6/1/07	Ambulances	500,000		2,516,075
31	7/1/07	BAO CHS Tech Asst FH & RB	160,000		2,356,075
32	8/1/07	OIT Master Contract (UFMS)	1,200,000		1,156,075
33	8/1/07	HR Contract OTSG portion	24,951		1,131,124
34	8/1/07	Transfer to Office Budget deficeit	50,000		1,081,124
35	8/4/07	Transfer to CAN # J940902 deficeit	45,000		1,036,124
36	8/4/07	Trvl of 3 OGC Attorneys	1,513		1,034,611
37	8/4/07	Transfer to Blgs for Severance Cost/RIF	43,000		991,611
38	21-Sep	Transfer to Office Budget deficeit	100,000		891,611
39	9/21/07	Transfer to HQ for assessment costs - this includes charges for/used by SG tribes.	891,611		0
		Total spent to date:	5,763,403		

SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2009 CONGRESSIONAL JUSTIFICATION
HOUSE REPORT 110-187

Item
Credentialing System -- The Committee remains interested in encouraging more volunteer health care providers to serve Indian country. Last year the Committee requested that the Service report on the feasibility of establishing a central credentialing system to facilitate increased use of volunteers. The Committee understands that the Service completed the report but it has not been released by the Department of Health and Human Services. The Committee expects to receive the report no later than October 31, 2007. (Initially, this language was included in House Appropriations Committee Report 109-465, page 169)

Action taken or to be taken

The requested report was submitted to Congress in June 2007. In order to ensure the highest possible quality of health care delivery, IHS policy requires that all its facilities be accredited in accordance with national standards; this includes complete primary source credentialing of all physicians, dentists, and other licensed independent practitioners, whether they be direct hires, contractors, or volunteers. National credentialing standards do not allow "credentialing volunteers to work at multiple sites and over multiple years without having to be re-credentialed" as the Subcommittee envisioned. The IHS has explored ways of streamlining the process currently utilized, evaluated the centralized credentialing efforts of the Department of Defense and the Veterans Health Administration, and addressed the feasibility of establishing a more centralized credentialing system. The benefit of a centralized credentials database to medical staff and volunteers appears small compared to the cost to establish and maintain the IHS on either system. Rather than pursuing a system-wide centralized credentialing program at this time, the IHS will improve upon regional coordination efforts that are underway and has developed an Agency-wide uniform, online medical staff application form which will be released shortly.

Item
Vacancy Rates of Health Care Providers -- The Committee continues to be concerned about the high vacancy rates of health care providers at IHS and tribal facilities. The Service should determine whether loan repayment is the most effective means of retaining health care professionals and evaluate what funding level for loan repayment would maximize the number of professionals retained by IHS. The Service should report on the results of this effort by January 30, 2008 (page 147).

Action taken or to be taken

The Indian Health Service (IHS) loan repayment program is designed to pay off educational loans (Loan Repayment Program) in exchange for service as a health care

provider to American Indian and Alaska Native communities. In the past, the loan repayment program database has not been designed to track providers throughout their service period (and beyond their service period). Individuals with a service commitment must report their employment status to IHS to receive credit toward their service obligation. However, after a loan repayment recipient completes his or her service commitment, they are under no obligation to continue to report their employment. This makes it difficult to develop retention data. The computer database for the LRP is being implemented in the first quarter of FY 2008 and has been redesigned and will allow for tracking of loan re-payers and will provide retention data. A preliminary survey will be available by the end of February 2008 and a detailed report on retention will be completed by the end of FY 2008. The vast majority of IHS scholarship and loan repayment recipients do complete their service obligation and many continue to work in American Indian and Alaska Native (AI/AN) communities after their service commitment is completed.

Item

Indian Health Care Improvement Fund -- The Committee directs the Service to allocate the increased funding for the Indian Health Care Improvement fund to bring those units with the highest level of need up to at least 40 percent of need before allocating any additional funds to units with needs above 40 percent (page 146).

Action taken or to be taken

In FY 2008, IHS will follow resource allocation policy that calls for an allocation formula that targets those units with the highest levels of need. The formula allocates the largest portion of additional funds to units below 40 percent of need (highest level of need) with a small portion of funds allocated to units between 40 percent and 60 percent of need (high levels of need).

The 2008 additional funds are not sufficient to raise all units to at least 40 percent. The agency's existing allocation policy essentially conforms to the directive in House Report 110-187, although strict implementation of the final clause "before allocating …" will not result in any funds allocated to units between 40 and 60 percent in 2008.

The process to update data used in the formula is underway and is scheduled to be completed by March 2008. Formula allocations are scheduled for April 1, 2008.

Item

Methamphetamine -- Within the increase provided for the prevention and treatment of methamphetamine use, at least $5,000,000 should be used for the mental health and behavioral issues associated with methamphetamine use, including programs that combat youth suicide. The Committee has included language at the front of this report delineating its position on methamphetamine use and the use of the increased funding (page 146).

Action taken or to be taken

In FY 2008, Alcohol & Substance Abuse received a program increase of $13,781,600 for the methamphetamine and suicide prevention and treatment initiatives. No funding is requested in FY 2009. Activities funded in FY 2008 include:

- $6,600,000 will be used to fund a grant program to establish or enhance methamphetamine prevention and treatment programs for I/T/Us;
- $2,400,000 will be used to fund a grant program to establish or enhance suicide prevention programs for I/T/Us;
- $1,200,000 will be used to fund the existing Residential Treatment Centers' methamphetamine and suicide initiatives;
- $1,800,000 will be used to enhance the Telebehavioral Health program;
- $1,800,000 will be used to establish suicide prevention grants or awards to Tribes or Tribal Organizations and IHS Service Units based on evidence-based practices.

Program accomplishments and performance outcomes will be detailed in the FY 2010 Congressional Justification.

Item

Electronic Health Record Initiative -- The Committee commends the Service for its electronic health records initiative, but is concerned that this effort does not include dental records. The Committee encourages the Service to include dental records in future efforts (page 146).

Action taken or to be taken

The Indian Health Service electronic health record initiative expands upon the Resource and Patient Management System (RPMS) and includes access by all categories of health care providers to all information necessary to the delivery of effective health services. The RPMS Dental Data System will be replaced by a fully functional Electronic Dental Record (EDR) under the initiative. The IHS Division of Oral Health is leading the acquisition of a commercial EDR product and anticipates initial implementation during FY 2008.

Item

Facility Equipment, Construction, Joint Venture -- The Committee encourages the Service to provide additional credit to tribes that are willing to provide full funding for facility equipment in addition to providing full funding for facility construction when determining priorities for project funding under the joint ventures program (page 147).

Action taken or to be taken

The above language was also included in the FY 2007 Appropriation language and the solicitation for Joint Venture projects indicated that additional credit would be given in the scoring of applicants that committed to also fund equipment. Tribes awarded three of the four projects selected in the last two years will fund all of the equipment costs on their Joint Venture project.