Portland Area 2020 Budget Formulation

Supporting Documents

- GPRA dashboard for Portland Area (July 2016 – June 2017) – 1 page

- 2016 IHS Health Statistics Fact Sheets – 2 pages

- Indian Health Care Improvement Reauthorization and Extension Act (IHCIA), April 2014 – 21 pages

10/26/2017

2017 Final Dashboard - Portland Area	2017 Target	2016 Final	Num.	Dem.	2017* Actual	# Needed to met
Good Glycemic Control <8	48.4%	49.5%	2853	5776	49.4%	MET
Controlled BP <140/90	63.8%	70.9%	4123	5776	71.4%	MET
Statin Therapy	61.9%	61.4%	2560	4015	63.8%	MET
Nephropathy Assessed	63.3%	67.6%	3651	5776	63.2%	6
Retinopathy Assessed	63.1%	55.2%	3220	5767	55.8%	419
Dental Access General	29.7%	33.6%	23648	67890	34.8%	MET
Sealants	16.6%	16.7%	2933	15938	18.4%	MET
Topical Fluoride	29.9%	34.6%	6310	16879	37.4%	MET
Influenza 6 mos-17 yrs	37.1%	36.8%	4855	13610	35.7%	195
Influenza 18+	38.7%	39.4%	12742	33404	38.1%	186
Pneumococcal 65+	86.7%	83.4%	3539	4244	83.4%	141
Active IMM 4313*314	74.8%	0.0%	456	750	60.8%	105
Pap Smear Rates 24-64	56.1%	50.7%	5895	12163	48.5%	929
Mammogram Rates 52-64	56.7%	49.6%	1745	3800	45.9%	410
Colorectal Cancer 50-75	40.2%	42.1%	4778	11451	41.7%	MET
Tobacco Cess Counsel/Quit	53.2%	48.6%	7307	15312	47.7%	839
Alcohol Screen 12-75	Baseline	61.9%	24268	38102	63.7%	N/A
SBIRT 9-75	Baseline	0.9%	47	3124	1.5%	N/A
IPV/DV Screen 14-46	65.3%	58.4%	7645	12506	61.1%	522
Depression Screen 12-17	Baseline	32.9%	2235	5098	43.8%	N/A
Depression Screen 18+	70%	63.2%	21088	33404	63.1%	2295
Antidepressant Med Mgmt - APT	Baseline	36.8%	324	771	42.0%	N/A
Antidepressant Med Mgmt - CONPT	Baseline	16.6%	135	771	17.5%	N/A
Childhood Weight Control	22.8%	27.3%	491	1693	29.0%	-105
Controlling High BP-MH	59.7%	60.4%	4509	7487	60.2%	MET
CVD Statin Therapy	Baseline	45.8%	3587	7601	47.2%	N/A
HIV Screening Ever	41.9%	37.1%	19354	47631	40.6%	604
Breastfeeding Rates	36.4%	44.3%	52	99	52.5%	MET

INDIAN HEALTH SERVICE

IHS Health Statistics Fact Sheet

Fiscal Year 2016 **April 2016**

The Indian Health Service produces statistical information and publications that measure and document the progress in assuring access to health care services and improving the health status of the American Indian and Alaska Native populations served. The IHS publications are developed by the Office of Public Health Support, Division of Program Statistics and available at: https://www.ihs.gov/dps/index.cfm/publications/

This document is a very brief overview of the types of IHS data available with references and definitions/sources of key health indicators. IHS reports several health indicators (i.e. life expectancy, suicide rates, etc.) in the annual Congressional Justification. This document also highlights important considerations in reporting health data.

Important Considerations

Privacy

- When reviewing Area level data, the first consideration is privacy. In using a statistic where an individual could be identified, violation of the privacy rule may occur.

Appropriateness

- Another important consideration is appropriateness. It is remarkably easy to use statistics, but it is rather difficult to use them in a way that you can defend against higher level scrutiny.
- There are people in every Area who know and understand health measures. These people should be consulted as part of developing your budget.

IHS Data

- If available, the IHS data should be used before all other sources. IHS has a method of correcting for misclassification by race on death certificates (adjustment or adjusted rate) as well as age adjustment (correction for age distribution in a population to allow for comparisons between populations for indicators such as a mortality rate).

IHS Area Health Statistics Resources

Life Expectancy, American Indian and Alaska Natives, Data Year: 2007-2009 Report

The life expectancy at birth is often thought to be a birth related measure because embedded in life expectancy are measures of mortality by age. The above publication reports life expectancy measures for IHS by Area.

IHS Inpatient and Outpatient Memoranda

Another form of workload reporting is the inpatient and outpatient memoranda. In this, you can see a single year snapshot of the important numbers by facility for that fiscal year. These are produced for the prior year in January (outpatient) and April (inpatient). These include counts of births as well.

Regional Differences in Indian Health 2012

The 2012 edition of Regional Differences in Indian Health describes IHS programs and provides tables and charts detailing the health status of AI/AN people. This is a useful publication with Area level information with comprehensive description for all IHS Areas by Area. It is anticipated another Regional Differences publication will be issued early calendar year 2017.

Tracking Regional Indian Health Status Objectives 2011

In this report, the mortality rates across years can be meaningfully compared.

Indian Health Performance Evaluation System (IHPES)

IHPES data marts can be viewed in their entirety at the above link. Many have Area specific information. These can be accessed through Area level program staff who have access; generally, this is a different person than the Area Statistical Officer.

Definitions

Population

Service Population - Eligible AI/ANs who live in the IHS service area

User Population - The number of Indian registrants, residing within a service delivery area with at least one face-to-face, direct or contract, inpatient stay, ambulatory care visit, or dental visit during the prior three fiscal years. User population is generally smaller than service population.

Socioeconomic factors – Factors such as educational attainment, poverty level and others can play a role in health status.

Workload – The amount of professional contact between a patient and a health care provider in a reimbursable setting (workload reportable). Generally, this is done face to face within a health care facility by a licensed, credentialed provider appropriate to the clinic where the patient is seen.

Area Resources

Area Privacy Officers

- Before displaying any community, facility, or service unit level data, or when using a full zip code, consult with your Area level privacy officer to see if such information can be included in a budget document which might be used publicly.
- Population data unattached to a disease condition or some other potentially unpleasant or embarrassing characteristic of an individual is generally safe to present privacy wise. Still, consult with your Area Privacy Officer if you have any question concerning this.

Area Statistical Officers

- For the structure of your Area (including facilities), please ask your Area Statistical Officer to provide the most recent information.
- For age specific user population rates, please contact your Area Statistical Officer who can obtain data from the National Data Warehouse.

Table 1. Important Data Indicators and IHS Source(s)

Data Indicator	Source(s)		
	Regional Differences in Indian Health 2012 (page references are for the print version)	National Data Warehouse	Other
IHS User Population	pgs. 3, 6		
IHS Service Population	p. 7		
Workload	p. 73[1]	Inpatient and outpatient report (1 ALOE report)	
Natality (Births)	p. 27, 71 (life expectancy at birth for 2005-2007)		Life Expectancy, American Indian and Alaska Natives, Data Year: 2007-2009 Report Life Expectancy at birth table
Mortality	p. 36, Part 4 for General Mortality Statistics		Tracking Regional Indian Health Status Objectives 2011 Comparisons begin on p. 16
Health Economics	p. 24, 26		

[1] Tables in Regional Differences include not only how much work is performed but what the leading causes of such work both in the inpatient and outpatient as well as direct and contract settings.

Other Resources

Cost of living index: https://en.wikipedia.org/wiki/United_States_Consumer_Price_Index

Cost of living index data can be purchased at https://www.coli.org/store.asp. IHS does not report cost of living data in any publication.

Here is how to calculate the percent change:

http://www.calculatorsoup.com/calculators/algebra/percent-change-calculator.php

Using the calculator above, have V1 be the current year Area service population figure (as of this writing, it was 2015 because the user population was available for that year), and let V2 be the budget year (i.e. 2019) service population for your Area. Take this percent change and multiply it by the Area level user population number.

The Indian Health Care Improvement Reauthorization and Extension Act
S. 1790 as Reported and included in H.R. 3590
Implementation Progress – April, 2014

SECTION	SUMMARY	PROGRESS UPDATE
Sec. 101. Reauthorization. { 25 U.S.C. § 1680o }	The Indian Health Care Improvement Act is now permanent and does not require periodic reauthorizations. The authority does not have a sunset timeline, but may be amended from time to time.	• Authorization to appropriate funds for Indian health is operative.
Sec. 102. Findings. Describes trust responsibility to provide health care to AI/ANs. { 25 U.S.C. §§ 1601, 1602 }	States a major national goal to provide the resources, processes, and structure to eradicate health disparities between American Indians and Alaska Natives and the general population.	• Statute reports findings
Sec. 103, Declarations. Reaffirms policy is to assure the highest possible health status for AI/ANs, and emphasizes maximum Indian participation. { 25 U.S.C. § 1602 }	Declares a National Indian Health policy to ensure the highest possible health status for Indians and urban Indians, and to provide all resources necessary to effect that policy; to ensure maximum Indian participation in the direction of health care; increase the proportion of Indians in all health professions in each service area to at least the level of that of the general population; ensures the government to government relationship; and require meaningful and active consultation with Indian tribes/tribal organizations; and conferring with urban Indian organizations.	• The policy declaration is operative.
Sec. 104. Definitions { 25 U.S.C. § 1603 }	Expands some definitions in current law and includes definitions for new terms used in the Act.	• Definitions are operative.

SECTION	SUMMARY	PROGRESS UPDATE
Sec. 111. Community Health Aid Program. { 25 U.S.C. § 1616l }	Authorizes the Secretary to establish a national community health aid program as long as the Secretary does not reduce the amounts of funding providing for the Alaska Community Health Aid Program, and shall exclude dental health aid therapist services from services covered under program, except in those states that authorize such dental health aid therapists.	• Community Health Aide Programs (CHAP) in Alaska are operative. • New CHAP programs are authorized in other States, but sufficient funds have not been appropriated. A CHAP option was added to annual budget formulation for prioritization. • Tribes or tribal organizations, that contract or compact with IHS, may locally implement a new CHAP program within available resources. • A Kellogg Foundation review panel addressed three of four criteria specified in Section 111. • On January 29, 2014, a Dental Health Aide Therapist Update was posted on the IHS Director's Blog and at www.ihs.gov/doh/DHAT.pdf
Sec. 112. Health professional chronic shortage demonstration program { 25 U.S.C. § 1616p }	Authorizes the Secretary to fund demonstrations programs for Indian health programs to address chronic shortages of health professionals.	• IHS existing recruitment programs promote availability of interns, post-doctoral students, and residents in communities with shortages of health care professionals. • New demonstration programs to address chronic shortages of health care professionals, but sufficient funds have not been appropriated. An option for demonstration programs was added to annual budget formulation for prioritization.
Sec. 113. Exemption From Payment of Certain Fees { 25 U.S.C. § 1616q }	Extends exemption from payment of licensing fees to employees of tribal health programs and urban Indian organizations, an exemption available to Federal employees.	• The exemption from certain licensing fees is operative. • The DEA Deputy Assistant Administrator issued Federal Government Doctor (FEDDOC) Program Memo (DFN: 601-04) indicating that DEA will no longer charge Tribal providers for certain licensing fees referenced in this section.

SECTION	SUMMARY	PROGRESS UPDATE
Sec. 121. Indian Health Care Improvement Fund { 25 U.S.C. § 1621 }	Authorizes additional services to be paid by the "fund" and expands the types of information to be included in deficiency reports for the Fund and requires Tribal Consultation on allocation of these funds.	• Authorization to use appropriations for comprehensive clinical care services is operative. • A 12/30/2010 Dear Tribal Leader Letter initiated consultation on whether or not to change the IHCIF allocation formula. • After considering input, IHS decided to retain the existing allocation formula, adopt certain technical data improvements, and defer expanding the formula for newly authorized services. • Additional funds for the formula were not appropriated in FY 2013 and FY 2014. • Beginning in 2014, the Affordable Care Act expands opportunities for many AIANs to purchase health insurance at reduced cost and expands Medicaid coverage to persons with incomes up to 133% of the federal poverty level (not all states have adopted Medicaid expansion). Until reliable data measuring actual insurance coverage and Medicaid participation by AIANs is available, calculations of AIAN health care resource deficiency will be premature.
Sec. 122. Catastrophic Health Emergency Fund { 25 U.S.C. § 1621a }	Amends certain provisions in current law establishing CHEF and the thresholds for reimbursement of costs connected with catastrophic illness and regulations to implement the requirements of CHEF.	• CHEF provisions were explained in a 2/9/2011 Dear Tribal Leader Letter. • The IHS and Tribal workgroup on improving Contract Health Services (CHS) recommended setting the CHEF threshold at $19,000 for the fiscal year of a regulation and index to medical inflation annually in subsequent years thereafter. • The IHS Director's Workgroup on Improving CHS (workgroup) designated a sub-group to make recommendations on improving CHEF. The sub-group's recommendations are pending review by the workgroup.
Sec. 123. Diabetes Prevention, Treatment and Control { 25 U.S.C. § 1621c }	Clarifies authorities/requirements for diabetes programs. Expands authority for dialysis to the extent funding is available. Maintains existing model diabetes projects and Area Office diabetes control officers.	• 19 Model Diabetes Projects existing on the date of enactment are preserved. • IHS clinical practice guidelines specify diabetes risk screening standards and prevention protocols. General informed consent is obtained during patient registration. • Dialysis programs are authorized, but sufficient funds have not been appropriated. A dialysis program option was added

SECTION	SUMMARY	PROGRESS UPDATE
		to annual budget formulation for prioritization. • Tribes or tribal organizations, that contract or compact with the IHS, may locally establish dialysis programs within available resources. • Diabetes control officer duties are carried out in each IHS Area. Tribal consultation is coordinated through the Tribal Leaders Diabetes Committee.
Sec. 124. Other authority for provision of services { 25 U.S.C. § 1621d }	Provides authority for new programs in Indian communities including authorization for hospice care, assisted living, long-term care and home-and community-based care, sharing of facilities.	• Long term care programs and assisted living services are authorized, but sufficient funds have not been appropriated. A long term care program option was added to annual budget formulation for prioritization. • Tribes or tribal organizations, that contract or compact with the IHS, may locally establish long term care and assisted living services within available resources. • A Dear Tribal Leader Letter on 1-6-2012 initiated consultation on recommendations developed at the national Indian Country Long Term Care conference. • IHS, CMS, and AOA continue to coordinate technical assistance for the provision of these services under an MOU signed on 9/23/2011.
Sec. 125. Reimbursement from Certain Third Parties of Costs of Health Services { 25 U.S.C. § 1621e }	Authorizes tribally operated facilities to recover the cost of care provided to beneficiaries injured by third parties, thus enabling them to provide more services to their communities/members.	• This provision was explained in a 7/22/2010 Dear Tribal Leader Letter and in the 8/26/2010 Dear Urban Indian Program Director letter. • On 11/19/2010, the IHS issued a "Prompt Payer Notice" to inform third party payers of the Tribal facilities right of recovery and features in statute designed to ensure full payment.
Sec. 126. Crediting of Reimbursements { 25 U.S.C. § 1621f }	Clarifies that the Service may not offset or limit funding to any Service Unit or entity because of the receipt of reimbursements. Identifies laws that authorize reimbursements for services provided by the Service, an Indian tribe or tribal organization, or Urban Indian organization.	• Directive crediting reimbursements to the collecting service units is operative. A Special General Memorandum clarified internal IHS procedures. • Crediting of reimbursements was explained in a 7/22/2010 Dear Tribal Leader Letter and in the 8/26/2010 Dear Urban Indian Program Director letter.

SECTION	SUMMARY	PROGRESS UPDATE
Sec. 127. Behavioral Health Training and Community Education Programs { 25 U.S.C. § 1621h(d) }	Clarifies current law on training and community education programs. Requires that IHS and DOI, with tribal consultation, identify a scope of positions for such training, and a plan to increase such staff by 500 positions.	• A new hiring plan was completed in June 2010, including plans for consultation. It was described in the 7/22/2010 Dear Tribal Leader Letter and updated in a 5/5/2011 Dear Tribal Leader Letter. • The IHS, BIA, and BIE have identified the scope of positions whose qualifications should include behavioral health skills, qualifications and training criteria. • Sufficient funds have not been appropriated to implement the hiring plan and comprehensive behavioral health training programs. An option for expanded behavioral health training was added to annual budget formulation for prioritization.
Sec. 128. Cancer Screenings { 25 U.S.C. § 1621k }	Expands the variety of authorized cancer screenings to other types of cancer screenings.	• Expanded cancer screening provisions are operative. • IHS clinical practice guidelines specify risk screening standards and protocols. • Collaboration with CDC to engage Tribes in CDC's grant programs on breast, cervical and colo-rectal cancer and tobacco screening programs is ongoing.
Sec. 129. Patient Travel Costs { 25 U.S.C. § 1621l }	Expands authorities for payment of certain patient travel costs that may be needed during transport for health care services.	• Authorization permitting expanded categories of patient travel is operative. Payment for additional travel costs is subject to availability of funds at each local program. • This provision was explained in a 7/22/2010 Dear Tribal Leader Letter. • Guidance clarifying expanded categories of allowable travel costs was issued.
Sec. 130. Epidemiology Centers { 25 U.S.C. § 1621m }	Confers to epidemiology centers the status of public health authorities for purposes of the Health Insurance Portability and Accountability Act of 1996.	• The provision deeming Epidemiology centers as public health authorities is operative. • Designation of tribal epidemiology centers as public health authorities was explained in a Dear Tribal Leader Letter (12/07/2010).
Sec. 131. Indian Youth Grant (see Sec.708) { 25 U.S.C. § 1621o }	Technical change to change section number.	• US Code reference was updated.

SECTION	SUMMARY	PROGRESS UPDATE
Sec. 132. American Indians Into Psychology Program { 25 U.S.C. § 1621p }	Increases the number of college and universities that will be awarded grants to administer the American Indians Into Psychology program and increases the grant amount to colleges to make the program accessible to more Indian students who wish to enter the behavioral health field.	• Authorization of new IHS grants to colleges and universities to promote psychology careers for Indians were explained in a Dear Tribal Leader Letter (12/07/2010). • The three current American Indians in Psychology Program grants will conclude in August 2014. Information about the FY 2014 grant cycle, including available funding and number of grants to be awarded, will be released through a Federal Register Notice in May 2014. • Additional grants are authorized, but sufficient funding has not been appropriated. An option for additional grants was added to annual budget formulation for prioritization.
Sec. 133. Prevention, Control, and Elimination of Communicable and Infectious Diseases { 25 U.S.C. § 1621q }	Expands current authority by (1) expanding the communicable diseases from tuberculosis to other communicable and infectious diseases; (2) encouraging coordination with the Centers for Disease Control and state and local health agencies; and (3) a biennial report on the progress made towards the prevention, control, and elimination of communicable/infectious diseases made among Indians and urban Indians.	• A Dear Tribal Leader Letter (12/07/2010) explained provisions for grants and demonstration projects. • IHS works with CDC in engaging Tribes in CDC's grant programs for communicable and infectious disease prevention. • New grants and demonstration projects are authorized, but sufficient funds have not been appropriated. An option for new demonstration projects was added to annual budget formulation for prioritization.
Sec. 134. Methods to increase clinician recruitment and retention { 25 U.S.C. § 1621t }	Stipulates health care professionals employed by tribally operated health programs will be eligible for state licensure exemptions that are similar to exemptions available to Federal employees. Expands authority to provide allowances for professional development or establish programs to Indians to join or continue in an Indian health program and to provide services in rural /remote areas.	• State licensing exemptions for health care professionals employed by tribally operated programs for services provided as defined in statute are operative. • These provisions were explained in a 12/7/2010 Dear Tribal Leader Letter. • New education allowances and stipends for professional development are authorized, but sufficient funds have not been appropriated. An option for new allowances and stipends was added to annual budget formulation for prioritization.
Sec. 135. Liability for Payment { 25 U.S.C. § 1621u }	Stipulates contract health providers do not have recourse against patients where the claim has been authorized by the Service.	• Protections for patients from unauthorized claims are operative. • These provisions were explained in a 7/22/2010 Dear Tribal Leader Letter. • A standard notification letter is available for Contract Health Service programs to distribute to contract health care providers.

SECTION	SUMMARY	PROGRESS UPDATE
Sec. 136. Office of Indian Men's and Indian Women's Health { 25 U.S.C. § 1621v }	Authorizes establishment of an office to focus on Indian men's health and maintains current law on the office of Indian women's health.	• Functions of an Office Indian Men's Health and Office of Indian Women's Health are carried out through the Office of Clinical and Preventive Health until sufficient appropriations are available to expand IHS' organizational structure. An option for new Offices was added to annual budget formulation for prioritization. • Men's Health report is in clearance.
Sec. 137. Contract Health Service Administration & Disbursement formula { 25 U.S.C. § 1621y }	Directs the Comptroller General to report on, (1) barriers to accessing care, (2) funding of the contract health service program (CHS), including historic funding levels and to recommend a needed funding level, (3) administration of the CHS program, including the distribution of funds to the CHS programs, and; (4) payments by CHS for health care provided by providers other than Indian health providers.	• The GAO published four reports: (1) GAO-11-767, "IHS Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need" • Implementation of GAO-11-767 recommendations is complete. (2) GAO-12-466, "Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Services Program." • One recommendation significantly departs from long standing policy and requires consultation. The Workgroup reviewed these other recommendations and decided not to make any changes at this time. • Implementation of the accepted GAO 12-466 recommendations is complete. (3) GAO-13-272, "Capping Payment Rates for Nonhospital Services Could Save Millions For Contract Health Services" • The Workgroup reviewed the GAO report and recommended the IHS seek to cap payment rates for physician and nonhospital services. •The Acting IHS Director wrote to Tribal Leaders to request input on rates charged for physician and other health care professional services purchased by Indian health programs and medical charges associated with non-provider-based care, on December 6, 2013. •Tribal leader input recommended IHS to pursue capping payment rates for physician and nonhospital services. (4) GAO-14-57, "Opportunities May Exist To Improve The Contract Health Services Program"

SECTION	SUMMARY	PROGRESS UPDATE
		•One GAO recommendation significantly departed from longstanding IHS policy and IHS did not concur. •Actions to implement the remaining GAO recommendations are underway.
Sec. 141. Health Care Facility Priority System { 25 U.S.C. § 1631(c) }	Amends current law by directing the Secretary to maintain a facilities priority system and sets certain requirements for the priority system. Amends requirements for a new report describing the comprehensive, national, ranked list of all health care facilities.	• The provision to maintain a health care facility priority system is operative. • This provision was explained in a 5/5/2011 Dear Tribal Leader Letter. • A report on facility needs, submitted to Congress on 3/23/2011, was developed from information available and previous Tribal consultation input. • The Facilities Appropriation Advisory Board (FAAB) has been reconstituted to advise the IHS Director with meetings in March and April of 2014.
Sec. 142. Priority of Certain Projects Protected { 25 U.S.C. § 1631(g) }	Stipulates the priority status of projects on the facilities construction priority list on the date of enactment (March 23, 2010) is not affected by any changes made to the priority system thereafter.	• The provision is operative. Priority of projects already on the construction priority list is preserved.
Sec. 143. Indian Health Care Delivery Demonstration Projects { 25 U.S.C. § 1637 }	Authorizes the Secretary to carry out or enter into contracts or compacts with Tribes and Tribal Organizations pursuant to ISDEAA to test new models/means of health care delivery. Permits the use of other Federal funds, third party collections, and non-Federal funds to support these programs.	• Demonstration projects for Tribes and tribal organizations to test alternative health care models/means are authorized, but sufficient funds have not been appropriated. An option for new demonstration projects was added to annual budget formulation for prioritization. • Tribes or tribal organizations, that contract or compact with the IHS, may locally implement alternative health care models within available resources.
Sec. 144. Tribal Management of Federally Owned Quarters { 25 U.S.C. § 1638a }	Tribes and Tribal Organizations operating programs under ISDEAA are authorized to manage their own staff quarters including setting and collecting rents from occupants of staff quarters.	• The provisions permitting programs operated under ISDEAA contracts to set rents for staff quarters are carried out through ISDEAA funding agreements. • Four Tribes/Tribal Organizations have exercised the option in FY 2014.

SECTION	SUMMARY	PROGRESS UPDATE
Sec. 145. Other - Funding, Equipment and Supplies for Facilities { 25 U.S.C. § 1638e }	New authority to allow transfer, acceptance of funds, equipment, and supplies for facilities for planning, design, construction, or operation of health care or sanitation facilities. Receipt of funds under this section shall not affect any priority established under Sec. 301.	• Provisions permitting acceptance of funds and equipment are operative. • No regulations are required. These authorizations are carried out through FAR, sanitation facilities authorities and through ISDEAA construction contracts on a project by project basis. • Planning, design, construction and operation adhere to industry, Federal/HHS and local standards, codes, ordinances, policies and procedures.
Sec. 146. Indian Country Modular Component Facilities Demonstration Program { 25 U.S.C. § 1638f }	Expands authorities for construction of modular types of health care facilities.	• Potential modular component demonstration projects within existing resources are being evaluated. • An option for a demonstration program was added to annual budget formulation for prioritization. • The modular construction evaluation report is completed.
Sec. 147. Mobile Health Stations Demonstration Program { 25 U.S.C. § 1638g }	Authorizes a demonstration program to fund new ways to provide health care to Indian communities.	• Demonstration projects to purchase mobile health stations for certain specialty health care services are authorized, but sufficient funds have not been appropriated. An option for a demonstration program was added to annual budget formulation for prioritization. • Tribes or tribal organizations, that contract or compact with the IHS, may purchase mobile health stations within available resources.
Sec. 151. Treatment of payments under the Social Security Act health benefits programs: { 25 U.S.C. § 1641 }	Amends current law regarding collection of reimbursements from Medicare, Medicaid and the Children's Health Insurance Program (CHIP) by Indian health facilities, and revises the procedures which allow a tribally-operated program to directly collect such reimbursements for such services.	• This provision was explained in a 7/22/2010 Dear Tribal Leader. •IHS requests Tribes provide identification numbers under contract and compact agreements on an on-going basis, as needed.
Sec. 152. Purchasing health care coverage: beneficiaries. { 25 U.S.C. § 1642 }	Authorizes tribes, tribal organizations, and urban Indian organizations to purchase health insurance coverage for their beneficiaries.	• These authorities are operative. Tribes, tribal organizations, and urban Indian organizations that contract or compact with the IHS, may purchase health insurance coverage within available resources.

SECTION	SUMMARY	PROGRESS UPDATE
Sec. 153. Grants to and Contracts with the Service, tribes, etc. to Facilitate Outreach, Enrollment, and Coverage of Indians under SSA and other Benefits Programs { 25 U.S.C. § 1644 }	New authority to issue grants or contracts to tribes, tribal organizations and urban Indian organizations to conduct outreach to enroll eligible Indians in Social Security Act health benefit programs.	• Grants or contracts for additional outreach and enrollment programs are authorized, but sufficient funds have not been appropriated. An option for new programs was added to annual budget formulation for prioritization. • Tribal organizations and urban Indian organizations may conduct outreach and enrollment within available resources.
Sec. 154. Sharing arrangements with Federal Agencies. { 25 U.S.C. § 1645 }	Authorizes IHS to enter into arrangements with the Department of Veterans Affairs and Department of Defense to share medical facilities and services. The Service, Indian tribes or tribal organizations shall be reimbursed by the Department of Veterans Affairs or the Department of Defense where services are provided through the Service/tribe, or a tribal organization to beneficiaries eligible for services from either VA/DOD, notwithstanding any other provision of law.	• A 3-5-2012 Dear Tribal Leader Letter initiated consultation on a draft agreement between the VA and IHS regarding reimbursable services provided by IHS and tribal health facilities to eligible AIAN veterans. The National Reimbursement Agreement was signed on 12- 5-2012. IHS and Tribes have collected over $5 million since this process started. • Implementation of these provisions is in progress. All 81 Federal sites have implementation plans in place and are billing or have the capacity to bill at all sites. A total of 77 sites have received payment from the VA with the remaining four not billing due to lack AI/AN veterans requiring treatment at the sites. Over 40 Tribal sites have plans in place and have started the billing process.
Sec. 155. Eligible Indian Veteran's Services { 25 U.S.C. § 1647 }	Directs the Secretary to provide veteran-related expenses incurred by eligible Indian veterans at a facility of the Service pursuant to a local memorandum of understanding with the Department of Veterans Affairs.	• Implementation of these provisions is in progress. • The 12/7/2010 Dear Tribal Leader Letter described a plan for these agencies to jointly consult with Tribes on the MOU, which was completed and a number of Tribes provided feedback on the Agreement. A joint IHS/VA workgroup continues to work on implementation.
Sec. 156. Nondiscrimination under Federal Health Care Programs In Qualifications For Reimbursement For Services { 25 U.S.C. § 1647a }	Provides that IHS, tribal and urban Indian organization programs shall be eligible for participation in any Federal health care program to the same extent as any other provider, if the Indian program meets the generally applicable State or other requirements for participation.	• Participation provisions in this section are operative. This provision was explained in a 7/22/2010 Dear Tribal Leader Letter.

SECTION	SUMMARY	PROGRESS UPDATE
Sec. 157. Access to Federal Insurance { 25 U.S.C. § 1647b }	Authorizes a tribe or tribal organization carrying out a program under the Indian Self-Determination and Education Assistance Act and an urban Indian organization carrying out a program under Title V of IHCIA to purchase coverage for its employees from the FEHB Program.	• The Office of Personnel Management oversees FEHB. OPM and IHS issued a joint "Dear Tribal Leader" letter on October 5, 2010 to gather information. OPM issued another "Dear Tribal Leader" on April 29, 2011 to initiate implementation consultation. • Tribal employers were able to enroll employees starting on March 22, 2012 with an effective coverage date of May 1, 2012. Some Tribal employers are exercising this authority. For more information go to http://www.opm.gov/tribalprograms
Sec. 158. General Exceptions { 25 U.S.C. § 1647c }	Provides that special purpose insurance products (such as those that provide compensation to a victim of a disease) are not subject to IHCIA Title IV provisions.	• Provisions in this section are operative
Sec. 159. Navajo Nation Medicaid Agency Feasibility Study { 25 U.S.C. § 1647d }	The Secretary is required to submit a report (on the results of the feasibility study) on treatment of the Navajo Nation as a State for the purposes of Title XIX of the Social Security Act.	• Implementation in progress • The Centers for Medicaid and Medicare Services has conducted a feasibility study. • The draft study is in clearance.
Sec. 161. Facilities Renovation { 25 U.S.C. § 1659 }	Title V, urban Indian organizations are authorized to receive funding from IHS for minor renovations and to construct or expand urban Indian health facilities.	This provision was explained in the 8/26/2010 Dear urban Indian program director letter. • Construction or expansion of urban facilities is authorized, but sufficient funds have not been appropriated. An option for expanded urban facilities was added to annual budget formulation for prioritization.

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Sec. 162. Treatment of Certain Demonstration Projects { 25 U.S.C. § 1660b }	Makes permanent the Tulsa Clinic and the Oklahoma City Clinic demonstrations. They shall continue to meet the requirements of an urban Indian organization and shall not be subject to the provisions of ISDEAA. These programs will be treated as IHS service units.	• The provision converting 2 demonstrations to permanent status is operative. • This provision was explained in a 7/22/2010 Dear Tribal Leader Letter and in the 8/26/2010 Dear urban Indian program director letter. • Addition consultation in 2011 focused on clarifying Area level procedures for Oklahoma City and Tulsa programs. In FY 11, the Oklahoma City Area Director convened an I/T/U workgroup to identify issues related to this section and provide recommendations. The workgroup's recommendations were supported in an area tribal consultation session. The primary recommendations were: 1) a methodology to incorporate the programs into the area funding distributions, and 2) a recommendation to seek authorization to extend FTCA to the programs.
Sec. 163. Requirement to Confer with Urban Indian Organizations { 25 U.S.C. § 1660d }	Defines how the Secretary will engage urban Indian organizations in discussions on matters/issues related to the Title V, urban Indian health programs.	• Implementation is in progress. • An 8/26/2010 Dear urban Indian program director letter explained this provision and IHS plans. • A special email (urbanconfer@ihs.gov) was established January 2013. • The confer policy for urban Indian organizations is in clearance. 32 comments were received in response to a Federal Register notice on conferring with urban Indian organizations. A listening session was held 1/22/2013 for final input and comment.
Sec. 164. Expand Program Authority for Sec. Urban Indian Organizations { 25 U.S.C. § 1660e }	Expands authorities to urban organizations to receive grants for additional health related activities.	• The 8/26/2010 dear urban Indian program director letter describes this provision. • New grants to urban Indian organizations are authorized, but sufficient funds have not been appropriated. An option for expanded programs was added to annual budget formulation for prioritization.

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Sec. 165. Community Health Representatives { 25 U.S.C. § 1660f }	Authorizes the establishment of a Community Health Representative (CHR) program for urban Indian organizations to train and employ Indians to provide health care services.	• The 8/26/2010 Dear urban Indian program director letter describes this provision. • CHR like programs in urban areas are authorized, but sufficient funds have not been appropriated. An option for urban CHR like programs was added to annual budget formulation for prioritization. • IHS is adapting the CHR curriculum for UIHPs for on-line training.
Sec. 166. Use of Federal Government Facilities and Sources of Supply; Health Information Technology. { 25 U.S.C. § 1660g }	Authorizes access to real and personal property under the jurisdiction of the Secretary of HHS to meet the needs of urban Indian organizations.	• The 8/26/2010 Dear urban Indian program director letter describes these provisions. • Protocols to transfer facility and real property were developed. However, "transfer" costs such as site survey and appraisals require additional funding. • The IHS currently provides limited funding for information technology improvements thru urban Indian health 4-in-1 grants. • New grants to develop, adopt, and implement health information technology in urban Indian health programs are authorized, but sufficient funds have not been appropriated. An option for new grants was added to annual budget formulation for prioritization.
Sec. 171. Establishment of the Indian Health Service as an Agency of the Public Health Service { 25 U.S.C. § 1661 }	Expands the duties of the IHS Director by authorizing the Director to facilitate advocacy for the development of appropriate Indian health policy and to promote consultation on matters related to Indian health.	• Provisions explicitly defining duties of the IHS Director are operative. • These provisions were explained in a 7/22/2010 Dear Tribal Leader Letter and in the 8/26/2010 Dear urban Indian program director letter.
Sec. 172. Office of Direct Service Tribes { 25 U.S.C. § 1663 }	Establishes office to support direct service tribes.	• This provision is operative. The IHS established the Office of Direct Service and Contracting Tribes within the Office of the Director prior to enactment of this provision.
Sec. 173. Nevada Area Office { 25 U.S.C. § 1663a }	Directs Secretary to submit a plan to Congress on establishment of a Nevada Area Office.	• These provisions were explained in a 5/5/2011 Dear Tribal Leader Letter. • The required plan detailing how a Nevada Area IHS Area Office could be established was submitted to Congress on 3/23/2011. This option was added to annual budget formulation for prioritization.

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Sec. 191. Confidentiality of Medical Quality Records; Qualified Immunity for Participants. { 25 U.S.C. § 1675 }	Provides protection from discovery of medical quality records. Allows for peer reviews to be conducted within Indian health programs without compromising confidentiality of medical records.	• This provision is under development and review; an update is expected by the end of CY 2014.
Sec. 192. Arizona, North Dakota and South Dakota as Contract Health Service Delivery Areas; eligibility of California Indians { 25 U.S.C. §§ 1678, 1678a, 1679 }	Establishes a single contract health services delivery area consisting of the states of North Dakota and South Dakota for the purposes of providing contract health care services to members of Indian tribes located in those states	• Implementation requires consultation. This provision would expand CHS eligibility in certain states if services to existing CHS patients are not diminished. • Establishment of new contract health service delivery areas is authorized, but sufficient funds have not been appropriated. An option was added to annual budget formulation for prioritization. • The CHS Workgroup reviewed Section 192 but decided not to make any recommendation at this time.
Sec. 193. Methods to Increase Access to Professionals of Certain Corps { 25 U.S.C. § 1680b }	Amends current law with technical updates.	• Implementation is in progress in collaboration with HRSA. • A total of 354 National Health Service Corps (NHSC) supported clinicians were serving in Indian communities in March 2014. NHSC Scholarship Program (SP) and Loan Repayment Program (LRP) recipients work at hundreds of Federal, IHS facilities, Tribal Health Clinics, Urban Indian Health Clinics, and Dual-Funded Tribal Health Clinics. A total of 637 Indian health sites are approved as NHSC service sites. In March 2014, Indian health programs advertised 104 vacant clinical positions on the NHSC Job Center.
Sec. 194. Health Services for Ineligible Persons { 25 U.S.C. § 1680c }	Provides that IHS-operated and tribally-operated programs may provide health care services to non-IHS eligible beneficiaries so long as there is no diminution in services to eligible Indians or the provisions of such services to non-IHS eligible beneficiaries does not result in denial of services to eligible Indians, and makes non-beneficiaries liable for payment for such services.	• Tribes and tribal organizations, that contract or compact with the IHS, may provide services to non-IHS beneficiaries if services to IHS beneficiaries are not diminished as a result.
Sec. 195. Annual Budget Submission { 25 U.S.C. § 1680p }	Amends current law by requiring that medical inflation and population growth be included as a part of the President's IHS budget submission to Congress beginning in fiscal year 2011.	• The President's budget submission customarily includes annual cost increases indexed to inflation and population growth. • This provision was explained in a 5/5/2011 Dear Tribal Leader Letter.

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Sec. 196. Prescription Drug Monitoring Program (PDMP) { 25 U.S.C. § 1680q }	Adds a new requirement, directing the Secretary, in coordination with the Secretary of the Interior and the Attorney General to establish a prescription drug monitoring program, to be carried out at health care facilities of the Service, tribal health care facilities and urban Indian health care facilities.	• IHS Prescription Drug Monitoring Program (PDMP) plan is underway with support by a SAMHSA grant. • Data monitoring and data export software are available as of 12-31-12 for federal sites and by 6-1-13 for Tribal sites that may participate. Connectivity is needed to make PDMP available on Electronic Health Record (EHR). Full project implementation with enhanced PDMP EHR functionality is projected for 2015. • A Memorandum of Understanding (MOU) has been accepted by most PDMP states and others (OK, CO, UT, WY) are pending. The MOU allows IHS to participate in a state's PDMP. Federal sites are all participating. Tribal site participation varies. • Testing, rollout, and active reporting are complete for Federal sites in AZ, NM, CA, NV, AK, OR, WA, ID, SD, ND, MN, KS, SC, NC, MT, MI, WI.
Sec. 197. Tribal Health Program Option for Cost Sharing { 25 U.S.C. § 1680r }	Nothing in this Act limits the ability of tribal health programs operated pursuant to Title V of the ISDEAA to charge an Indian for services provided by the tribal health program. Further, nothing in this Act authorizes the Service to charge an Indian for services or to require any tribal health program to charge an Indian for services.	• The provision permitting tribal programs to charge for services is operational. Guidance clarifying ISDEAA contract terms was issued. • The IHS may not charge nor require a tribal program to charge for services to an Indian.
Sec. 198. Disease and Injury Prevention Report { 25 U.S.C. § 1680s }	Requires a report describing all disease and injury prevention activities conducted by the Service, independently or in conjunction with other Federal departments and agencies and Indian tribes, and the effectiveness of such activities, including the reductions of injury or disease conditions achieved by such activities.	• Implementation is in progress. • A draft of the required disease and injury prevention report is in clearance.

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Sec. 199. Other GAO Reports { 25 U.S.C. § 1680t }	Directs the Comptroller General to conduct a study, and evaluate the effectiveness of coordination of health care services provided to Indians through Medicare, Medicaid, or CHIP, IHS, or using funds provided by State or local governments, or Indian tribes.	•Several GAO reviews have been conducted and many improvements have been made as a result of these reviews. • Many of the GAO recommendations have been completed and IHS is working on finalizing all of the GAO recommendations in FY 2014.
Sec. 199A. Liability for Traditional Health Care Practices { 25 U.S.C. § 1680u }	Authorizes the Secretary to use traditional health practices for the purposes of providing health care, health promotion, and disease prevention services, but the United States is not liable for any provision of traditional health care practices that results in death, injury, or death to the patient.	• Provisions permitting IHS to promote traditional health care practices without liability are operative.
Sec. 199B. Director of HIV/AIDS Prevention and Treatment { 25 U.S.C. § 1680v }	Directs the Secretary to establish the position of Director of HIV/AIDS Prevention and Treatment and includes specific authorities for the Service to address this serious health problem.	• Report to Congress is under review. • A vacancy announcement for the Director HIV/AIDS is in clearance.
Sec. 202. Reauthorization of Native Hawaiian Healthcare programs { }	Authorizes a straight reauthorization and extension of Native Hawaiian laws until 2019.	• Not applicable to IHS. Implementation by HRSA.
Sec. 701. Definitions { 25 U.S.C. § 1667a }	Provides definitions for terms used in this Title.	• Definitions are operative.
Sec. 702. Behavioral Health Prevention and Treatment Services Overview { 25 U.S.C. § 1665a }	Authorizes a comprehensive continuum of behavioral health care to include community-based care, detoxification, hospitalization, intensive out-patient treatment, residential treatment, transitional living, emergency shelter, case management, and diagnostic services. The Secretary, acting through the Service, shall coordinate behavioral health planning, to the extent feasible with other Federal agencies and with State agencies to encourage comprehensive behavioral health services for Indians regardless of their place of residence.	• These provisions were explained in a 5/5/2011 Dear Tribal Leader Letter. • The required inpatient mental health needs assessment was completed on March 17, 2011. • Existing behavioral health programs will continue. Providing an expanded continuum of behavioral health services is authorized, but sufficient funds have not been appropriated. An option for expanded programs was added to annual budget formulation for prioritization. • Tribes or tribal organizations, that contract or compact with the IHS, may implement the expanded services within available resources.
Sec. 703. Memoranda of Agreement with the	Requires IHS to enter into a memorandum of agreement (MOA) with the Secretary of the Interior to develop a	• This provision was explained in 3/8/2011 and 5/5/2011 Dear Tribal Leader Letters and also requested consultation and

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Department of Interior { 25 U.S.C. § 1665b }	comprehensive strategy for addressing Indian alcohol and substance abuse and mental health issues no later than 1 year after the date of enactment of this Act.	strategies to address alcohol abuse, substance abuse, and mental health issues among AIAN. • The required MOA with BIA signed 3/1/2011 is operative. • Implementation is in progress in coordination with DOI/BIA and BIE through monthly meetings.
Sec. 704. Comprehensive Behavioral Health Prevention and Treatment Program { 25 U.S.C. § 1665c }	Clarifies and extends authority for a program of comprehensive behavioral health, prevention, treatment, and aftercare for members of Indian tribes including prevention through education, acute detox, psychiatric hospitalization, residential and intensive outpatient treatment, community based rehabilitation, community education and training, specialized residential treatment, diagnostic services	• This provision was explained in 3/8/2011 and 5/5/2011 Dear Tribal Leader Letters. Existing behavioral health programs continue. • Expanded behavioral health prevention and treatment programs are authorized, but sufficient funds have not been appropriated. An option for expanded programs was added to annual budget formulation for prioritization. • Tribes or tribal organizations, that contract or compact with the IHS, may expand services within available resources. • The Tribal Law and Order Act Minimum Program Standards Workgroup continue to develop guidelines.
Sec. 705. Mental Health Technician Program: { 25 U.S.C. § 1665d }	Authorizing the establishment of a mental health technician program within IHS to train Indians as mental health technicians to provide community-based mental health care to include identification, prevention, education, referral, and treatment services. The Secretary shall provide high-standard paraprofessional training in mental health care and shall ensure that the program involves the use/promotion of traditional health care practices of Indian tribes to be served.	• Comprehensive program within IHS to train mental health paraprofessionals is authorized, but sufficient funds have not been appropriated. An option for training mental health paraprofessionals was added to annual budget formulation for prioritization.
Sec. 706. Licensing Requirement for Mental Health Care Workers { 25 U.S.C. § 1665e }	Prescribes mandatory licensing requirements for mental health workers and establishes protocols for oversight of mental health trainees.	• Licensing provisions for mental health professions are operative. IHS employment policies and manuals address requirements - psychologist, social work, and marriage and family therapist positions require license (in any state).
Sec. 707. Indian Women Treatment Programs { 25 U.S.C. § 1665f }	Authorizing IHS grants to Indian health programs to develop and implement comprehensive behavioral health programs that specifically address the cultural, historical, and social and child care needs of Indian women.	• IHS grants to Indian health programs to develop additional behavioral health programs for Indian women are authorized, but sufficient funds have not been appropriated. An option for new grants was added to annual budget formulation for prioritization.

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Sec. 708. Indian Youth Program { 25 U.S.C. § 1665g }	Clarifies and expands authorities/requirements for the Youth Regional Treatment Centers (YRTCs).	• Expanded detoxification including behavioral care and family involvement is authorized, but sufficient funds have not been appropriated. An option for detoxification programs was added to annual budget formulation for prioritization. • 10 Youth Regional Treatment Centers (YRTC) currently provide residential substance abuse and other behavioral health interventions to Indian youth. • IHS acquired property for both the Northern and Southern California YRTC facilities. The Southern California YRTC is fully funded for construction to be completed in 2015. Construction funding is requested in the FY 2015 President's Budget for the Northern California YRTC. Staff funds will also need to be appropriated through the budget formulation process.
Sec. 709. Inpatient and Community Mental Health Facilities Design, Construction, and Staffing { 25 U.S.C. § 1665h }	Authorizes the establishment, in each IHS area, of not less than one inpatient mental health care facility, or equivalent, to serve Indians with behavioral health problems.	• Construction and staffing for one inpatient mental health care facility per IHS Area is authorized, but sufficient funds have not been appropriated. An option for additional inpatient facilities was added to annual budget formulation for prioritization. • The 3-17-2011 inpatient mental health needs assessment included an assessment of conversion of existing hospital beds to psychiatric units.
Sec. 710: Training and Community Education { 25 U.S.C. § 1665i }	Directs the Secretary to work with the Interior Secretary to develop and implement or assist Indian tribes and organizations in establishing a community education program to educate political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, health providers, including traditional practitioners, and other critical members of each tribal community about behavioral health issues.	• Implementation in progress. • In 2011, IHS, BIA, BIE, and SAMHSA provided behavioral health training at two action summits. In 2012, IHS hosted a national behavioral health conference for Indian country. • Collaboration is ongoing among IHS, BIA, BIE, and SAMHSA on community education, e.g., multi-agency online newsletter on alcohol and drug abuse information and prevention tools. • Comprehensive assistance from IHS to Tribes and tribal organizations to establish cross-cutting programs is authorized, but sufficient funds have not been appropriated. An option for comprehensive assistance was added to annual budget formulation for prioritization. • IHS provides ongoing training opportunities through its Tele-Behavioral Health Center of Excellence and the Tribal Forensic

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		Healthcare Training project. Training is provided at no cost and offers continuing education credits for health care providers. Training topics include child maltreatment, alcohol and substance abuse, behavioral health topics, family relations, crisis intervention, and youth topics.
Sec. 711. Behavioral Health Program { 25 U.S.C. § 1665j }	Amends current law to expand a grant program for Indian health programs to establish innovative community-based behavioral health services to Indians. The grant program will be competitive.	• A new competitive grant program for innovative community-based behavioral health programs is authorized, but sufficient funds have not been appropriated. An option for a new grant program was added to annual budget formulation for prioritization.
Sec. 712. Fetal Alcohol Spectrum Disorders Programs { 25 U.S.C. § 1665k }	Expands authority in current law for a serious health problem in Indian communities.	• IHS clinical protocols specify risk identification and treatment of pregnant women for fetal alcohol spectrum disorders. One GPRA performance measure for IHS screens all women of child bearing age (15-44) for alcohol use. • A new comprehensive training program for FASD is authorized, but sufficient funds have not been appropriated. An option for a new training programs was added to annual budget formulation for prioritization. • Currently, the IHS Tele-behavioral Health Center for Excellence offers FASD training for providers.
Sec. 713. Child Sexual Abuse and Prevention Treatment Programs { 25 U.S.C. § 1665l }	Provides new authority for nation-wide prevention and treatment programs for victims of child sexual abuse, and their families.	• The Tribal Law and Order Act, Section 13, addresses multidisciplinary teams including health services for prevention and treatment of violence. • Child maltreatment policy and training protocols have been drafted and are under Agency review. • New regional demonstration projects and new treatment programs in every service area are authorized, but sufficient funds have not been appropriated. An option for new regional demonstration projects was added to annual budget formulation for prioritization.
Sec. 714. Domestic and Sexual Violence Prevention and Treatment { 25 U.S.C. § 1665m }	Authorizes the establishment of a culturally appropriate program, in each IHS area, to prevent and treat Indian victims of domestic and sexual abuse, and other members of the household or family of the victims of domestic violence or sexual violence.	• Existing programs for domestic and sexual violence in each IHS area are continuing. IHS currently funds 65 projects for domestic violence, sexual assault, and SANE/SAFE/SART activities. • In 2013 through February 2014, seven regional classroom trainings, four clinical skills workshops, and 20 webinars

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		resulted in over 400 trained providers in the area of domestic and sexual violence, including child maltreatment. • The national Sexual Assault Policy was adopted in March 2011 and was revised to include health clinics and stations. The revised policy is currently is in clearance. One, screening females ages 15-40 for domestic and intimate partner violence is an IHS GPRA performance measure. A national Intimate Partner Violence policy is in clearance. • Partnerships with the DOJ Office for Victims of Crime and FBI to improve coordination will continue for applicable provisions of the Tribal Law and Order Act.
Sec. 715. Behavioral Health Research { 25 U.S.C. § 1665n }	Authorizes IHS to make grants to Indian and non-Indian entities to perform research on Indian behavioral health issues, including the causes of Indian youth suicide.	• New grants to perform Indian behavioral health research are authorized, but sufficient funds have not been appropriated. An option for new grants was added to annual budget formulation for prioritization.
Sec. 721. Findings and Purpose { 25 U.S.C. § 1667 }	Sets out Congressional findings on the high prevalence of suicide among Indian youth and stipulates the purpose of the title is to address this critical situation. Authorize demonstration projects to use tele-mental health services in suicide prevention, intervention, and treatment of Indian youth.	• Statute reports findings aimed jointly at work of SAMHSA, CDC, NIH, and HRSA.
Sec. 722. Definitions { 25 U.S.C. § 1667a }	Includes new and applicable definitions, including tele-mental health.	• Definitions are operative.
Sec. 723. Indian Youth Tele-mental Health Demonstration Project { 25 U.S.C. § 1667b }	Adds new authority for a grant program for technologically innovative approaches to assess/prevent/treat youth suicide.	• New demonstration projects to develop innovative tele-mental health approaches to youth suicide and other problems are authorized, but sufficient funds have not been appropriated. An option for demonstration projects was added to annual budget formulation for prioritization. • The IHS Tele-Behavioral Health Center of Excellence provides technical assistance to IHS and tribal Youth Regional Treatment Centers to reach at risk youth. The TBHCE website is scheduled to launch through www.ihs.gov in the spring of 2014.

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Sec. 724. Substance Abuse and Mental Health Services Administration Grants { 25 U.S.C. § 1667c }	Directs the Secretary to carry out measures to facilitate the SAMHSA grant application process for tribes.	• Implementation in progress by SAMHSA.
Sec. 725. Use of Predoctoral Psychology and Psychiatry Interns { 25 U.S.C. § 1667d }	Directs the Secretary to encourage Indian tribes, tribal organizations and other mental health care providers serving Indian Country to utilize pre-doctoral psychology and psychiatry interns.	• Provision is operative. IHS encourages use of pre-doctoral psychology and psychiatry interns and promotes availability of interns, post-doctoral students, and residents, to enhance recruitment of mental health professionals in communities with shortages.
Sec. 726. Indian Youth Life Skills Development Demonstration Program { 25 U.S.C. § 1667e }	Authorizes a demonstration grant program through the Substance Abuse and Mental Health Services Administration to provide grants to tribes and tribal organizations to provide culturally compatible, school-based suicide prevention curriculum to strengthen AI/AN teen “life skills”.	• A new demonstration grant program is under review by SAMHSA, but funds have not been appropriated.