DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year 2014

Indian Health Service

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

MAR 12 2013

I am pleased to present the Indian Health Service (IHS) FY 2014 Congressional Justification. This budget request provides support for the President's and Secretary's priority initiatives and reflects the goals and objectives of the Department. The IHS budget represents extensive consultation with Tribes, and exemplifies the continued IHS and Tribal partnership on IHS priorities that are included in the FY 2014 budget request.

Performance measurement and reporting at IHS includes a comprehensive set of measures and outcomes in four major areas which provides results-oriented information that enables IHS to share progress with stakeholders towards achieving our four Agency priorities:

- To renew and strengthen our partnership with Tribes;
- To reform the IHS;
- To improve the quality of and access to care; and
- To make our work accountable, transparent, fair, and inclusive.

IHS's implementation of performance management improvements has created a consistent framework for linking IHS-wide goals with program priorities and for targeting resources to meet the needs of American Indians and Alaska Natives. The Agency's priorities provide a shared vision of what needs to be accomplished with our Tribal partners and provide a consistent and effective way to measure our achievements as we continue to change and improve the IHS.

Our FY 2014 budget request represents our efforts to sustain the Agency's valuable programs and maintain improvements made in performance measures in recent years. These efforts are essential to meeting the health care needs of American Indian and Alaska Native people.

/Yvette Roubideaux/

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2014 Performance Budget Submission to Congress

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

INDIAN HEALTH SERVICE

Approved: /Yvette Roubideaux/
Yvette Roubideaux

Date: 03/08/2013

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

DEPUTY DIRECTOR
Vacant

DEPUTY DIRECTOR FOR MANAGEMENT OPERATIONS
Robert G. McSwain

CHIEF MEDICAL OFFICER
Susan V. Karol

DEPUTY DIRECTOR FOR INTER-GOVERNMENTAL AFFAIRS
Sandra Pattea

DEPUTY DIRECTOR FOR FIELD OPERATIONS
Randy Grinnell

SENIOR ADVISOR TO THE DIRECTOR
Geoffrey Roth

(Positions are listed in order of succession to the IHS Director)

OFFICE OF TRIBAL SELF-GOVERNANCE
DIRECTOR
Benjamin Smith

OFFICE OF DIRECT SERVICE AND CONTRACTING TRIBES
DIRECTOR
Chris Buchanan

OFFICE OF URBAN INDIAN HEALTH PROGRAMS
DIRECTOR
Phyllis Wolfe

OFFICE OF CLINICAL AND PREVENTIVE SERVICES
DIRECTOR
Charlene Avery

OFFICE OF INFORMATION TECHNOLOGY
DIRECTOR
Howard Hays
(Acting)

OFFICE OF PUBLIC HEALTH SUPPORT
DIRECTOR
Richard Church

OFFICE OF RESOURCE ACCESS AND PARTNERSHIPS
DIRECTOR
Carl Harper

OFFICE OF FINANCE AND ACCOUNTING
DIRECTOR
Elizabeth Fowler

OFFICE OF MANAGEMENT SERVICES
DIRECTOR
Athena S. Elliott

OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING
DIRECTOR
Gary Hartz

ABERDEEN AREA OFFICE
DIRECTOR
Ron Cornelius
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ALASKA AREA OFFICE
DIRECTOR
Christopher Mandregan, Jr.

ALBUQUERQUE AREA OFFICE
DIRECTOR
Richie Grinnell

BEMIDJI AREA OFFICE
DIRECTOR
Jenny Jenkins
(Acting)

BILLINGS AREA OFFICE
DIRECTOR
Anna Whiting Sorrell

CALIFORNIA AREA OFFICE
DIRECTOR
Margo Kerrigan

NASHVILLE AREA OFFICE
DIRECTOR
Martha Ketcher

NAVAJO AREA OFFICE
DIRECTOR
John Hubbard, Jr.

OKLAHOMA CITY AREA OFFICE
DIRECTOR
Kevin Meeks

PHOENIX AREA OFFICE
DIRECTOR
Dorothy Dupree

PORTLAND AREA OFFICE
DIRECTOR
Dean Seyler

TUCSON AREA OFFICE
DIRECTOR
George Bearpaw
(Acting)

INTRODUCTION AND MISSION
Indian Health Service

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

The IHS provides comprehensive primary health care and disease prevention services to approximately 2.2 million American Indians and Alaska Natives through a network of over 620 hospitals, clinics, and health stations on or near Indian reservations. Facilities are predominantly located in rural primary care settings and are managed by IHS, Tribal, and Urban Indian health programs. The IHS provides a wide range of clinical, public health and community services primarily to members of 566 federally recognized Tribes. The IHS has approximately 15,600 employees, including 3,500 nurses, 900 physicians, 400 engineers, 600 pharmacists, 300 dentists, and 300 sanitarians.

United States Government and Indian Nations

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

Indian Health Service and Its Partnership with Tribes

In the 1970s, Federal Indian policy was re-evaluated leading to adoption of a policy of Indian self-determination. This policy promotes Tribal administration of Federal Indian programs, including health care. Self-Determination does not lessen any Federal obligation, but provides an opportunity for Tribes to assume the responsibility of providing health care for their members. IHS partners with Tribes on health care delivery in the context of regular Tribal consultation.

The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), as amended, and the Indian Health Care Improvement Act of 1976 (IHCIA), as amended, provided new opportunities for the IHS and Tribes to deliver quality and accessible health care. The recently enacted Patient Protection and Affordable Care Act builds upon these laws by: including provisions to modernize and update the IHS; expanding health insurance and Medicaid coverage; and reforming health care delivery systems. The Affordable Care Act will help the Indian Health Service further improve access to quality, affordable health care .

The IHCIA includes specific authorizations such as improvements for urban Indian health programs, Indian health professions programs, and the authority to collect from Medicare/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 facilities where Tribes have chosen not to contract or compact health programs.

INDIAN HEALTH SERVICE
Performance Budget Overview

Overview of Budget Request

Tribal Consultation - Tribal consultation is fundamental to the IHS budget process, and at its core are the priorities and recommendations developed by Tribes through an annual budget formulation process. The IHS budget request incorporates Tribal priorities and recommendations to the extent possible.

Summary of Request – The FY 2014 President's Budget request for IHS is $4.430 billion in budget authority and $5.662 in program level, a total increase of $243.6 million over the FY 2012 Enacted level. The request includes funds to support activities identified by the Tribes as budget priorities including increasing resources for pay costs, funding medical inflationary costs for the Purchased/Referred Care program (formerly known as Contract Health Services); funding contract support costs shortfall; and staffing for new/replacement facilities. Specifically, this request includes:

CURRENT SERVICES (+$118.3 million)

Pay Costs (+$6.0 million)
The budget request includes pay increases for Federal and Tribal employees.

Medical Inflation for Purchased/Referred Care (+$35.0 million)
Medical inflationary costs help maintain the current level of services and offset the rising cost in providing health care. The $35 million is the calculated need to address a 3.7 percent medical inflation rate for the Purchased/Referred Care program.

Additional Staffing and Operating Costs for New Healthcare Facilities (+$77.3 million)
This request will fund the staffing and operating costs for 10 newly constructed healthcare facilities scheduled to open in FY 2014, including 7 Joint Venture projects.

PROGRAM INCREASE (+$5.8 million)

Contract Support Costs (+$5.8 million)
The increase will be applied to the Contract Support Costs (CSC) shortfall associated with ongoing contracts and compacts with Tribes and Tribal organizations under the Indian Self-Determination and Educational Assistance Act.

REIMBURSEMENT INCREASE (+$119.5 million)
IHS anticipates receiving a significant increase in third-party health insurance payments including an increase of +$95 million as a result of the Medicaid eligibility expansion included in the Affordable Care Act.

Also, a new VA/IHS National Reimbursement Agreement, to be executed over the coming year, will provide an estimated increase of +$52 million when fully implemented and represents a positive partnership to support improved coordination of care between IHS and the VA. However, estimating the increase in IHS collections for FY 2014 is uncertain given the lack of information about the number of American Indians and Alaska Natives who will be eligible for VA benefits. This estimate will likely be revised as the agreement is fully implemented in the coming year. This Agreement also paves the way for future agreements negotiated between VA and tribal health programs.

Overview of Performance

Priority Setting - To help the IHS undertake its mission and strategic goals, four priorities were established by the IHS Director to guide the Agency's work and to address areas that key stakeholders are most interested in for improvement. The priorities were communicated widely to IHS employees at all organizational levels for feedback as well as to the Agency's delivery partners who responded with input and support for implementation. The priorities are: to renew and strengthen the Agency's partnership with tribes; to reform the IHS; to improve the quality of and access to care; and to make all the Agency's work transparent, accountable, fair and inclusive.

The IHS has managed agency performance since 2005 through an agency performance plan, updated annually, that cascades performance goals and objectives and performance-related metrics agency wide. To focus performance on agency priorities, IHS recently strengthened its performance management process. In FY 2010, the Agency performance plan was fully aligned to the Agency priorities and measures were cascaded from senior executive performance plans to managers to supervisors and into employee plans, so that the performance of all employees relates to their job duties in the context of the priorities. Along with the four priorities, a fifth critical program objective on improving customer service was added to the Agency performance plan in FY 2011. The four priorities will remain the same through FY 2014.

IHS Priorities, Broad Goals and Objectives, and the HHS Strategic Plan - Each agency priority and broad program performance objective aligns to and directly contributes to the Department's goals and priorities established in the HHS Strategic Plan for Fiscal Years 2010-2015 and the Secretary's top priorities and approved budget. Specifically, all four Agency priorities align to the HHS Strategic Plan Goal 1, Strengthen Health Care, and to several of the Goal's objectives. The IHS quality and access to care priority area also aligns to Goal 5, Strengthen the Nation's Health and Human Service Infrastructure and Workforce. The transparency and accountability priority area also aligns to Goal 4, Increase Efficiency, Transparency, and Accountability of HHS programs. Therefore, the IHS shares in the Secretary's future-oriented priority setting, definition of success, and action planning through its agency priorities and the Agency program performance plan. The IHS has two performance measures, tribal consultation and depression screening, in the HHS Strategic Plan.

Progress Reviews - Measuring progress, communicating progress and problems, and being open about the challenges to advancement are important to performance management. The IHS uses an internally-developed technological performance management tool, the Executive Performance Management System (EPMS), to review agency-wide progress in meeting the performance measures on each critical element and sub-elements within the Agency performance plan. The EPMS is a secure electronic reporting and tracking tool that includes capability for monitoring progress and for producing narrative, dashboard, and rollup reports. The system provides an input field for senior executives to enter quarterly progress narratives for documenting achievements and/or describing how challenges were addressed in meeting performance elements and sub-elements. In addition, the EPMS provides senior executives a status menu to designate progress on meeting the performance measures, which produces a dashboard report.

Internal Agency Review - Agency leadership periodically reviews progress in meeting the Agency performance plan measures and holds regular discussions with senior executives. Accountability for each performance plan element is clearly communicated at the start of the performance cycle and progress reviews are conducted at least biannually. Discussions about

progress on the Agency priorities are part of regular leadership meetings, such as the Headquarters monthly general staff meetings, the bi-monthly teleconference with IHS executives, Area Directors' meetings, and frequent senior staff meetings. Cascading performance plan elements to employees holds them accountable for performing their work duties, holds supervisors accountable for the quality of the work, and holds managers and executives responsible for performance results and for taking corrective actions. The connection between performance measures and employee accountability contributes to the Agency leadership decision making on how and when to adjust targets or to take corrective actions to address obstacles that could prevent achieving the desired results. In addition, the IHS Director provides monthly reports to the HHS Secretary, which includes progress on the agency priorities.

HHS FY 2013 Quarterly Performance Review – The FY 2013 HHS Priority Goals reviews include quarterly reporting and face-to-face quarterly review meetings to provide an opportunity for Goal Owners and Goal Partners and Contributors and HHS leaders to discuss performance around the HHS Priority Goals that link to the goals and objectives in the HHS Strategic Plan. The IHS is participating as a partner and contributor to two FY 2013 HHS Priority Goals. The IHS partners with six other HHS Operating Divisions and the Office of the Assistant Secretary for Health, that serves as the Goal Leader, on the HHS's Tobacco Cessation Goal - Reduce Cigarette Smoking: By December 31, 2013, reduce annual adult's cigarette consumption in the U.S. from 1,281 cigarettes per capita to 1,062 cigarettes per capita, a 17.1 percent decrease from the baseline.

Tobacco Cessation is an IHS-wide budget performance measure. In FY 2013 this measure was revised requiring a baseline target in FY 2013. The FY 2014 target will be determined after the FY 2013 results are collected. The IHS collects data through the IHS Clinical Reporting System (CRS) on this budget measure and others and holds regular teleconferences with the 12 IHS Area Government Performance and Results Act (GPRA) coordinators to discuss the status of this measure and to share best practices and ways to address challenges in achieving targets.

The IHS is also a contributor to another HHS Priority Goal: Health Information Technology (IT): Improve healthcare through meaningful use (MU) of health IT. The Office of the National Coordinator for Health Information Technology is the Goal Leader for the Health IT Goal and other HHS agencies act as partners or contributors. Key Outcome Indicators for this Goal relate to incentive payments from the Centers for Medicare and Medicaid Services (CMS). Internally, IHS contributes to electronic certification and meaningful use by maintaining certification and by working toward development for 2014 certification. The IHS is tracking the status of MU payments to eligible providers in Indian Country. Internally, IHS contributes to Electronic Health Record certification and Meaningful Use by maintaining certification and by working toward development for 2014 certification. The IHS is tracking the status of MU payments to eligible providers in Indian Country. As of February 2013, 1805 Eligible Providers from IHS, Tribal, and Urban Indian health programs have registered with CMS, and 1365 have attested to Meaningful Use. IHS facilities have received $6.4 million in incentive payments for these providers, and Tribal/Urban programs have received $10.1 million. Also as of February 2013, 20 IHS hospitals have received a total of $24 million from the Medicare and Medicaid incentive programs, and an additional six Tribal hospitals that use the IHS Resource and Patient Management System (RPMS) have received $10 million. The IHS Senior Staff meets face-to-face with the IHS Chief Information Officer monthly to review IHS' progress, and IHS Area Directors report monthly to the IHS senior staff on incentive payments received in the Areas.

The IHS has three internal key performance goals that link to the goals and objectives in the HHS Strategic Plan. Leadership focus on the three performance goals produced notable

accomplishments in FY 2012. The first performance goal is linked to the first IHS priority: To renew and improve the partnership with Tribes. The IHS has an annual performance goal to implement three recommendations, based on Tribal input, to improve the Tribal consultation process. At the end of FY 2012, the IHS has implemented a total of eleven recommendations from tribes to improve the tribal consultation process. Among these accomplishments IHS counts the annual Tribal Consultation Summits, first introduced in July 2011, where Tribes learned about current consultation activities in a "one stop shop" event. The IHS has been consulting with Tribes on numerous issues, including: improving the Tribal consultation process; improving the Purchased/Referred Care (formerly Contract Health Services) program; priorities for health reform and implementation of the Indian Health Care Improvement Act; the annual IHS budget request; implementation of the Memorandum of Understanding between the Department of Veterans Affairs (VA) and the IHS; the Indian Healthcare Improvement Fund (IHCIF) allocation; Tribal Epidemiology Centers data sharing agreement; updating the DOI/IHS memorandum of agreement on alcohol and substance abuse; and the IHS Sexual Assault Policy and Protocol. For example, significant work has been accomplished through a Tribal workgroup on improving the Purchased/Referred Care program that resulted in recommendations and sharing of best practices that will improve management of IHS operated Purchased/Referred Care programs and third-party collections. In addition to the consultations continuing into FY 2012, nine new consultations were initiated in FY 2012 on a myriad of issues, such as: the Federal Advisory Committee Act; the Contract Support Costs policy in effect since 2007; IHS/VA Reimbursement of Services for Eligible Veterans; the IHS Health Facilities Construction Process; implementing long-term care provisions arising from the IHCIA; Prescription Drug Abuse; Traditional Medicine; Purchased/Referred Care Prevention Services; and the draft Urban Confer Policy. These consultations will result in better decisions for the future of IHS and will help to improve patient care.

A second performance goal is related to recruitment and retention of health care providers. The IHS and the Health Resources and Services Administration (HRSA) worked collaboratively to pre-approve all Indian health system sites for participation in the National Health Service Corp (NHSC), a result that far exceeded the original 10 percent increase target, in FY 2011. Site eligibility places Indian health program facilities on the lists of pre-qualified facilities for NHSC placements sent to NHSC loan repayment and scholarship recipients. In FY 2011, the collaborative work resulted in approval of 490 IHS, Tribal, and urban Indian health programs for placement of the NHSC health care providers, and the number of placements increased to 221 providers. At the end of FY 2012, Indian health programs had 588 active sites (IHS federal, tribally-operated sites, and urban Indian health clinics plus dual-funded tribal health clinics). The NHSC programs (Loan Replacement and Scholarships) had placed 305 clinicians/providers. Progress is tracked on a monthly basis.

To improve hiring time, the IHS has made available Agency-wide, standardized position descriptions in different job series that the Agency recruits for and the IHS has improved the effectiveness of the on-line application process. The IHS reduced its average overall hiring time from 140 days to 81 days by the end of FY 2011. The FY 2013 performance goal for IHS executives across the IHS is to have an IHS average overall hiring time of fewer than 80 days.

Performance Measures and Analysis

<u>HHS Performance Plan Measures</u> - The IHS has six performance measures approved by HHS for inclusion within the HHS Performance Plan for FY 2014. The measures and their FY 2014 targets are: 1) 100 percent of hospitals and outpatient clinics operated by the IHS maintain accreditation; 2) American Indian and Alaska Native patients with diagnosed diabetes achieve

good glycemic control [this measure was revised in FY 2013 and a FY 2014 target will not be determined until the FY 2013 results are collected]; 3) 60.4 percent of adults 18 and older are screened for depression in IHS-funded clinical facilities per year; 4) to implement at least three recommendations from tribes annually to improve the tribal consultation process; 5) 36.6 percent of American Indian and Alaska Native patients, 22 years and older, with Coronary Heart Disease are assessed for five cardiovascular disease risk factors; and 6) American Indian and Alaska Native patients, aged 19-35 months, receive childhood immunizations[this measure was revised in FY 2013 and a FY 2014 target will not be determined until the FY 2013 results are collected]. These measures are included in the set of measures within the HHS Performance Plan to meet the formal reporting requirements for the GPRA Modernization Act of 2010 (GPRAMA). All of the measures align to the HHS Strategic Plan for Fiscal Years 2010-2015.

Agency Performance Accomplishments and Challenges - Historically, the IHS has succeeded in substantially improving the health status of the American Indian/Alaska Native (AI/AN) population, primarily by focusing on preventive and primary care services and developing a community-based public health system. For the AI/AN population, life expectancy, the expected number of years that a person has to live, increased by 3.7 years between the time periods of 1999-2001 (72.3 years) and 2005-2007 (76.0 years). During that same time period, the life expectancy for U.S. All Races increased by 0.8 years from 2000 (76.9 years) to 2006 (77.7 years). IHS reports unintentional injury mortality rates, those who died by accidents, as an overarching performance measure. Between calendar years 1972 – 1974, the age-adjusted IHS unintentional injury mortality rate, one that best takes into account that the average AI/AN is younger than the average person in the U.S., was 223.2 per 100,000 population. The most current age-adjusted, unintentional injury mortality rate, for calendar years 2005 – 2007, was 94.8 per 100,000 population. Even though the unintentional injury mortality rate has declined, the AI/AN rate in the IHS Service Area is 2.4 times that of US all races.

Despite complex, ongoing challenges, the agency has made significant progress on some important indicators of health and clinical care. Early identification of diabetes and improved diabetes management has helped prevent or delay the need for renal dialysis and transplant. Nephropathy (kidney disease) assessment is an essential diabetes management component. The agency has been measuring nephropathy assessment rates since it began reporting GPRA rates in FY 2002. The nephropathy assessment rate increased from 35 percent to 55 percent between FY 2002 and FY 2006, and after the new, more stringent standards of care were adopted, reached 66.7 percent in FY 2012. Such efforts support the President's stated goals of investing in prevention, wellness, and improving the quality of care.

Significant progress was also made in improving the pneumococcal vaccination rate for non-institutionalized adults over 65 years of age from 64 percent in FY 2002 to 88.5 percent in FY 2012. The improvement and maintenance of pneumococcal vaccination rates is important since AI/AN people are at high risk for this disease; the 2005-2007 AI/AN death rate from pneumonia and influenza was 1.3 times greater than the 2006 U.S. all-races death rate. Pneumococcal vaccination is a low-cost medical intervention that has been shown to prevent serious health complications among the elderly. This effort also supports the President's stated goals of investing in prevention, wellness, and improving the quality of care.

These preventive health approaches demonstrates our commitment to targeting measures via performance management. One concern is that certain screening rates (e.g., behavioral health assessments done in the primary care setting) may be easier to improve, compared to cost-intensive health interventions requiring medications and follow-up care. It is worth noting that the Agency's leadership is targeting all clinical measures in the Agency performance plan. There

are additional factors that make the achievement of the proposed performance targets in the Agency performance plan challenging. Examples include:

- High vacancy rates for many provider groups may have significant negative impacts on access to care as well as the ability to achieve performance targets.,
- The continued growth in the prevalence and incidence of diabetes in the AI/AN population and its associated co-morbidities greatly impact the resources available for care.

In light of these issues, the proposed performance targets in the budget request are ambitious.

The IHS remains committed to improving efficiency and effectiveness through the appropriate use of technology and sharing of best practices. The CRS software provides the capability for local programs to identify patients requiring preventive screenings and/or care for a chronic condition. The nationally deployed Integrated Care (iCare) application, a more sophisticated case and population management tool, is also used by local programs to track patient care. The Improving Patient Care (IPC) Initiative uses active networking to share information and material on successful programs, as well as technical assistance to identify ways to improve clinical business processes. The IHS hosts "best practices" conferences and WebEx presentations, which offer provider training opportunities to integrate medical standards of care with improved agency performance.

IHS performance improvement requires a concerted effort by all members of the Indian health system. This includes all clinic-, hospital- and community-based programs, as well as federal, tribal, and urban programs, working together to improve agency performance on the comprehensive set of existing performance measures. The IHS will continue to evaluate interventions/methods to address the persistent health disparities facing the AI/AN population.

Discretionary All Purpose Table
Indian Health Service
(Dollars in Thousands)

Mar 19, 2013

Program	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Budget Request	FY 2014 +/- FY 2012
SERVICES				
Hospitals & Health Clinics	1,810,966	1,822,049	1,865,630	54,664
Dental Services	159,440	160,416	168,225	8,785
Mental Health	75,589	76,052	79,873	4,284
Alcohol & Substance Abuse	194,297	195,486	196,405	2,108
Purchased/Referred Care	843,575	848,739	878,575	35,000
Total, Clinical Services	3,083,867	3,102,742	3,188,708	104,841
Public Health Nursing	66,632	67,040	71,194	4,562
Health Education	17,057	17,161	17,677	620
Community Health Reps.	61,407	61,783	61,661	254
Immunization AK	1,927	1,939	1,931	4
Total, Preventive Health	147,023	147,923	152,463	5,440
Urban Health	42,984	43,247	43,049	65
Indian Health Professions	40,596	40,844	40,602	6
Tribal Management Grants	2,577	2,593	2,577	0
Direct Operations	71,653	72,092	71,845	192
Self-Governance	6,044	6,081	6,049	5
Total, Other Services	163,854	164,857	164,122	268
TOTAL, SERVICES	3,394,744	3,415,522	3,505,293	110,549
CONTRACT SUPPORT COSTS				
TOTAL, CONTRACT SUPPORT COSTS	471,437	474,322	477,205	5,768
FACILITIES				
Maintenance & Improvement	53,721	54,050	53,721	0
Sanitation Facilities Construction	79,582	80,069	79,582	0
Health Care Facilities Construction	85,048	85,568	85,048	0
Facilities & Environmental Health Support	199,413	200,633	207,206	7,793
Equipment	22,582	22,720	22,582	0
TOTAL, FACILITIES	440,346	443,040	448,139	7,793
TOTAL, BUDGET AUTHORITY	**4,306,527**	**4,332,884**	**4,430,637**	**124,110**
COLLECTIONS / MANDATORY				
Medicare	201,973	204,685	204,685	2,712
Medicaid	666,709	683,483	778,483	111,774
Subtotal, M / M	*868,682*	*888,168*	*983,168*	*114,486*
Private Insurance	85,370	85,370	90,370	5,000
Total, M / M / PI	*954,052*	*973,538*	*1,073,538*	*119,486*
Quarters	7,500	7,500	7,500	
TOTAL, COLLECTIONS	961,552	981,038	1,081,038	119,486
Special Diabetes Program for Indians	150,000	150,000	150,000	0
TOTAL, MANDATORY	150,000	150,000	150,000	0
TOTAL, PROGRAM LEVEL	**5,418,079**	**5,463,922**	**5,661,675**	**243,596**

INDIAN HEALTH SERVICE
FY 2014 President's Budget Request
(Dollars in Thousands)

Mar 19, 2013

Sub Sub Activity	2012 Enacted	2013 Continuing Resolution	Pay: CS	Pay: CO	Pay: Tribal Pay	Pay: Total	Medical Inflation 3.7%	Staffing for New Facilities	**Curr Svcs Subtotal**	**Program Increase**	**FY 2014 Budget Request**
SERVICES											
Hospitals & Health Clinics	1,810,966	1,822,049	1,334	329	2,131	3,794	0	50,870	54,664	0	**1,865,630**
Dental Services	159,440	160,416	172	67	176	415	0	8,370	8,785	0	**168,225**
Mental Health	75,589	76,052	78	7	100	185	0	4,099	4,284	0	**79,873**
Alcohol & Substance Abuse	194,297	195,486	46	7	362	415	0	1,693	2,108	0	**196,405**
Purchased/Referred Care	843,575	848,739	0	0	0	0	35,000	0	35,000	0	**878,575**
Total, Clinical Services	3,083,867	3,102,742	1,630	410	2,769	4,809	35,000	65,032	104,841	0	**3,188,708**
Public Health Nursing	66,632	67,040	81	22	76	179	0	4,383	4,562	0	**71,194**
Health Education	17,057	17,161	11	1	28	40	0	580	620	0	**17,677**
Comm. Health Reps	61,407	61,783	1	1	132	134	0	120	254	0	**61,661**
Immunization AK	1,927	1,939	0	0	4	4	0	0	4	0	**1,931**
Total, Preventive Health	147,023	147,923	93	24	240	357	0	5,083	5,440	0	**152,463**
Urban Health	42,984	43,247	4	1	60	65	0	0	65	0	**43,049**
Indian Health Professions	40,596	40,844	5	1	0	6	0	0	6	0	**40,602**
Tribal Management	2,577	2,593	0	0	0	0	0	0	0	0	**2,577**
Direct Operations	71,653	72,092	126	24	42	192	0	0	192	0	**71,845**
Self-Governance	6,044	6,081	5	0	0	5	0	0	5	0	**6,049**
Total, Other Services	163,854	164,857	140	26	102	268	0	0	268	0	**164,122**
TOTAL, SERVICES	3,394,744	3,415,522	1,863	460	3,111	5,434	35,000	70,115	110,549	0	**3,505,293**
CONTRACT SUPPORT COSTS											
TOTAL, CONTRACT SUPPORT COSTS	471,437	474,322	0	0	0	0	0	0	0	5,768	**477,205**
FACILITIES											
Maintenance & Improvement	53,721	54,050	0	0	0	0	0	0	0	0	**53,721**
Sanitation Facilities Constr.	79,582	80,069	0	0	0	0	0	0	0	0	**79,582**
Health Care Fac. Constr.	85,048	85,568	0	0	0	0	0	0	0	0	**85,048**
Facil. & Envir. Hlth Supp.	199,413	200,633	252	125	188	565	0	7,228	7,793	0	**207,206**
Equipment	22,582	22,720	0	0	0	0	0	0	0	0	**22,582**
TOTAL, FACILITIES	440,346	443,040	252	125	188	565	0	7,228	7,793	0	**448,139**
TOTAL, IHS	4,306,527	4,332,884	2,115	585	3,299	5,999	35,000	77,343	118,342	5,768	4,430,637

ADDITIONAL STAFFING AND OPERATING COSTS FOR NEW / EXPANDED HEALTHCARE FACILITIES -- Estimates

FY 2014 Budget Request

(Dollars in Thousands)

Revised Feb 25, 2013

	Ardmore, OK		Vinita, OK		Wasilla, AK		Fairbanks, AK		Nome, AK		Tishomingo, OK		Tazlina, AK		Kenai, AK		Barrow, AK		San Carlos, AZ			
	Chickasaw Nation Health Clinic Joint Venture		Cherokee Nation Health Center Joint Venture		Southcentral Foundation Valley Primary Care Ctr Joint Venture		Tanana Chiefs Conference Health Center Joint Venture		Norton Sound Regional Hospital		Chickasaw Nation Health Clinic Joint Venture		Copper River Health Clinic Joint Venture		Kenaitze Tribe Dena'ina Hlth Clinic Joint Venture		Samuel Simmonds Hospital		San Carlos Health Center		**TOTAL**	
Sub Sub Activity	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	Pos	Amount	**Pos**	**AMOUNT**
Hospitals & Health Clinics	55	$5,388	6	$599	82	$11,462	102	$14,103	76	$9,833	28	$2,757	2	$281	4	$508	40	$5,328	6	$611	401	$50,870
Dental Health	12	$1,143	5	$508	17	$2,051	17	$2,190	9	$1,109	6	$611	1	$125	1	$135	3	$405	1	$93	72	$8,370
Mental Health	6	$559	1	$94	9	$1,083	7	$815	4	$420	6	$562	1	$94	1	$126	2	$250	1	$96	38	$4,099
Alcohol & Substance Abuse	3	$273	1	$91	4	$400	2	$257	1	$96	3	$273	0	$0	0	$0	1	$211	1	$92	16	$1,693
Total, Clinical Services	76	$7,363	13	$1,292	112	$14,996	128	$17,365	90	$11,458	43	$4,203	4	$500	6	$769	46	$6,194	9	$892	527	$65,032
Public Health Nursing	6	$720	1	$121	9	$1,247	6	$884	5	$640	4	$486	0	$0	0	$0	1	$165	1	$120	33	$4,383
Health Education	1	$91	0	$0	1	$114	2	$218	1	$96	1	$61	0	$0	0	$0	0	$0	0	$0	6	$580
Comm. Health Representatives	0	$0	2	$120	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	2	$120
Total, Preventive Health	7	$811	3	$241	10	$1,361	8	$1,102	6	$736	5	$547	0	$0	0	$0	1	$165	1	$120	41	$5,083
Total, Services	83	$8,174	16	$1,533	122	$16,357	136	$18,467	96	$12,194	48	$4,750	4	$500	6	$769	47	$6,359	10	$1,012	568	$70,115
Facilities Support	4	$774	1	$220	5	$1,325	5	$1,446	4	$1,131	3	$541	0	$0	1	$231	2	$480	1	$169	26	$6,317
Environmental Health Support	0	$0	0	$0	0	$0	3	$511	2	$264	0	$0	0	$0	0	$0	0	$0	1	$136	6	$911
Total, FEHS	4	$774	1	$220	5	$1,325	8	$1,957	6	$1,395	3	$541	0	$0	1	$231	2	$480	2	$305	32	$7,228
Total, Facilities	4	$774	1	$220	5	$1,325	8	$1,957	6	$1,395	3	$541	0	$0	1	$231	2	$480	2	$305	32	$7,228
Grand Total [1]	**87**	**$8,948**	**17**	**$1,753**	**127**	**$17,682**	**144**	**$20,424**	**102**	**$13,589**	**51**	**$5,291**	**4**	**$500**	**7**	**$1,000**	**49**	**$6,839**	**12**	**$1,317**	**600**	**$77,343**

[1] Includes utilities

Note: These estimates reflect competing priorities within the budget request level and information available as of February 2013. The estimates reflect funding needs for both FY 2013 and FY 2014. Amounts are estimated and may change due to changing dates of beneficial occupancy. The 600 additional staff, along with the 674 existing staff at these 10 health care facilities, are necessary to effectively carry out the expanded and new health care for the eligible populations being served.

Workload Projection	Ardmore, OK	Vinita, OK	Wasilla, AK	Fairbanks, AK	Nome, AK	Tishomingo, OK	Tazlina, AK	Kenai, AK	Barrow, AK	San Carlos, AZ	**TOTAL**
Inpatient Days									2,226	1,745	**3,971**
Outpatient Visits	49,146	35,091	65,096	139,618	56,012	34,995	7,265	27,281	48,419	128,118	**591,041**
User Population (est.)	6,195	4,359	8,515	14,389	10,435	4,505	830	3,140	6,142	12,985	**71,495**

(Dollars in Thousands)

Capital Invested (est.)	Ardmore, OK	Vinita, OK	Wasilla, AK	Fairbanks, AK	Nome, AK	Tishomingo, OK	Tazlina, AK	Kenai, AK	Barrow, AK	San Carlos, AZ	**TOTAL**
Tribes	$30,847	$30,135	$45,490	$64,323		$25,251	$19,403	$21,913			**$237,362**
Federal Government					$171,000				$160,098	$116,000	**$447,098**

Statement of Personnel Resources
INDIAN HEALTH SERVICE

	FY 2012 Enacted	FY 2013 CR	FY 2014 Request
Direct:			
Hospitals & Health Clinics	6,387	6,520	6,520
Dental Health	699	699	699
Mental Health	216	216	216
Alcohol & Substance Abuse	189	189	189
Purchased/Referred Care	0	0	0
Total, Clinical Services	7,491	7,624	7,624
Public Health Nursing	241	241	241
Health Education	26	26	26
Community Health Reps	7	7	7
Immunization, AK	0	0	0
Total, Preventive Health	274	274	274
Urban Health	6	6	6
Indian Health Professions	26	26	26
Tribal Management	0	0	0
Direct Operations	290	290	290
Self Governance	11	11	11
Contract Support Costs	0	0	0
Total, SERVICES	8,098	8,231	8,231
Maint. & Improvement	0	0	0
Sanitation Facilities	156	156	156
Hlth Care Facs Construction	0	0	0
Facil. & Envir. Hlth Support	1,035	1,035	1,035
Equipment	0	0	0
Total, FACILITIES	1,191	1,191	1,191
Total, Direct FTE	9,289	9,422	9,422
Reimbursable:			
Buybacks	1,451	1,451	1,451
Medicare	754	754	754
Medicaid	3,360	3,382	3,382
Private Insurance	523	523	523
Quarters	32	32	32
Total, Reimbursable FTE	6,120	6,142	6,142
Trust Funds (Gift)	23	23	23
Health Reform non -add:	0	0	0
TOTAL FTE	**15,432**	**15,587**	**15,587**
Total, Civilian FTE	**13,361**	**13,495**	**13,495**
Total, Military FTE	**2,071**	**2,092**	**2,092**

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Feb 20, 2013

Sub Sub Activity	2012 Enacted					2013 Continuing Resolution				
	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	1,810,966	85,370	868,682 [2/]	0	2,765,018	1,822,049	85,370	888,168 [2/]	0	2,795,587
Dental Health	159,440	0	0	0	159,440	160,416	0	0	0	160,416
Mental Health	75,589	0	0	0	75,589	76,052	0	0	0	76,052
Alcohol & Substance Abuse	194,297	0	0	0	194,297	195,486	0	0	0	195,486
Purchased/Referred Care	843,575	0	0		843,575	848,739	0	0	0	848,739
Total, Clinical Services	3,083,867	85,370	868,682	0	4,037,919	3,102,742	85,370	888,168	0	4,076,280
Public Health Nursing	66,632	0	0	0	66,632	67,040	0	0	0	67,040
Health Education	17,057	0	0	0	17,057	17,161	0	0	0	17,161
Comm. Health Reps.	61,407	0	0	0	61,407	61,783	0	0	0	61,783
Immunization AK	1,927	0	0	0	1,927	1,939	0	0	0	1,939
Total, Preventive Health	147,023	0	0	0	147,023	147,923	0	0	0	147,923
Urban Health	42,984	0	0	0	42,984	43,247	0	0	0	43,247
Indian Health Professions	40,596	0	0	0	40,596	40,844	0	0	0	40,844
Tribal Management	2,577	0	0	0	2,577	2,593	0	0	0	2,593
Direct Operations	71,653	0	0	0	71,653	72,092	0	0	0	72,092
Self-Governance	6,044	0	0	0	6,044	6,081	0	0	0	6,081
Contract Support Costs	471,437	0	0	0	471,437	474,322	0	0	0	474,322
Total, Other Services	635,291	0	0	0	635,291	639,179	0	0	0	164,857
TOTAL, SERVICES	3,866,181	85,370	868,682	0	4,820,233	3,889,844	85,370	888,168	0	4,389,060
FACILITIES:										
Maintenance & Improvement	53,721	0	0	7,500	61,221	54,050	0	0	7,500	61,550
Sanitation Facilities Construction	79,582	0	0	0	79,582	80,069	0	0	0	80,069
Health Care Facs. Constr.	85,048	0	0	0	85,048	85,568	0	0	0	85,568
Facil. & Envir. Health Support	199,413	0	0	0	199,413	200,633	0	0	0	200,633
Equipment	22,582	0	0	0	22,582	22,720	0	0	0	22,720
TOTAL, FACILITIES	440,346	0	0	7,500	447,846	443,040	0	0	7,500	450,540
TOTAL, IHS	4,306,527	85,370	868,682	7,500	5,268,079	4,332,884	85,370	888,168	7,500	4,839,600
Special Diabetes Program for Indians [1/]	150,000	0	0	0	150,000	150,000	0	0	0	150,000
GRAND TOTAL	4,456,527	85,370	868,682	7,500	5,418,079	4,957,206	85,370	888,168	7,500	5,463,922

[1/] The Special Diabetes Program for Indians is reauthorized for a total of $150,000,000 in FY 2012.

[2/] Includes $29,203,000 in Medicaid/Medicare for CMS estimates of tribal collections as well as $181,277,000 in FY 2012 and FY 2013 for tribal direct collection estimates, which began in FY 2002.

Indian Health Service

Breakdown of Program Level

(Dollars in Thousands)

Feb 20, 2013

Sub Sub Activity	2014 Request					Increase/Decrease of 2014 Over 2012				
	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	1,865,630	90,370	983,168 [2/]	0	2,939,168	54,664	5,000	114,486	0	174,150
Dental Health	168,225	0	0	0	168,225	8,785	0	0	0	8,785
Mental Health	79,873	0	0	0	79,873	4,284	0	0	0	4,284
Alcohol & Substance Abuse	196,405	0	0	0	196,405	2,108	0	0	0	2,108
Purchased/Referred Care	878,575	0	0	0	878,575	35,000	0	0	0	35,000
Total, Clinical Services	3,188,708	90,370	983,168	0	4,262,246	104,841	5,000	114,486	0	224,327
Public Health Nursing	71,194	0	0	0	71,194	4,562	0	0	0	4,562
Health Education	17,677	0	0	0	17,677	620	0	0	0	620
Comm. Health Reps.	61,661	0	0	0	61,661	254	0	0	0	254
Immunization AK	1,931	0	0	0	1,931	4	0	0	0	4
Total, Preventive Health	152,463	0	0	0	152,463	5,440	0	0	0	5,440
Urban Health	43,049	0	0	0	43,049	65	0	0	0	65
Indian Health Professions	40,602	0	0	0	40,602	6	0	0	0	6
Tribal Management	2,577	0	0	0	2,577	0	0	0	0	0
Direct Operations	71,845	0	0	0	71,845	192	0	0	0	192
Self-Governance	6,049	0	0	0	6,049	5	0	0	0	5
Total, Other Services	164122	0	0	0	164122	268	0	0	0	268
TOTAL, SERVICES	3,505,293	90,370	983,168	0	4,578,831	110,549	5,000	114,486	0	230,035
CONTRACT SUPPORT COSTS:										
Toal, Contract Support Costs	477,205	0	0	0	477,205	5,768	0	0	0	5,768
FACILITIES:										
Maintenance & Improvement	53,721	0	0	7,500	61,221	0	0	0	0	0
Sanitation Facilities Construction	79,582	0	0	0	79,582	0	0	0	0	0
Health Care Facs. Constr.	85,048	0	0	0	85,048	0	0	0	0	0
Facil. & Envir. Health Support	207,206	0	0	0	207,206	7,793	0	0	0	7,793
Equipment	22,582	0	0	0	22,582	0	0	0	0	0
TOTAL, FACILITIES	448,139	0	0	7,500	455,639	7,793	0	0	0	7,793
TOTAL, IHS	4,430,637	90,370	983,168	7,500	5,511,675	124,110	5,000	114,486	0	243,596
Special Diabetes Program for Indians [1/]	150,000	0	0	0	150,000	0	0	0	0	0
GRAND TOTAL	4,580,637	90,370	983,168	7,500	5,661,675	124,110	5,000	114,486	0	243,596

[1/] The Special Diabetes Program for Indians is reauthorized for a total of $150,000,000 in FY 2014.

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

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

Sub Activity	Federal Health Administration: Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Tribal Health Administration: Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	FY 2012 Enacted
SERVICES																	
Hospitals & Health Clinics	839,594	0	0	0	0	0	0	839,594	971,372	0	0	0	0	0	0	971,372	1,810,966
Dental Health	79,229	0	0	0	0	0	0	79,229	80,211	0	0	0	0	0	0	80,211	159,440
Mental Health	29,985	0	0	0	0	0	0	29,985	45,604	0	0	0	0	0	0	45,604	75,589
Alcohol & Substance Abuse	29,218	0	0	0	0	0	0	29,218	165,079	0	0	0	0	0	0	165,079	194,297
Purchased/Referred Care	402,504	0	0	0	0	0	0	402,504	441,071	0	0	0	0	0	0	441,071	843,575
Subtotal (CS)	1,380,530	0	0	0	0	0	0	1,380,530	1,703,337	0	0	0	0	0	0	1,703,337	3,083,867
Public Health Nursing	0	0	31,985	0	0	0	0	31,985	0	34,647	0	0	0	0	0	34,647	66,632
Health Education	0	0	4,205	0	0	0	0	4,205	0	12,852	0	0	0	0	0	12,852	17,057
Community Health Repr.	0	0	1,379	0	0	0	0	1,379	0	60,028	0	0	0	0	0	60,028	61,407
Immunization AK	0	0	(3)	0	0	0	0	(3)	0	1,930	0	0	0	0	0	1,930	1,927
Subtotal (PH)	0	0	37,566	0	0	0	0	37,566	0	109,457	0	0	0	0	0	109,457	147,023
Urban Health Project	0	15,759	0	0	0	0	0	15,759	0	0	27,225	0	0	0	0	27,225	42,984
Indian Health Professions	0	0	0	40,596	0	0	0	40,596	0	0	0	0	0	0	0	0	40,596
Tribal Management	0	0	0	187	0	0	0	187	0	0	0	2,390	0	0	0	2,390	2,577
Direct Operations	0	0	0	0	52,582	0	0	52,582	0	0	0	19,071	0	0	0	19,071	71,653
Self-Governance	0	0	0	0	0	3,218	0	3,218	0	0	0	0	2,826	0	0	2,826	6,044
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	471,437	0	471,437	471,437
Subtotal (OS)	0	15,759	0	40,783	52,582	3,218	0	112,342	0	0	27,225	21,461	2,826	471,437	0	522,949	635,291
Total, Services	1,380,530	15,759	37,566	40,783	52,582	3,218	0	1,530,438	1,703,337	109,457	27,225	21,461	2,826	471,437	0	2,335,743	3,866,181
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	18,906	18,906	0	0	0	0	0	0	34,815	34,815	53,721
Sanitation Facilities Constr.	0	0	0	0	0	0	27,854	27,854	0	0	0	0	0	0	51,728	51,728	79,582
Health Care Facs. Constr.	0	0	0	0	0	0	12,979	12,979	0	0	0	0	0	0	72,069	72,069	85,048
Facs. & Env. Health Sup	0	0	0	0	0	0	113,567	113,567	0	0	0	0	0	0	85,846	85,846	199,413
Equipment	0	0	0	0	0	0	5,857	5,857	0	0	0	0	0	0	16,725	16,725	22,582
Total, Facilities	0	0	0	0	0	0	179,163	179,163	0	0	0	0	0	0	261,183	261,183	440,346
TOTAL, IHS	1,380,530	15,759	37,566	40,783	52,582	3,218	179,163	1,709,601	1,703,337	109,457	27,225	21,461	2,826	471,437	261,183	2,596,926	4,306,527

FY 2013 Crosswalk
Budget Authority
Estimated 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 2013 Estimate
SERVICES																	
Hospitals & Health Clinics	816,096	0	0	0	0	0	0	816,096	1,005,953	0	0	0	0	0	0	1,005,953	1,822,049
Dental Health	74,137	0	0	0	0	0	0	74,137	86,279	0	0	0	0	0	0	86,279	160,416
Mental Health	27,935	0	0	0	0	0	0	27,935	48,117	0	0	0	0	0	0	48,117	76,052
Alcohol & Substance Abuse	29,353	0	0	0	0	0	0	29,353	166,133	0	0	0	0	0	0	166,133	195,486
Purchased/Referred Care	379,487	0	0	0	0	0	0	379,487	469,252	0	0	0	0	0	0	469,252	848,739
Subtotal (CS)	1,327,008	0	0	0	0	0	0	1,327,008	1,775,734	0	0	0	0	0	0	1,775,734	3,102,742
Public Health Nursing	0	0	29,241	0	0	0	0	29,241	0	37,799	0	0	0	0	0	37,799	67,040
Health Education	0	0	3,918	0	0	0	0	3,918	0	13,243	0	0	0	0	0	13,243	17,161
Community Health Repr.	0	0	1,635	0	0	0	0	1,635	0	60,148	0	0	0	0	0	60,148	61,783
Immunization AK	0	0	9	0	0	0	0	9	0	1,930	0	0	0	0	0	1,930	1,939
Subtotal (PH)	0	0	34,803	0	0	0	0	34,803	0	113,120	0	0	0	0	0	113,120	147,923
Urban Health Project	0	16,022	0	0	0	0	0	16,022	0	0	27,225	0	0	0	0	27,225	43,247
Indian Health Professions	0	0	0	40,844	0	0	0	40,844	0	0	0	0	0	0	0	0	40,844
Tribal Management	0	0	0	203	0	0	0	203	0	0	0	2,390	0	0	0	2,390	2,593
Direct Operations	0	0	0	0	52,724	0	0	52,724	0	0	0	19,368	0	0	0	19,368	72,092
Self-Governance	0	0	0	0	0	3,255	0	3,255	0	0	0	0	2,826	0	0	2,826	6,081
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	474,322	0	474,322	474,322
Subtotal (OS)	0	16,022	0	41,047	52,724	3,255	0	113,048	0	0	27,225	21,758	2,826	474,322	0	526,131	639,179
Total, Services	1,327,008	16,022	34,803	41,047	52,724	3,255	0	1,474,859	1,775,734	113,120	27,225	21,758	2,826	474,322	0	2,414,985	3,889,844
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	18,103	18,103	0	0	0	0	0	0	35,947	35,947	54,050
Sanitation Facilities Constr.	0	0	0	0	0	0	28,024	28,024	0	0	0	0	0	0	52,045	52,045	80,069
Health Care Facs. Constr.	0	0	0	0	0	0	44,079	44,079	0	0	0	0	0	0	41,489	41,489	85,568
Facs. & Env. Health Sup	0	0	0	0	0	0	110,331	110,331	0	0	0	0	0	0	90,302	90,302	200,633
Equipment	0	0	0	0	0	0	5,995	5,995	0	0	0	0	0	0	16,725	16,725	22,720
Total, Facilities	0	0	0	0	0	0	206,532	206,532	0	0	0	0	0	0	236,508	236,508	443,040
TOTAL, IHS	1,327,008	16,022	34,803	41,047	52,724	3,255	206,532	1,681,391	1,775,734	113,120	27,225	21,758	2,826	474,322	236,508	2,651,493	4,332,884

FY 2014 Crosswalk
Budget Authority
Estimated Distribution
(Dollars in Thousands)

Sub Activity	Federal Health Administration: Clinical Services	Urban Health	Preventive Health	Indian Health Professions	Federal Administration	Self-Governance	Facilities	TOTAL Federal Health Admini-stration	Tribal Health Administration: Clinical Services	Preventive Health	Urban Health	Management Training	Self-Governance	Contract Support	Facilities	TOTAL Tribal Health Admini-stration	FY 2014 Estimate
SERVICES																	
Hospitals & Health Clinics	841,257	0	0	0	0	0	0	841,257	1,024,373	0	0	0	0	0	0	1,024,373	1,865,630
Dental Health	79,468	0	0	0	0	0	0	79,468	88,757	0	0	0	0	0	0	88,757	168,225
Mental Health	30,070	0	0	0	0	0	0	30,070	49,803	0	0	0	0	0	0	49,803	79,873
Alcohol & Substance Abuse	29,271	0	0	0	0	0	0	29,271	167,134	0	0	0	0	0	0	167,134	196,405
Purchased/Referred Care	419,234	0	0	0	0	0	0	419,234	459,341	0	0	0	0	0	0	459,341	878,575
Subtotal (CS)	1,399,300	0	0	0	0	0	0	1,399,300	1,789,408	0	0	0	0	0	0	1,789,408	3,188,708
Public Health Nursing	0	0	32,088	0	0	0	0	32,088	0	39,106	0	0	0	0	0	39,106	71,194
Health Education	0	0	4,217	0	0	0	0	4,217	0	13,460	0	0	0	0	0	13,460	17,677
Community Health Repr.	0	0	1,381	0	0	0	0	1,381	0	60,280	0	0	0	0	0	60,280	61,661
Immunization AK	0	0	(3)	0	0	0	0	(3)	0	1,934	0	0	0	0	0	1,934	1,931
Subtotal (PH)	0	0	37,683	0	0	0	0	37,683	0	114,780	0	0	0	0	0	114,780	152,463
Urban Health Project	0	15,764	0	0	0	0	0	15,764	0	0	27,285	0	0	0	0	27,285	43,049
Indian Health Professions	0	0	0	40,602	0	0	0	40,602	0	0	0	0	0	0	0	0	40,602
Tribal Management	0	0	0	187	0	0	0	187	0	0	0	2,390	0	0	0	2,390	2,577
Direct Operations	0	0	0	0	52,732	0	0	52,732	0	0	0	19,113	0	0	0	19,113	71,845
Self-Governance	0	0	0	0	0	3,223	0	3,223	0	0	0	0	2,826	0	0	2,826	6,049
Subtotal (OS)	0	15,764	0	40,789	52,732	3,223	0	112,508	0	0	27,285	21,503	2,826	0	0	51,614	164,122
Total, Services	1,399,300	15,764	37,683	40,789	52,732	3,223	0	1,549,491	1,789,408	114,780	27,285	21,503	2,826	0	0	1,955,802	3,505,293
CONTRACT SUPPORT COSTS																	
Contract Support Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	477,205	0	477,205	477,205
FACILITIES																	
Maintenance & Improvement	0	0	0	0	0	0	18,906	18,906	0	0	0	0	0	0	34,815	34,815	53,721
Sanitation Facilities Constr.	0	0	0	0	0	0	27,854	27,854	0	0	0	0	0	0	51,728	51,728	79,582
Health Care Facs. Constr.	0	0	0	0	0	0	72,548	72,548	0	0	0	0	0	0	12,500	12,500	85,048
Facs. & Env. Health Sup	0	0	0	0	0	0	113,944	113,944	0	0	0	0	0	0	93,262	93,262	207,206
Equipment	0	0	0	0	0	0	5,857	5,857	0	0	0	0	0	0	16,725	16,725	22,582
Total, Facilities	0	0	0	0	0	0	239,109	239,109	0	0	0	0	0	0	209,030	209,030	448,139
TOTAL, IHS	1,399,300	15,764	37,683	40,789	52,732	3,223	239,109	1,788,600	1,789,408	114,780	27,285	21,503	2,826	477,205	209,030	2,642,037	4,430,637

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, [$3,394,744,000,] *$3,505,293,000*, together with payments received during the fiscal year pursuant to 42 U.S.C. 238(b) and 238b for services furnished by the Indian Health Service: *Provided*, That funds made available to tribes and tribal organizations through contracts, grant agreements, or any other agreements or compacts authorized by the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), shall be deemed to be obligated at the time of the grant or contract award and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: *Provided further*, That [$843,575,000] *$878,575,000* for [contract medical care] *Purchased/Referred Care*, including $51,500,000 for the Indian Catastrophic Health Emergency Fund, shall remain available until expended [1]: [*Provided further*, That of the funding provided for information technology activities and, notwithstanding any other provision of law, $4,000,000 shall be allocated at the discretion of the Director of the Indian Health Service:][2] *Provided further*, That of the funds provided, up to $36,000,000 shall remain available until expended for implementation of the loan repayment program under section 108 of the Indian Health Care Improvement Act: *Provided further*, That the amounts collected by the Federal Government as authorized by section 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. 1613a and 1616a) during the preceding fiscal year for breach of contracts shall be deposited to the Fund authorized by section 108A of the Act (25 U.S.C. 1616a-1) and shall remain available until expended and, notwithstanding section 108(c) of the Act (25 U.S.C. 1616a-1(c)), funds shall be available to make new awards under the loan repayment and scholarship programs under sections 104 and 108 of the Act (25 U.S.C. 1613a and 1616a): *Provided further*, That, notwithstanding any other provision of law, the amounts made available within this account for the methamphetamine and suicide prevention and treatment initiative and for the domestic violence prevention initiative shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended: *Provided further*, That funds provided in this Act may be used for annual contracts and grants that fall within 2 fiscal years, provided the total obligation is recorded in the year the funds are appropriated: *Provided further*, That the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act shall remain available until expended for the purpose of

achieving compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act, except for those related to the planning, design, or construction of new facilities: *Provided further*, That funding contained herein for scholarship programs under the Indian Health Care Improvement Act (25 U.S.C. 1613) shall remain available until expended: *Provided further*, That amounts received by tribes and tribal organizations under title IV of the Indian Health Care Improvement Act shall be reported and accounted for and available to the receiving tribes and tribal organizations until expended. *Provided further*, That, the Bureau of Indian Affairs may collect from the Indian Health Service, tribes and tribal organizations operating health facilities pursuant to Public Law 93-638, such individually identifiable health information relating to disabled children as may be necessary for the purpose of carrying out its functions under the Individuals with Disabilities Education Act (20 U.S.C. 1400, et seq.): *Provided further*, That, the Indian Health Care Improvement Fund may be used, as needed, to carry out activities typically funded under the Indian Health Facilities account. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2012.)*

Indian Health Contract Support Costs

[*Provided further*, That, notwithstanding any other provision of law, of the amounts provided herein, not to exceed [$471,437,000] *$471,437,000* 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 2013, of which not to exceed $10,000,000 may be used for contract support costs associated with new or expanded self-determination contracts, grants, self-governance compacts, or annual funding agreements:] [3]

For payments of contract support costs associated with ongoing Indian Self-Determination Act agreements with the Indian Health Service for fiscal or calendar year 2014, not to exceed [$471,437,000], $477,205,000;

Provided, That, notwithstanding any other provision of law, the amount available for contract support costs associated with each ongoing Indian Self-Determination Act agreement with the Indian Health Service for fiscal or calendar year 2014 shall not exceed the amount identified in the "Indian Health Service Contract Support Costs" table submitted by the Secretary of Health and Human Services to the House and Senate Committees on Appropriations;

In addition, not to exceed [$10,000,000], $500,000 shall be available for payments for contract support costs associated with new or expanded Indian Self-Determination Act agreements with the Indian Health Service for fiscal or calendar year 2014 [4]

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, [$440,346,000,] *$448,139,000*, to remain available until expended: *Provided*, That, notwithstanding any other provision of law, funds appropriated for the planning, design, construction, renovation or expansion of health facilities for the benefit of an Indian tribe or tribes may be used to purchase land on which such facilities will be located: *Provided further*, That not to exceed $500,000 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 constructions for new homes funded with grants by the housing programs of the United States Department of Housing and Urban Development: *Provided further*, That not to exceed $2,700,000 from this account and the "Indian Health Services" account 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, to remain available until expended, and be used by the Indian Health Service for the demolition of Federal buildings. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2012.)*

ADMINISTRATIVE PROVISIONS, INDIAN HEALTH SERVICE

Appropriations provided in this Act to the Indian Health Service shall be available for services as authorized by 5 U.S.C. 3109 at rates not to exceed the per diem rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. 5376; hire of passenger motor vehicles and aircraft; purchase of medical equipment; purchase of reprints; purchase, renovation and erection of modular buildings and renovation of existing facilities; payments for telephone service in private residences in the field, when authorized under regulations approved by the Secretary; uniforms or allowances therefor as authorized by 5 U.S.C. 5901-5902; and for

expenses of attendance at meetings that relate to the functions or activities of the Indian Health Service: *Provided*, That in accordance with the provisions of the Indian Health Care Improvement Act, non-Indian patients may be extended health care at all tribally administered or Indian Health Service facilities, subject to charges, and the proceeds along with funds recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2651-2653) shall be credited to the account of the facility providing the service and shall be available without fiscal year limitation: *Provided further*, That notwithstanding any other law or regulation, funds transferred from the Department of Housing and Urban Development to the Indian Health Service shall be administered under Public Law 86-121, the Indian Sanitation Facilities Act and Public Law 93-638, as amended: *Provided further,* That funds appropriated to the Indian Health Service in this Act, except those used for administrative and program direction purposes, shall not be subject to limitations directed at curtailing Federal travel and transportation: *Provided further*, That none of the funds made available to the Indian Health Service in this Act shall be used for any assessments or charges by the Department of Health and Human Services unless identified in the budget justification and provided in this Act, or approved by the House and Senate Committees on Appropriations through the reprogramming process: *Provided further*, That notwithstanding any other provision of law, funds previously or herein made available to a tribe or tribal organization through a contract, grant, or agreement authorized by title I or title V of the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450), may be deobligated and reobligated to a self-determination contract under title I, or a self-governance agreement under title V of such Act and thereafter shall remain available to the tribe or tribal organization without fiscal year limitation: *Provided further*, That none of the funds made available to the Indian Health Service in this Act shall be used to implement the final rule published in the Federal Register on September 16, 1987, by the Department of Health and Human Services, relating to the eligibility for the health care services of the Indian Health Service until the Indian Health Service has submitted a budget request reflecting the increased costs associated with the proposed final rule, and such request has been included in an appropriations Act and enacted into law: *Provided further*, That with respect to functions transferred by the Indian Health Service to tribes or tribal organizations, the Indian Health Service is authorized to provide goods and services to those entities on a reimbursable basis, including payments in advance with subsequent adjustment, and the reimbursements received therefrom, along with the funds received from those entities pursuant to the Indian Self-Determination Act, may be credited to the same or subsequent appropriation account from which the funds were originally derived, with such amounts to remain available until expended: *Provided further*, That reimbursements for training, technical assistance, or services provided by the Indian Health Service will contain total costs, including direct, administrative, and overhead associated with the provision of goods, services, or technical

assistance: *Provided further*, That the appropriation structure for the Indian Health Service may not be altered without advance notification to the House and Senate Committees on Appropriations.

GENERAL PROVISIONS

SEC. 408. Notwithstanding any other provision of law, amounts appropriated to or otherwise designated in committee reports for the Bureau of Indian Affairs and the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, 108-447, 109-54, 109-289, division B and Continuing Appropriations Resolution, 2007 (division B of Public Law 109-289, as amended by Public Laws 110-5 and 110-28), Public Laws 110-92, 110-116, 110-137, 110-149, 110-161, 110-329, 111-6, 111-8, 111-88, 112-10, 112-74, and ______ for payments for contract support costs associated with Indian Self-Determination Act agreements with the Bureau of Indian Affairs or the Indian Health Service, are the total amounts available for fiscal years 1994 through [2012] *2014* for such purposes, except that the Bureau of Indian Affairs, tribes and tribal organizations may use their tribal priority allocations for unmet contract support costs of ongoing contracts, grants, self-governance compacts, or annual funding agreements.[5]

Language Analysis

Language Provision	Explanation
SERVICES PROVISIONS	
[1] *Provided further*, That [$843,575,000] *$878,575,000* for [contract medical care]*Purchased/Referred Care*, including $51,500,000 for the Indian Catastrophic Health Emergency Fund, shall remain available until expended:	Name change for program.
[2] [*Provided further*, That of the funding provided for information technology activities and, notwithstanding any other provision of law, $4,000,000 shall be allocated at the discretion of the Director of the Indian Health Service:]	Language not needed.
[3] [Provided further, That, notwithstanding any other provision of law, of the amounts provided herein, not to exceed [$471,437,000] $471,437,000 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 2013, of which not to exceed $10,000,000 may be used for contract support costs associated with new or expanded self-determination contracts, grants, self-governance compacts, or annual funding agreements:]	New bill language is needed to implement the recommendations of the Supreme Court (see new language and explanation below).
[4] *For payments of contract support costs associated with ongoing Indian Self-Determination Act agreements with the Indian Health Service for fiscal or calendar year 2014, not to exceed [$471,437,000], $477,205,000;* *Provided, That, notwithstanding any other provision of law, the amount available for contract support costs associated with each ongoing Indian Self-Determination Act agreement with the Indian Health Service for fiscal or calendar year 2014 shall not exceed the amount identified in the "Indian Health Service Contract Support Costs" table submitted by the Secretary of Health and Human Services to the House and Senate Committees on Appropriations;* *In addition, not to exceed [$10,000,000], $500,000 shall be available for payments for contract support costs associated with new or expanded Indian Self-Determination Act agreements with the Indian Health Service for fiscal or calendar year 2014.*	New bill language is needed to implement the recommendations of the Supreme Court. This language represents a consistent Administration approach, which is needed to balance contract support costs with funding with health care services for tribes. BIA concurs with this approach.
GENERAL PROVISIONS	
[5] SEC. 408. Notwithstanding any other provision of law, amounts appropriated to or otherwise designated in committee reports for the Bureau of Indian Affairs and	Added to continue provision to limit payments for Contract Support Costs in past years (FY 1994 through 2012) to

the Indian Health Service by Public Laws 103-138, 103-332, 104-134, 104-208, 105-83, 105-277, 106-113, 106-291, 107-63, 108-7, 108-108, 108-447, 109-54, 109-289, division B and Continuing Appropriations Resolution, 2007 (division B of Public Law 109-289, as amended by Public Law 110-5 and 110-28), Public Laws 110-92, 110-116, 110-137, 110-149, 110-161, 110-329, 111-6, 111-8, and 111-88, 112-10, 112-74 and _____ for payments for contract support costs associated with self-determination or self-governance contracts, grants, compacts, or annual funding agreements with the Bureau of Indian Affairs or the Indian Health Service as funded by such Acts, are the total amounts available for fiscal years 1994 through **[**2012**]** *2014* for such purposes, except that for the Bureau of Indian Affairs, tribes and tribal organizations may use their tribal priority allocations for unmet contract support costs of ongoing contracts, grants, self-governance compacts or annual funding agreements.	the funds available in law and accompanying the report language in those years for the Bureau of Indian Affairs and Indian Health Service. While recognizing that Indian tribes have the right to recover the full amount of contract support costs (CSC) incurred under their Indian Self-Determination and Education Assistance Act (ISDEAA) contracts, the Supreme Court also held that the "not to exceed language" in the annual appropriations "prevents the Secretary from reprogramming other funds to pay [CSC]." *Salazar v. Ramah Navajo Chapter*, -- U.S. ---, 132 S. Ct. 2181, 2192 (2012). Thus, the benefit of such language is to ensure that the agency's lump-sum appropriation, which is used for purposes such as direct services or contract health services in the case of the Indian Health Service, are not used to pay CSC. The "not to exceed" language at issue in *Ramah* protects against the use of other funds from the lump sum appropriation for CSC payments toward contracts in the fiscal year covered by the annual appropriations act. The general provision, on the other hand, protects against the use of other funds from the lump sum appropriation for payments toward contract *claims* for underpayment of CSC in prior years. *See, e.g.*, Pub. L. No. 112-74, tit. IV, sec. 408, 125 Stat. 1038-39. Generally, a contract claim under the Contract Disputes Act is payable from the agency's appropriation that is current at the time of the claim award. *See, e.g.*, General Accounting Office, III Principles of Federal Appropriations Law 12-32, 12-78 (2nd ed. 1994) (II GAO Redbook). In the case of CSC, the general provision prohibits the use of the current appropriation to pay claims for underfunding of CSC in prior years. As a result, the agencies can deny payment due to lack of available appropriations in order allow the tribes to appeal their claims to the Civilian Board of Contract Appeals or to Federal

	court, at which time the Judgment Fund is available to pay the claims. 41 U.S.C. 7108(a), II GAO Redbook 12-78; *see also Ramah*, 132 S. Ct. at 2185. Without the general provision, the Indian Health Service could be required to pay claim awards from its current appropriations.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
SERVICES

Amounts Available for Obligations

	FY 2012	FY 2013	FY 2014
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$3,400,184,000	$3,415,522,000	$3,505,293,000
Across-the-board reductions (Interior)	($5,440,000)	$0	$0
Subtotal, Appropriation (Interior)	$3,394,744,000	$3,415,522,000	$3,505,293,000
Subtotal, adjusted appropriation	$3,394,744,000	$3,415,522,000	$3,505,293,000
Mandatory Appropriation:			
Appropriation	$150,000,000	$150,000,000	$150,000,000
Offsetting Collections:			
Federal sources	($324,000,000)	($368,000,000)	($368,000,000)
Non-federal sources	($823,000,000)	($797,000,000)	($797,000,000)
Subtotal	($1,147,000,000)	($1,165,000,000)	($1,165,000,000)
Unobligated Balance, Discrentionary, Start of Year	700,296,197	513,738,924	510,000,000
Unobligated Balance, Mandatory, Start of Year	44,703,803	46,261,076	--
Unobligated Balance End of Year	560,000,000	510,000,000	575,000,000
Total Obligations	$2,432,744,000	$2,300,522,000	$2,275,293,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
CONTRACT SUPPORT COSTS

Amounts Available for Obligations

	FY 2012	FY 2013	FY 2014
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$472,193,000	$474,322,000	$477,205,000
Across-the-board reductions (Interior)	($756,000)	$0	$0
Subtotal, Appropriation (Interior)	$471,437,000	$474,322,000	$477,205,000
Subtotal, adjusted appropriation	$471,437,000	$474,322,000	$477,205,000
Total Obligations	$471,437,000	$474,322,000	$477,205,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FACILITIES

Amounts Available for Obligations

	FY 2012	FY 2013	FY 2014
General Fund Discretionary Appropriation:			
Appropriation (Interior)	$441,052,000	$443,502,000	$448,139,000
Across-the-board reductions (Interior)	($706,000)	$0	$0
Subtotal, Appropriation (Interior)	$440,346,000	$443,502,000	$448,139,000
Subtotal, adjusted appropriation	$440,346,000	$443,502,000	$448,139,000
Offsetting Collections:			
Federal sources	($18,000,000)	($6,000,000)	($6,000,000)
Subtotal	($18,000,000)	($6,000,000)	($6,000,000)
Unobligated Balance, Start of Year	216,000,000	167,000,000	115,000,000
Unobligated Balance End of Year	167,000,000	115,000,000	90,000,000
Total Obligations	$471,346,000	$489,502,000	$467,139,000

INDIAN HEALTH SERVICE

SERVICES

Summary of Changes

FY 2012 Enacted	$3,394,744,000
Total estimated budget authority	3,394,744,000
Less Obligations	(3,394,744,000)
FY 2014 Estimate	3,505,293,000
Less Obligations	(3,505,293,000)
Net Change	110,549,000
Less Obligations	(110,549,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2014 Pay Raise CO (9months)	--	n/a	--	460,000
3	Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2014 Pay Raise CS (9months)	--	n/a	--	1,863,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	3,111,000
7	Increased Cost of Travel	--	43,080,000	--	1,621,000
8	Increased Cost of Transportation & Things	--	6,714,000	--	116,000
9	Increased Cost of Printing	--	209,000	--	4,000
10	Increased Cost of Rents, Communications, & Utilities	--	21,453,000	--	472,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	518,316,000	--	19,426,000
12	Increased Cost of Supplies	--	107,362,000	--	4,262,000
13	Increased Cost of Medical or other Equipment	--	11,244,000	--	351,000
14	Increased Cost of Land & Structure	--	31,000	--	35,000
15	Increased Cost of Grants	--	1,944,661,000	--	41,428,000
16	Increased Cost of Insurance / Indemnities	--	406,000	--	21,000
17	Increased Cost of Interest / Dividends	--	38,000	--	1,000
18	Population Growth	--	n/a	--	64,229,000
	Subtotal, Built-In	--	2,653,514,000	--	137,400,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	568	70,115,000
C. Program Increases		--	0	--	0
TOTAL INCREASES		--	2,653,514,000	568	207,515,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(96,966,000)
TOTAL DECREASES		--	0	--	(96,966,000)
NET CHANGE		--	**$2,653,514,000**	**568**	**$110,549,000**

INDIAN HEALTH SERVICE
CLINICAL Services
Summary of Changes

FY 2012 Enacted	$3,083,867,000
Total estimated budget authority	3,083,867,000
Less Obligations	(3,083,867,000)
FY 2014 Estimate	3,188,708,000
Less Obligations	(3,188,708,000)
Net Change	104,841,000
Less Obligations	(104,841,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2014 Pay Raise CO (9months)	--	n/a	--	410,000
3	Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2014 Pay Raise CS (9months)	--	n/a	--	1,630,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	2,769,000
7	Increased Cost of Travel	--	41,586,000	--	1,585,000
8	Increased Cost of Transportation & Things	--	5,488,000	--	98,000
9	Increased Cost of Printing	--	195,000	--	4,000
10	Increased Cost of Rents, Communications, & Utilities	--	20,606,000	--	446,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	499,566,000	--	18,987,000
12	Increased Cost of Supplies	--	104,501,000	--	4,148,000
13	Increased Cost of Medical or other Equipment	--	9,302,000	--	328,000
14	Increased Cost of Land & Structure	--	31,000	--	0
15	Increased Cost of Grants	--	1,735,884,000	--	38,270,000
16	Increased Cost of Insurance / Indemnities	--	383,000	--	21,000
17	Increased Cost of Interest / Dividends	--	38,000	--	1,000
18	Population Growth	--	n/a	--	60,547,000
	Subtotal, Built-In	--	2,417,580,000	--	129,244,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	527	65,032,000
C. Health IT		--	0	--	0
D. PRC		--	0	--	0
	TOTAL INCREASES	--	2,417,580,000	527	194,276,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(89,435,000)
	TOTAL DECREASES	--	0	--	(89,435,000)
NET CHANGE		--	**$2,417,580,000**	**527**	**$104,841,000**

INDIAN HEALTH SERVICE
Hospitals & Health Clinics
Summary of Changes

FY 2012 Enacted	$1,810,966,000
Total estimated budget authority	1,810,966,000
Less Obligations	(1,810,966,000)
FY 2014 Estimate	1,865,630,000
Less Obligations	(1,865,630,000)
Net Change	54,664,000
Less Obligations	(54,664,000)

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	329,000
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	1,334,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	2,131,000
7 Increased Cost of Travel	--	5,497,000	--	118,000
8 Increased Cost of Transportation & Things	--	4,774,000	--	89,000
9 Increased Cost of Printing	--	181,000	--	4,000
10 Increased Cost of Rents, Communications, & Utilities	--	20,214,000	--	436,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	150,109,000	--	4,603,000
12 Increased Cost of Supplies	--	86,302,000	--	3,354,000
13 Increased Cost of Medical or other Equipment	--	6,010,000	--	214,000
14 Increased Cost of Land & Structure	--	31,000	--	0
15 Increased Cost of Grants	--	976,282,000	--	14,551,000
16 Increased Cost of Insurance / Indemnities	--	286,000	--	21,000
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	35,137,000
Subtotal, Built-In	--	1,249,686,000	--	62,321,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	401	50,870,000
C. Health IT	--	0	--	0
TOTAL INCREASES	--	1,249,686,000	401	113,191,000
DECREASES				
A. Built-In				
Absoprtion of Built-In Increases	--	0	--	(58,527,000)
TOTAL DECREASES	--	0	--	(58,527,000)
NET CHANGE	--	**$1,249,686,000**	**401**	**$54,664,000**

INDIAN HEALTH SERVICE

Dental Health

Summary of Changes

FY 2012 Enacted	$159,440,000
Total estimated budget authority	159,440,000
Less Obligations	(159,440,000)
FY 2014 Estimate	168,225,000
Less Obligations	(168,225,000)
Net Change	8,785,000
Less Obligations	(8,785,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2014 Pay Raise CO (9months)	--	n/a	--	67,000
3	Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2014 Pay Raise CS (9months)	--	n/a	--	172,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	176,000
7	Increased Cost of Travel	--	582,000	--	12,000
8	Increased Cost of Transportation & Things	--	346,000	--	4,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	160,000	--	5,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	6,467,000	--	296,000
12	Increased Cost of Supplies	--	4,904,000	--	218,000
13	Increased Cost of Medical or other Equipment	--	756,000	--	25,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	79,970,000	--	1,191,000
16	Increased Cost of Insurance / Indemnities	--	5,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	3,160,000
	Subtotal, Built-In	--	93,190,000	--	5,326,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	72	8,370,000
C. Health IT		--	0	--	0
TOTAL INCREASES		--	93,190,000	72	13,696,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(4,911,000)
TOTAL DECREASES		--	0	--	(4,911,000)
NET CHANGE		--	**$93,190,000**	**72**	**$8,785,000**

INDIAN HEALTH SERVICE
Mental Health
Summary of Changes

FY 2012 Enacted	$75,589,000
Total estimated budget authority	75,589,000
Less Obligations	(75,589,000)
FY 2014 Estimate	79,873,000
Less Obligations	(79,873,000)
Net Change	4,284,000
Less Obligations	(4,284,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2014 Pay Raise CO (9months)	--	n/a	--	7,000
3	Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2014 Pay Raise CS (9months)	--	n/a	--	78,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	100,000
7	Increased Cost of Travel	--	409,000	--	5,000
8	Increased Cost of Transportation & Things	--	229,000	--	4,000
9	Increased Cost of Printing	--	5,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	34,000	--	2,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	4,522,000	--	164,000
12	Increased Cost of Supplies	--	1,392,000	--	32,000
13	Increased Cost of Medical or other Equipment	--	192,000	--	4,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	45,020,000	--	678,000
16	Increased Cost of Insurance / Indemnities	--	90,000	--	0
17	Increased Cost of Interest / Dividends	--		--	0
18	Population Growth	--	n/a	--	1,484,000
	Subtotal, Built-In	--	51,893,000	--	2,558,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	38	4,099,000
	TOTAL INCREASES	--	51,893,000	38	6,657,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(2,373,000)
	TOTAL DECREASES	--	0	--	(2,373,000)
NET CHANGE		--	**$51,893,000**	**38**	**$4,284,000**

INDIAN HEALTH SERVICE
Alcohol and Substance Abuse
Summary of Changes

FY 2012 Enacted	$194,297,000
Total estimated budget authority	194,297,000
Less Obligations	(194,297,000)
FY 2014 Estimate	196,405,000
Less Obligations	(196,405,000)
Net Change	2,108,000
Less Obligations	(2,108,000)

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	7,000
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	46,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	362,000
7 Increased Cost of Travel	--	276,000	--	4,000
8 Increased Cost of Transportation & Things	--	129,000	--	1,000
9 Increased Cost of Printing	--	9,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	119,000	--	2,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	8,837,000	--	254,000
12 Increased Cost of Supplies	--	816,000	--	84,000
13 Increased Cost of Medical or other Equipment	--	457,000	--	6,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	168,822,000	--	2,507,000
16 Increased Cost of Insurance / Indemnities	--	2,000	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	3,712,000
Subtotal, Built-In	--	179,467,000	--	6,985,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	16	1,693,000
TOTAL INCREASES	--	179,467,000	16	8,678,000
DECREASES				
A. Built-In				
Absoprtion of Built-In Increases	--	0	--	(6,570,000)
TOTAL DECREASES	--	0	--	(6,570,000)
NET CHANGE	--	**$179,467,000**	**16**	**$2,108,000**

INDIAN HEALTH SERVICE
Purchased/Referred Care
Summary of Changes

FY 2012 Enacted	$843,575,000
Total estimated budget authority	843,575,000
Less Obligations	(843,575,000)
FY 2014 Estimate	878,575,000
Less Obligations	(878,575,000)
Net Change	35,000,000
Less Obligations	(35,000,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2014 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2014 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	34,822,000	--	1,446,000
8	Increased Cost of Transportation & Things	--	10,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	79,000	--	1,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	329,631,000	--	13,670,000
12	Increased Cost of Supplies	--	11,087,000	--	460,000
13	Increased Cost of Medical or other Equipment	--	1,887,000	--	79,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	465,790,000	--	19,343,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	38,000	--	1,000
18	Population Growth	--	n/a	--	17,054,000
	Subtotal, Built-In	--	843,344,000	--	52,054,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C. PRC		--	0	--	0
	TOTAL INCREASES	--	843,344,000	--	52,054,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(17,054,000)
	TOTAL DECREASES	--	0	--	(17,054,000)
NET CHANGE		--	**$843,344,000**	**--**	**$35,000,000**

INDIAN HEALTH SERVICE
PREVENTIVE Health
Summary of Changes

FY 2012 Enacted	$147,023,000
Total estimated budget authority	147,023,000
Less Obligations	(147,023,000)
FY 2014 Estimate	152,463,000
Less Obligations	(152,463,000)
Net Change	5,440,000
Less Obligations	(5,440,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2014 Pay Raise CO (9months)	--	n/a	--	24,000
3	Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2014 Pay Raise CS (9months)	--	n/a	--	93,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	240,000
7	Increased Cost of Travel	--	187,000	--	7,000
8	Increased Cost of Transportation & Things	--	977,000	--	16,000
9	Increased Cost of Printing	--	13,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	113,000	--	1,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	2,856,000	--	95,000
12	Increased Cost of Supplies	--	2,464,000	--	99,000
13	Increased Cost of Medical or other Equipment	--	467,000	--	9,000
14	Increased Cost of Land & Structure	--	0	--	35,000
15	Increased Cost of Grants	--	111,440,000	--	1,571,000
16	Increased Cost of Insurance / Indemnities	--	1,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	2,865,000
	Subtotal, Built-In	--	118,518,000	--	5,055,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	41	5,083,000
	TOTAL INCREASES	--	118,518,000	41	10,138,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(4,698,000)
	TOTAL DECREASES	--	0	--	(4,698,000)
NET CHANGE		--	**$118,518,000**	**41**	**$5,440,000**

INDIAN HEALTH SERVICE
Public Health Nursing
Summary of Changes

FY 2012 Enacted	$66,632,000
Total estimated budget authority	66,632,000
Less Obligations	(66,632,000)
FY 2014 Estimate	71,194,000
Less Obligations	(71,194,000)
Net Change	4,562,000
Less Obligations	(4,562,000)

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	22,000
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	81,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	76,000
7 Increased Cost of Travel	--	110,000	--	4,000
8 Increased Cost of Transportation & Things	--	930,000	--	15,000
9 Increased Cost of Printing	--	12,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	82,000	--	1,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	1,552,000	--	53,000
12 Increased Cost of Supplies	--	2,030,000	--	64,000
13 Increased Cost of Medical or other Equipment	--	379,000	--	5,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	36,754,000	--	503,000
16 Increased Cost of Insurance / Indemnities	--	1,000	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	1,327,000
Subtotal, Built-In	--	41,850,000	--	2,151,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	33	4,383,000
TOTAL INCREASES	--	41,850,000	33	6,534,000
DECREASES				
A. Built-In				
Absoprtion of Built-In Increases	--	0	--	(1,972,000)
TOTAL DECREASES	--	0	--	(1,972,000)
NET CHANGE	--	**$41,850,000**	**33**	**$4,562,000**

INDIAN HEALTH SERVICE
Health Education
Summary of Changes

FY 2012 Enacted	$17,057,000
Total estimated budget authority	17,057,000
Less Obligations	(17,057,000)
FY 2014 Estimate	17,677,000
Less Obligations	(17,677,000)
Net Change	620,000
Less Obligations	(620,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2014 Pay Raise CO (9months)	--	n/a	--	1,000
3	Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2014 Pay Raise CS (9months)	--	n/a	--	11,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	28,000
7	Increased Cost of Travel	--	73,000	--	2,000
8	Increased Cost of Transportation & Things	--	32,000	--	1,000
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	29,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	741,000	--	11,000
12	Increased Cost of Supplies	--	418,000	--	27,000
13	Increased Cost of Medical or other Equipment	--	78,000	--	3,000
14	Increased Cost of Land & Structure	--	0	--	6,000
15	Increased Cost of Grants	--	12,500,000	--	187,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	332,000
	Subtotal, Built-In	--	13,871,000	--	609,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	6	580,000
	TOTAL INCREASES	--	13,871,000	6	1,189,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(569,000)
	TOTAL DECREASES	--	0	--	(569,000)
NET CHANGE		--	**$13,871,000**	**6**	**$620,000**

INDIAN HEALTH SERVICE
Community Health Representatives
Summary of Changes

FY 2012 Enacted	$61,407,000
Total estimated budget authority	61,407,000
Less Obligations	(61,407,000)
FY 2014 Estimate	61,661,000
Less Obligations	(61,661,000)
Net Change	254,000
Less Obligations	(254,000)

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	1,000
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	1,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	132,000
7 Increased Cost of Travel	--	4,000	--	1,000
8 Increased Cost of Transportation & Things	--	15,000	--	0
9 Increased Cost of Printing	--	1,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	2,000	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	563,000	--	31,000
12 Increased Cost of Supplies	--	16,000	--	8,000
13 Increased Cost of Medical or other Equipment	--	10,000	--	1,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	60,259,000	--	881,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	1,169,000
Subtotal, Built-In	--	60,870,000	--	2,225,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	2	120,000
TOTAL INCREASES	--	60,870,000	2	2,345,000
DECREASES				
A. Built-In				
Absoprtion of Built-In Increases	--	0	--	(2,091,000)
TOTAL DECREASES	--	0	--	(2,091,000)
NET CHANGE	--	**$60,870,000**	**2**	**$254,000**

INDIAN HEALTH SERVICE
Immunization AK
Summary of Changes

FY 2012 Enacted	$1,927,000
Total estimated budget authority	1,927,000
Less Obligations	(1,927,000)
FY 2014 Estimate	1,931,000
Less Obligations	(1,931,000)
Net Change	4,000
Less Obligations	(4,000)

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	0
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	4,000
7 Increased Cost of Travel	--	0	--	0
8 Increased Cost of Transportation & Things	--	0	--	0
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12 Increased Cost of Supplies	--	0	--	0
13 Increased Cost of Medical or other Equipment	--	0	--	0
14 Increased Cost of Land & Structure	--	0	--	29,000
15 Increased Cost of Grants	--	1,927,000	--	0
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	37,000
Subtotal, Built-In	--	1,927,000	--	70,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	--	0
TOTAL INCREASES	--	1,927,000	--	70,000
DECREASES				
A. Built-In				
Absoprtion of Built-In Increases	--	0	--	(66,000)
TOTAL DECREASES	--	0	--	(66,000)
NET CHANGE	--	**$1,927,000**	--	**$4,000**

INDIAN HEALTH SERVICE
OTHER Services
Summary of Changes

FY 2012 Enacted	$163,854,000
Total estimated budget authority	163,854,000
Less Obligations	(163,854,000)
FY 2014 Estimate	164,122,000
Less Obligations	(164,122,000)
Net Change	268,000
Less Obligations	(268,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2014 Pay Raise CO (9months)	--	n/a	--	26,000
3	Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2014 Pay Raise CS (9months)	--	n/a	--	140,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	102,000
7	Increased Cost of Travel	--	1,307,000	--	29,000
8	Increased Cost of Transportation & Things	--	249,000	--	2,000
9	Increased Cost of Printing	--	1,000	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	734,000	--	25,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	15,894,000	--	344,000
12	Increased Cost of Supplies	--	397,000	--	15,000
13	Increased Cost of Medical or other Equipment	--	1,475,000	--	14,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	97,337,000	--	1,587,000
16	Increased Cost of Insurance / Indemnities	--	22,000	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	817,000
	Subtotal, Built-In	--	117,416,000	--	3,101,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
C, Direct Operations		--	0	--	0
	TOTAL INCREASES	--	117,416,000	--	3,101,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(2,833,000)
	TOTAL DECREASES	--	0	--	(2,833,000)
NET CHANGE		--	**$117,416,000**	--	**$268,000**

INDIAN HEALTH SERVICE
Urban Indian Health
Summary of Changes

FY 2012 Enacted	$42,984,000
Total estimated budget authority	42,984,000
Less Obligations	(42,984,000)
FY 2014 Estimate	43,049,000
Less Obligations	(43,049,000)
Net Change	65,000
Less Obligations	(65,000)

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	1,000
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	4,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	60,000
7 Increased Cost of Travel	--	102,000	--	2,000
8 Increased Cost of Transportation & Things	--	6,000	--	0
9 Increased Cost of Printing	--	1,000	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	35,000	--	5,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	6,293,000	--	92,000
12 Increased Cost of Supplies	--	243,000	--	4,000
13 Increased Cost of Medical or other Equipment	--	183,000	--	1,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	34,853,000	--	543,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	817,000
Subtotal, Built-In	--	41,716,000	--	1,529,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	--	0
TOTAL INCREASES	--	41,716,000	--	1,529,000
DECREASES				
A. Built-In				
Absoprtion of Built-In Increases	--	0	--	(1,464,000)
TOTAL DECREASES	--	0	--	(1,464,000)
NET CHANGE	--	**$41,716,000**	--	**$65,000**

INDIAN HEALTH SERVICE
Indian Health Professions
Summary of Changes

FY 2012 Enacted	$40,596,000
Total estimated budget authority	40,596,000
Less Obligations	(40,596,000)
FY 2014 Estimate	40,602,000
Less Obligations	(40,602,000)
Net Change	6,000
Less Obligations	(6,000)

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	1,000
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	5,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	0
7 Increased Cost of Travel	--	34,000	--	1,000
8 Increased Cost of Transportation & Things	--	0	--	0
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	37,000	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	966,000	--	119,000
12 Increased Cost of Supplies	--	7,000	--	0
13 Increased Cost of Medical or other Equipment	--	0	--	3,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	38,088,000	--	537,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	0
Subtotal, Built-In	--	39,132,000	--	666,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	--	0
TOTAL INCREASES	--	39,132,000	--	666,000
DECREASES				
A. Built-In				
Absoprtion of Built-In Increases	--	0	--	(660,000)
TOTAL DECREASES	--	0	--	(660,000)
NET CHANGE	--	**$39,132,000**	**--**	**$6,000**

INDIAN HEALTH SERVICE
Tribal Management
Summary of Changes

FY 2012 Enacted	$2,577,000
Total estimated budget authority	2,577,000
Less Obligations	(2,577,000)
FY 2014 Estimate	2,577,000
Less Obligations	(2,577,000)
Net Change	0
Less Obligations	0

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	0
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	0
7 Increased Cost of Travel	--	0	--	0
8 Increased Cost of Transportation & Things	--	0	--	0
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	0	--	0
12 Increased Cost of Supplies	--	1,000	--	0
13 Increased Cost of Medical or other Equipment	--	1,000	--	0
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	2,575,000	--	91,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	0
Subtotal, Built-In	--	2,577,000	--	91,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	--	0
TOTAL INCREASES	--	2,577,000	--	91,000
DECREASES				
A. Built-In				
Absoprtion of Built-In Increases	--	0	--	(91,000)
TOTAL DECREASES	--	0	--	(91,000)
NET CHANGE	--	**$2,577,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Direct Operations
Summary of Changes

FY 2012 Enacted	$71,653,000
Total estimated budget authority	71,653,000
Less Obligations	(71,653,000)
FY 2014 Estimate	71,845,000
Less Obligations	(71,845,000)
Net Change	192,000
Less Obligations	(192,000)

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	24,000
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	126,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	42,000
7 Increased Cost of Travel	--	1,077,000	--	24,000
8 Increased Cost of Transportation & Things	--	238,000	--	2,000
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	646,000	--	20,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	7,376,000	--	115,000
12 Increased Cost of Supplies	--	138,000	--	11,000
13 Increased Cost of Medical or other Equipment	--	1,291,000	--	8,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	19,073,000	--	304,000
16 Increased Cost of Insurance / Indemnities	--	22,000	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	0
Subtotal, Built-In	--	29,861,000	--	676,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	--	0
C, Direct Operations	--	0	--	0
TOTAL INCREASES	--	29,861,000	--	676,000
DECREASES				
A. Built-In				
Absoprtion of Built-In Increases	--	0	--	(484,000)
TOTAL DECREASES	--	0	--	(484,000)
NET CHANGE	--	**$29,861,000**	**--**	**$192,000**

INDIAN HEALTH SERVICE
Self-Governance
Summary of Changes

FY 2012 Enacted	$6,044,000
Total estimated budget authority	6,044,000
Less Obligations	(6,044,000)
FY 2014 Estimate	6,049,000
Less Obligations	(6,049,000)
Net Change	5,000
Less Obligations	(5,000)

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2014 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2014 Pay Raise CS (9months)	--	n/a	--	5,000
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	94,000	--	2,000
8	Increased Cost of Transportation & Things	--	5,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilities	--	16,000	--	0
11	Increased Cost of Health Care Provided under Contracts & Grants	--	1,259,000	--	18,000
12	Increased Cost of Supplies	--	8,000	--	0
13	Increased Cost of Medical or other Equipment	--	0	--	2,000
14	Increased Cost of Land & Structure	--	0	--	0
15	Increased Cost of Grants	--	2,748,000	--	112,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Population Growth	--	n/a	--	0
	Subtotal, Built-In	--	4,130,000	--	139,000
B. Phasing-In of Staff & Operating Cost of New Facilities:		--	0	--	0
	TOTAL INCREASES	--	4,130,000	--	139,000
DECREASES					
A. Built-In					
	Absoprtion of Built-In Increases	--	0	--	(134,000)
	TOTAL DECREASES	--	0	--	(134,000)
NET CHANGE		--	**$4,130,000**	**--**	**$5,000**

INDIAN HEALTH SERVICE

CONTRACT SUPPORT COSTS

Summary of Changes

FY 2012 Enacted	$471,437,000
Total estimated budget authority	471,437,000
Less Obligations	(471,437,000)
FY 2014 Estimate	477,205,000
Less Obligations	(477,205,000)
Net Change	5,768,000
Less Obligations	(5,768,000)

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	0
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	0
7 Increased Cost of Travel	--	0	--	0
8 Increased Cost of Transportation & Things	--	1,000	--	0
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilities	--	0	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	289,000	--	0
12 Increased Cost of Supplies	--	52,000	--	0
13 Increased Cost of Medical or other Equipment	--	0	--	0
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	471,095,000	--	8,020,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Population Growth	--	n/a	--	0
Subtotal, Built-In	--	471,437,000	--	8,020,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	--	0
C. Contract Support Costs	--	0	--	5,768,000
TOTAL INCREASES	--	471,437,000	--	13,788,000
DECREASES				
A. Built-In				
Absoprtion of Built-In Increases	--	0	--	(8,020,000)
TOTAL DECREASES	--	0	--	(8,020,000)
NET CHANGE	**--**	**$471,437,000**	**--**	**$5,768,000**

INDIAN HEALTH SERVICE

FACILITIES

Summary of Changes

FY 2012 Enacted	$440,346,000
Total budget authority	440,346,000
Less Obligations	(440,346,000)
FY 2014 Estimate	448,139,000
Less Obligations	(448,139,000)
Net Change	7,793,000
Less Obligations	(7,793,000)

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	125,000
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	252,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	188,000
7 Increased Cost of Travel	--	2,374,000	--	40,000
8 Increased Cost of Transportation & Things	--	4,101,000	--	47,000
9 Increased Cost of Printing	--	56,000	--	0
10 Increased Cost of Rents, Communications, & Utilties	--	16,230,000	--	308,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	88,155,000	--	1,115,000
12 Increased Cost of Supplies	--	6,570,000	--	136,000
13 Increased Cost of Medical or other Equipment	--	12,455,000	--	274,000
14 Increased Cost of Land & Structure	--	41,291,000	--	271,000
15 Increased Cost of Grants	--	176,221,000	--	3,985,000
16 Increased Cost of Insurance / Indemnities	--	7,000	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Increased Cost of Service & Supply Fund	--	0	--	0
19 Population Growth	--	n/a	--	6,883,000
Subtotal, Built-In	--	347,460,000	--	13,624,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	32	7,228,000
C. Program Increases	--	0	--	0
TOTAL INCREASES	--	347,460,000		20,852,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(13,059,000)
B. Base Funding Reduction	--	0	--	0
TOTAL DECREASES	--	0	--	(13,059,000)
NET CHANGE	**--**	**$347,460,000**	**32**	**$7,793,000**

INDIAN HEALTH SERVICE

Maintenance & Improvement

Summary of Changes

FY 2012 Enacted	$53,721,000
Total budget authority	53,721,000
Less Obligations	(53,721,000)
FY 2014 Estimate	53,721,000
Less Obligations	(53,721,000)
Net Change	0
Less Obligations	0

		FY 2012 Enacted Base		Change from Base	
		FTE	BA	FTE	BA
INCREASES					
A. Built-In:					
1	Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2	FY 2014 Pay Raise CO (9months)	--	n/a	--	0
3	Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4	FY 2014 Pay Raise CS (9months)	--	n/a	--	0
5	One Days Pay	--	n/a	--	0
6	Tribal Pay Cost	--	n/a	--	0
7	Increased Cost of Travel	--	19,000	--	1,000
8	Increased Cost of Transportation & Things	--	18,000	--	0
9	Increased Cost of Printing	--	0	--	0
10	Increased Cost of Rents, Communications, & Utilties	--	500,000	--	8,000
11	Increased Cost of Health Care Provided under Contracts & Grants	--	16,031,000	--	213,000
12	Increased Cost of Supplies	--	3,145,000	--	80,000
13	Increased Cost of Medical or other Equipment	--	703,000	--	7,000
14	Increased Cost of Land & Structure	--	5,384,000	--	67,000
15	Increased Cost of Grants	--	27,921,000	--	529,000
16	Increased Cost of Insurance / Indemnities	--	0	--	0
17	Increased Cost of Interest / Dividends	--	0	--	0
18	Increased Cost of Service & Supply Fund	--	0	--	0
19	Population Growth	--	0	--	1,054,000
	Subtotal, Built-In	--	53,721,000	--	1,959,000
	TOTAL INCREASES	--	53,721,000	--	1,959,000
A.	Maintenance & Improvement	--	0	--	0
DECREASES					
A. Built-In					
	Absorption of Built-In Increases	--	0	--	(1,959,000)
	TOTAL DECREASES	--	0	--	(1,959,000)
NET CHANGE		**--**	**$53,721,000**	**--**	**$0**

INDIAN HEALTH SERVICE

Sanitation Facilities Construction

Summary of Changes

FY 2012 Enacted	$79,582,000
Total budget authority	79,582,000
Less Obligations	(79,582,000)
FY 2014 Estimate	79,582,000
Less Obligations	(79,582,000)
Net Change	0
Less Obligations	0

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	0
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	0
7 Increased Cost of Travel	--	91,000	--	1,000
8 Increased Cost of Transportation & Things	--	678,000	--	10,000
9 Increased Cost of Printing	--	4,000	--	0
10 Increased Cost of Rents, Communications, & Utilties	--	1,000	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	54,284,000	--	767,000
12 Increased Cost of Supplies	--	664,000	--	9,000
13 Increased Cost of Medical or other Equipment	--	90,000	--	6,000
14 Increased Cost of Land & Structure	--	1,691,000	--	0
15 Increased Cost of Grants	--	18,806,000	--	191,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Increased Cost of Service & Supply Fund	--	0	--	0
19 Population Growth	--	0	--	1,517,000
Subtotal, Built-In	--	76,309,000	--	2,501,000
TOTAL INCREASES	--	76,309,000	--	2,501,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(2,501,000)
TOTAL DECREASES	--	0	--	(2,501,000)
NET CHANGE	**--**	**$76,309,000**	**--**	**$0**

INDIAN HEALTH SERVICE
Health Care Facilities Construction
Summary of Changes

FY 2012 Enacted	$85,048,000
Total budget authority	85,048,000
Less Obligations	(85,048,000)
FY 2014 Estimate	85,048,000
Less Obligations	(85,048,000)
Net Change	0
Less Obligations	0

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a		0
5 One Days Pay	--	n/a		0
6 Tribal Pay Cost	--	n/a	--	0
7 Increased Cost of Travel	--	0	--	0
8 Increased Cost of Transportation & Things	--	0	--	0
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilties	--	0	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	363,000	--	17,000
12 Increased Cost of Supplies	--	0	--	0
13 Increased Cost of Medical or other Equipment	--	0	--	0
14 Increased Cost of Land & Structure	--	33,942,000	--	191,000
15 Increased Cost of Grants	--	50,743,000	--	1,095,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Increased Cost of Service & Supply Fund	--	0	--	0
19 Population Growth	--	0	--	0
Subtotal, Built-In	--	85,048,000	--	1,303,000
B. HCFC Increase	--	0	--	0
C. IHCIA Implementation	--	0	--	0
TOTAL INCREASES	--	85,048,000	--	1,303,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(1,303,000)
B. Base Funding Reduction	--	0	--	0
TOTAL DECREASES	--	0	--	(1,303,000)
NET CHANGE	**--**	**$85,048,000**	**--**	**$0**

INDIAN HEALTH SERVICE

Facilities & Environmental Health Support

Summary of Changes

FY 2012 Enacted	$199,413,000
Total budget authority	199,413,000
Less Obligations	(199,413,000)
FY 2014 Estimate	207,206,000
Less Obligations	(207,206,000)
Net Change	7,793,000
Less Obligations	(7,793,000)

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	125,000
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	252,000
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	188,000
7 Increased Cost of Travel	--	2,248,000	--	38,000
8 Increased Cost of Transportation & Things	--	3,374,000	--	37,000
9 Increased Cost of Printing	--	52,000	--	0
10 Increased Cost of Rents, Communications, & Utilties	--	15,677,000	--	300,000
11 Increased Cost of Health Care Provided under Contracts & Grants	--	16,345,000	--	116,000
12 Increased Cost of Supplies	--	2,669,000	--	45,000
13 Increased Cost of Medical or other Equipment	--	4,207,000	--	42,000
14 Increased Cost of Land & Structure	--	274,000	--	13,000
15 Increased Cost of Grants	--	64,947,000	--	1,590,000
16 Increased Cost of Insurance / Indemnities	--	7,000	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Increased Cost of Service & Supply Fund	--	0	--	0
19 Population Growth	--	n/a	--	3,883,000
Subtotal, Built-In	--	109,800,000	--	6,629,000
B. Phasing-In of Staff & Operating Cost of New Facilities:	--	0	32	7,228,000
TOTAL INCREASES	--	109,800,000	--	13,857,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(6,064,000)
B. Base Adjustment:	--	0	--	0
TOTAL DECREASES	--	0	--	(6,064,000)
NET CHANGE	**--**	**$109,800,000**	**32**	**$7,793,000**

INDIAN HEALTH SERVICE
Equipment
Summary of Changes

FY 2012 Enacted	$22,582,000
Total budget authority	22,582,000
Less Obligations	(22,582,000)
FY 2014 Estimate	22,582,000
Less Obligations	(22,582,000)
Net Change	0
Less Obligations	0

	FY 2012 Enacted Base		Change from Base	
	FTE	BA	FTE	BA
INCREASES				
A. Built-In:				
1 Annualization of FY 2013 CO Pay Raise (3months)	--	n/a	--	0
2 FY 2014 Pay Raise CO (9months)	--	n/a	--	0
3 Annualization of FY 2013 CS Pay Raise (3months)	--	n/a	--	0
4 FY 2014 Pay Raise CS (9months)	--	n/a	--	0
5 One Days Pay	--	n/a	--	0
6 Tribal Pay Cost	--	n/a	--	0
7 Increased Cost of Travel	--	16,000	--	0
8 Increased Cost of Transportation & Things	--	31,000	--	0
9 Increased Cost of Printing	--	0	--	0
10 Increased Cost of Rents, Communications, & Utilties	--	52,000	--	0
11 Increased Cost of Health Care Provided under Contracts & Grants	--	1,132,000	--	2,000
12 Increased Cost of Supplies	--	92,000	--	2,000
13 Increased Cost of Medical or other Equipment	--	7,455,000	--	219,000
14 Increased Cost of Land & Structure	--	0	--	0
15 Increased Cost of Grants	--	13,804,000	--	580,000
16 Increased Cost of Insurance / Indemnities	--	0	--	0
17 Increased Cost of Interest / Dividends	--	0	--	0
18 Increased Cost of Service & Supply Fund	--	0	--	0
19 Population Growth	--	0	--	429,000
Subtotal, Built-In	--	22,582,000	--	1,232,000
TOTAL INCREASES	--	22,582,000	--	1,232,000
DECREASES				
A. Built-In				
Absorption of Built-In Increases	--	0	--	(1,232,000)
B. Base Funding Reduction	--	0	--	0
TOTAL DECREASES	--	0	--	(1,232,000)
NET CHANGE	**--**	**$22,582,000**	**--**	**$0**

INDIAN HEALTH SERVICE

Budget Authority by Activity

(Dollars in Thousands)

	2012 Enacted		2013 Cont. Resolution		2014 Request	
	FTE	Amount	FTE	Amount	FTE	Amount
SERVICES:						
Hospitals & Health Clinics	6,387	$1,810,966	6,520	$1,822,049	6,520	$1,865,630
Dental Services	699	159,440	699	160,416	699	168,225
Mental Health	216	75,589	216	76,052	216	79,873
Alcohol & Substance Abuse	189	194,297	189	195,486	189	196,405
Contract Health Services	0	843,575	0	848,739	0	878,575
Total, Clinical Services	7,491	3,083,867	7,624	3,102,742	7,624	3,188,708
Public Health Nursing	241	66,632	241	67,040	241	71,194
Health Education	26	17,057	26	17,161	26	17,677
Comm. Health Reps.	7	61,407	7	61,783	7	61,661
Immunization AK	0	1,927	0	1,939	0	1,931
Total, Preventive Health	274	147,023	274	147,923	274	152,463
Urban Health	6	42,984	6	43,247	6	43,049
Indian Health Professions	26	40,596	26	40,844	26	40,602
Tribal Management	0	2,577	0	2,593	0	2,577
Direct Operations	290	71,653	290	72,092	290	71,845
Self-Governance	11	6,044	11	6,081	11	6,049
Total, Other services	333	163,854	333	164,857	333	164,122
Total, Services	8,098	3,394,744	8,231	3,415,522	8,231	3,505,293
CONTRACT SUPPORT COSTS:						
Total, Contract Support Costs	0	471,437	0	474,322	0	477,205
FACILITIES:						
Maintenance & Improvement	0	53,721	0	54,050	0	53,721
Sanitation Facilities Constr.	156	79,582	156	80,069	156	79,582
Health Care Facs. Constr.	0	85,048	0	85,568	0	85,048
Facil. & Envir. Health Supp.	1,035	199,413	1,035	200,633	1,035	207,206
Equipment	0	22,582	0	22,720	0	22,582
Total, Facilities	1,191	440,346	1,191	443,040	1,191	448,139
Total IHS	9,289	$4,306,527	9,422	$4,332,884	9,422	$ 4,430,637

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

INDIAN HEALTH SERVICE

Authorizing Legislation

(Dollars in Thousands)

March 22, 2013

	FY 2012		FY 2013		FY 2014	
	Amount Authorized	Enacted	Amount Authorized	Budget Request	Amount Authorized	Budget Request
1. Services Appropriation:	3,866,181	3,866,181	3,889,844	3,978,974	3,505,293	3,505,293
Snyder Act, 25 U.S.C. 13.						
Transfer Act (P.L. 83-568), 42 U.S.C. 2001.						
Indian Health Care Improvement Act (IHCIA) (P.L. 94-437), as amended (most recently amended by the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), § 10221, 124 Stat. 119, 935 (2010)), 25 U.S.C. 1601 *et seq.*						
Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.*						
Public Health Service Act, titles II & III, as amended, 25 U.S.C. 201-280m.						
2. Contract Support Costs Appropriation:					477,205	477,205
Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.*						
3. Facilities Appropriation:	440,346	440,346	443,040	443,502	448,139	448,139
Indian Sanitation Facilities Act (P.L. 86-121), as amended, 42 U.S.C. 2004a.						
IHCIA, title III, as amended, 25 U.S.C. 1631-1638g.						
ISDEAA, sec. 102 & 509, as amended, 25 U.S.C. 450f & 458aaa-8.						
5 U.S.C. 5911 note (Quarters Rent Funds).	7,500	7,500	7,500	7,500	7,500	7,500
4. Public and Private Collections:	954,052	954,052	973,538	921,717	1,073,538	1,073,538
IHCIA sec. 206, 25 U.S.C. 1621e.						
Social Security Act, sec. 1880 & 1911, 42 U.S.C. 1395qq & 1396j.						
5. Special Diabetes Program for Indians:	150,000	150,000	150,000	150,000	150,000	150,000
42 U.S.C. 245c-3.						
Unfunded authorizations:	0	0	0	0	0	0
Total appropriations:	5,418,079	5,418,079	5,463,922	5,501,693	5,661,675	5,661,675
Total appropriations against Definite authorizations:	5,418,079	5,418,079	5,463,922	5,501,693	5,661,675	5,661,675

INDIAN HEALTH SERVICE
Appropriation History Table
Services

March 22, 2013

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2005	$2,612,824,000	$2,627,918,000	$2,633,624,000	$2,632,667,000
Rescission (PL 108-447, Sec. 501)				($15,638,000)
Rescission (PL 108-447, Sec. 122)				($20,936,000)
2006	$2,732,298,000	$2,732,298,000	$2,732,323,000	$2,732,298,000
Rescission (PL 109-54)				($13,006,000)
Rescission (PL 109-148)				($27,192,000)
2007	$2,822,449,000	$2,830,085,000	$2,835,493,000	$2,818,871,000
2008	$2,931,530,000	$3,023,532,000	$2,991,924,000	$3,018,624,000
Rescission (PL 110-161)				($47,091,000)
2009 Omnibus	$2,971,533,000	-	-	$3,190,956,000
2009 ARRA (PL 111-5)	-	-	-	$85,000,000
2010	$3,639,868,000	$3,657,618,000	$3,639,868,000	$3,657,618,000
2011	$3,657,618,000	-	-	$3,672,618,000
Rescission (PL 112-10)				($7,345,000)
2012	$4,166,139,000	$4,034,322,000	-	$3,872,377,000
Recission (PL 112-74)				($6,195,804)
2013	$3,978,974,000	-	$ 3,914,599,000	-
Continuing Resolution				$3,889,844,000
2014	$3,505,293,000			

INDIAN HEALTH SERVICE
Appropriation History Table
Contract Support Costs

March 22,2013

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2014	$477,205,000			

INDIAN HEALTH SERVICE
Appropriation History Table
Facilities

March 22, 2013

	Budget Request to Congress	House Allowance	Senate Allowance	Appropriation
2004	$387,269,000	$392,560,000	$391,188,000	$396,232,000
Rescission (PL 108-108)	-	-	-	($2,560,000)
Rescission (PL 108-199)	-	-	-	($2,322,000)
2005	$354,448,000	$405,453,000	$364,148,000	$394,453,000
Rescission (PL 108-447, Sec. 501)				($2,343,000)
Rescission (PL 108-447, Sec. 122)				($3,137,000)
2006	$315,668,000	$370,774,000	$335,643,000	$358,485,000
Rescission (PL 109-54)				($1,706,000)
Rescission (PL 109-148)				($3,569,000)
2007	$347,287,000	$363,573,000	$357,287,000	$361,226,000
2008	$339,196,000	$360,895,000	$375,475,000	$380,583,000
Rescission (PL 110-161)				($5,937,000)
2009 Omnibus	$353,329,000	-	-	$390,168,000
2009 ARRA (PL 111-5)	-	-	-	$415,000,000
2010	$394,757,000	$394,757,000	$394,757,000	$394,757,000
2011	$394,757,000	-	-	$404,757,000
Rescission (PL 112-10)				($810,000)
2012	$457,669,000	$427,259,000	-	$441,052,000
Rescission (PL 112-74)				($705,683)
2013	$443,502,000	-	$ 441,605,000	-
Continuing Resolution				$443,040,000
2014	$448,139,000			

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$3,083,867	$3,102,742	$3,188,708	+$104,841
FTE**	7,491	7,624	7,624	+133

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

SUMMARY OF THE BUDGET REQUEST

The FY 2014 budget submission for Clinical Services of $3,188,708,000 is an increase of $104,841,000 above the FY 2012 Enacted level. The detailed explanation of the request is described in each of the budget narratives that follow.

- The FY 2014 budget request for **Hospitals and Health Clinics** (H&HC) is $1.866 billion, an increase of $3.8 million to cover pay costs and $50.9 million for additional staffing for newly constructed healthcare facilities. H&HC funds support access to quality healthcare in IHS and Tribal hospitals, clinics and health stations and help address health priorities such as diabetes, cardiovascular disease, obesity, maternal and child health, and behavioral health issues.

- The FY 2014 budget request for **Dental Health** is $168.2 million, an increase of $415,000 for pay costs and $8.4 million for staffing newly constructed healthcare facilities. Dental Health funds provide primarily preventive and basic care, with about 90 percent of services covering basic and emergency care. Basic services are prioritized over more complex rehabilitative care such as root canals, crown and bridge, dentures, and surgical extractions. The demand for dental treatment remains high due to the high dental caries rate in AI/AN children; however, a continuing emphasis on community oral health promotion/disease prevention is essential to impact long-term improvement of the oral health of AI/AN people.

- The FY 2014 budget request for **Mental Health** is $79.9 million, an increase of $185,000 for pay costs and $4.1 million for mental health staffing at newly constructed healthcare facilities. Mental Health funds provide a community-oriented clinical and preventive mental health service program that provides outpatient mental health and related services, crisis triage, case management, prevention programming, and outreach services.

- The FY 2014 budget request for **Alcohol and Substance Abuse** (ASA) is $196.4 million, an increase of $415,000 for pay costs and $1.7 million for ASA staffing at newly constructed healthcare facilities. ASA funds provide overall program support. The program 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.

- The FY 2014 budget request for **Purchased/Referred Care (PRC; formerly known as Contract Health Services)** is $878.6 million, an increase of $35.0 million for inflationary costs associated with medical care. PRC funds are used to purchase essential health care services not available in IHS and Tribal healthcare facilities including inpatient and

outpatient care, routine emergency ambulatory care, transportation, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, etc. The demand for PRC remains high as the cost of medical care increases. The PRC program continues to emphasize adherence to medical priorities, enrolling patients in alternate resources (such as Medicare, Medicaid and private insurance) available to them, negotiating discounted rates with medical providers, and implementing improvements recommended by Tribes and oversight authorities.

The bulk of clinical services funds are provided to 12 Area (regional) Offices which distribute resources, monitor and evaluate activities, and provide administrative and technical support to 168 Federal and Tribal Service Units (local level) for 577 healthcare facilities providing care to 2.2 million AI/ANs primarily in service areas that are rural, isolated, and underserved.

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

Long Term Measure	**Most Recent Result**	**Long Term Target**
31: Childhood Weight Control: Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher. IHS – All (Outcome)	FY 2012: 24.0% No annual target	FY 2014: Develop a new process measure
28: Unintentional Injury Rates: Unintentional injury mortality rate in AI/AN population*. IHS – All (Outcome)	FY 2005: 93.8 FY 2005 Target: 94.0 (Target Exceeded)	FY 2014: 93.8 (Results available Dec 2017)

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

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$1,810,966	$1,822,049	$1,865,630	+$54,664
FTE**	6,387	6,520	6,520	+133

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

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

FY 2014 Authorization...Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Hospitals and Health Clinics (H&HC) funds essential personal health services for 2.2 million American Indians and Alaska Natives (AI/AN) including medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, and physical therapy. In addition, the program includes public/community health initiatives targeting health conditions disproportionately affecting AI/ANs such as programs for diabetes; maternal and child health; communicable diseases including influenza, HIV/AIDS, tuberculosis, and hepatitis; and a recent focus on planning and organizing regional trauma/emergency medical services delivery systems. The IHS system of care is unique in that personal health care services are integrated with community health services. Collecting, analyzing, and interpreting health information is done through a network of Tribally-operated epidemiology centers in collaboration with a national IHS coordinating center leading to the identification of health conditions as well as promoting interventions. Information technology that supports both personal health services (including the electronic health record and telemedicine) and public health initiatives is primarily funded through the H&HC budget.

Slightly more than one-half of the H&HC budget is transferred under P.L. 93-638 contracts or compacts to Tribal governments or Tribal organizations that design and manage the delivery of these individual and community health services. Most of the remainder is managed by direct Federal programs providing health care at the Service Unit (SU) and community level.

Although the health status of AI/ANs has improved significantly in the past 50 years since the inception of the IHS, the average life expectancy at birth is 72.5 years compared to the U.S. all races life expectancy of 77.5 years[1]. The IHS and Tribes primarily serve small, rural populations with mainly primary medical care and community-health services through over 600 locations, relying on the private sector for much of the secondary and all of the tertiary medical care needs.

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

Some IHS and Tribal hospitals provide secondary medical services such as ophthalmology and orthopedics. Of 44 IHS and Tribal hospitals, only one has an average daily census of greater than 45 patients. Nineteen of these 44 hospitals have operating rooms, which demonstrates the IHS focus on primary and community based care rather than secondary or tertiary care.

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

Improving Patient Care – There are 127 sites that have participated in the Improving Patient Care (IPC) Program. The current goal is to expand to 153 sites by Fiscal Year (FY) 2014. The aim of the IPC program is to transform the Indian health system to a more integrated, well organized, and higher performing model of care. To advance the health and wellness of patients who utilize the Indian health system, the IPC program is leading participating sites to improve the health status and reduce the health disparities in care by improving the quality of and access to care across all ages and chronic conditions, assuring all preventive care needs are met, and improving our patients' experience of care. To achieve this transformation, teams will work to redefine clinical services by creating a health system, also known as a "Medical Home", for all AI/ANs that delivers health care services that are safe, timely, effective, efficient, and equitable.

A comprehensive measurement plan guides assessment in four domains: clinical prevention and screenings, care coordination of chronic conditions, patient experience of care, and access to care. Improvements have occurred in clinical prevention screenings for blood pressure, depression, domestic violence/intimate partner violence; age-appropriate screening for colorectal, breast, and cervical cancer; chronic disease and care coordination for the treatment of high blood pressure, cardiovascular disease including diabetes and hyperlipidemia; and in the patient experience of care.

Based on early combined team reporting from the IPC Program, from August 2012 to December 2012, there were 261,180 active patients empanelled to a primary care provider. The following are preliminary results of screening/prevention rates for teams reporting on individuals eligible for screening: Cervical Cancer 61%, Mammography 57.9%, Colorectal Cancer 53.8%, Depression 67.9%, and Domestic Violence/Intimate Partner Violence 66.8%. Furthermore, 56.3% of individuals with known Cardiovascular Disease have achieved Blood Pressure in Control (better than 140/90) and 42% have achieved Low Density Lipoprotein (LDL) less than 100. Also, patient survey results from IPC sites have shown patients' satisfaction with their care has risen from 55 % to 72 % from April 2011 to December 2012.

Of the 76 IPC sites reporting on the Diabetes Comprehensive Care measure (HgbA1C, BP, LDL, nephropathy assessment, retinal screen, and foot exam) during this reporting period, 27% of eligible patients have received all appropriate screenings. Emphasis on assuring diabetes standards of care are met promotes early detection and prevention of co-morbid conditions. The IPC teams are collectively having a positive impact on the provision of diabetes standards of care.

Nursing - Nursing represents the largest provider of health care and has a major impact on patient safety and health care outcomes. According to the 2011 and 2012 IHS Nurse Position Reports, over 3,500 registered nurses work in Indian health programs with a vacancy rate of 16%. The link between reduced nurse staffing and adverse outcomes is well documented.
Indicators chosen by the Joint Commission draw heavily on the literature regarding nurse staffing. A higher nurse staffing ratio (e.g., 1 Registered Nurse: 4 patients) is associated with lower failure-to-rescue incidents, lower rates of infection, and shorter hospital stays.

Nursing addresses all Agency priorities, but focuses heavily on the Agency priority of improving quality and access to care for AI/ANs. Nurses are important leaders and contributors to every facet of clinical care for AI/ANs. Nurses are critical to the success of the Improving Patient Care, Partnership for Patients, and the Baby Friendly Hospital initiatives as they are well positioned to help transform the health care system into one that places more emphasis on prevention, wellness, and coordination of care. Nurses are often the first point of contact for patients. They conduct intake screening measures (e.g., blood pressure, tobacco use, depression) throughout the continuum of health care, and often initiate, implement, or reinforce quality care for patients. Nurses are leading the IHS Baby Friendly Hospital Initiative (BFHI), a component of the First Lady's *Let's Move!* in Indian Country initiative. This initiative promotes breastfeeding to reduce the risk that children will develop obesity, diabetes, and other obesity-related conditions in the future. The BFHI aims to certify all IHS operated hospitals that provide obstetric care as "baby friendly" by the end of 2014. Ambulatory Care, Inpatient, and Public Health Nursing are focused on quality measurements identified in the President's Partnership for Patients initiative. By the end of FY 2013, this initiative aims to reduce re-hospitalization within 30 days of discharge by 20 percent (as compared to FY 2010) and to reduce hospital acquired conditions by 40% within the next three years.

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

A trauma care program encompasses injury prevention, emergency medical services (EMS), emergency medicine, surgery, rehabilitation, hospital planning, and the regionalization of acute medical care. IHS and Tribal trauma care is often dependent on distant regional hospitals with advanced critical care capabilities for definitive care. The strength of the interrelationships developed between IHS and Tribal hospitals with their regional trauma centers influences patient outcomes. The goal is to ensure optimal trauma care through transfer agreements with a "first option" regional trauma center. These interrelationships are comprehensive and include patient care, patient care information sharing, health professional training, technical assistance, use of trauma registries, data coordination, and problem solving on a regional basis. Program development began in FY 2010 at IHS service units in the Tucson Area in affiliation with the University of Arizona; the program will continue to expand to other IHS Areas in FY 2012 and out-years. During FY 2011, all IHS and Tribal hospitals became active in the IHS-University of New Mexico Tele-Radiology Program to impact traumatic brain injury. Major emphasis was placed on implementation in the IHS Billings and Aberdeen Area hospitals in 2012, and both of these Trauma Regionalization projects are intended for system-wide implementation in 2013 and out-years. Similarly, the IHS-University of Arizona "Smart Phone" Tele-Trauma Program is ongoing and making excellent progress. The Navajo Area Tele-Radiology Program continues with UNM and has expanded from Neurology to other surgical trauma and has plans to add a Tele-Stroke Program.

The closest facility for EMS providers to transport individuals with traumatic injuries is frequently the local IHS or Tribal hospital. Staffing capacity and capabilities as well as state of the art equipment are essential. The role of diagnostic (e.g., CT scanners, ultrasound) and surgical and emergency department treatment equipment cannot be overstated. The CT is now the standard of care in trauma and many acute illnesses. Emergency medicine physicians, nurses, and other highly trained staff are essential for improving patient care and disaster management. Emergency room nurses are an essential and often underappreciated element in every trauma

emergency plan and program. To address one aspect of this critical need, IHS established a registered nurse "mini-residency" trauma and emergency medicine management course at the University of New Mexico (UNM) Regional Trauma Center in July 2010. Nurse training is ongoing in the IHS Albuquerque Area Service Units, and will be replicated for other IHS Areas following the Tele-Radiology program implementation. Navajo Area met with UNM on re-establishing the Trauma Nurse Capstone Program and enrollment is planned for June 2013. The Navajo Area also continues to participate in the State Trauma Registry and currently has approximately three years of data which will be submitted to the National Trauma Data Bank. Albuquerque and Navajo Areas both participate at the Local and State levels with the Regional Trauma Advisory Committee and the Trauma System Stakeholder Advisory Committee.

Domestic Violence Prevention Initiative - According to the Centers for Disease Control and Prevention, 39% of AI/AN women have experienced intimate partner violence – the highest percentage in the U.S.[2] In addition, one out of every three AI/AN women will be sexually assaulted in her lifetime,[3] and AI/AN women are more than five times as likely to die from domestic violence-related injuries than women of any other race.[4] Intimate partner violence and sexual assault have been correlated with adverse health conditions, including increases in heart disease, asthma, and stroke as well as migraines and fibromyalgia. Victims also experience mental health problems such as depression and post-traumatic stress disorder. Domestic violence and sexual assault have been correlated with an increase in high-risk health behaviors. For example, people who have been victimized are more likely to smoke cigarettes, drink alcohol, use drugs, and engage in risky sexual behaviors.[5]

The Domestic Violence Prevention Initiative (DVPI) is a Congressionally-appropriated, nationally-coordinated demonstration/pilot program. The annual appropriation supports 65 pilot projects that target domestic violence and sexual assault prevention and intervention resources to communities in Indian Country. The IHS is using these funds to further expand its outreach advocacy programs into AI/AN communities, expand the Domestic Violence and Sexual Assault Pilot project, and provide for training and the purchase of forensic equipment to support the Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner programs. The projects adhere to reporting requirements established by the IHS and report on data and evidence-based outcome measures designed to help determine the most effective means for combating these issues in Tribal and Urban Indian communities. The completion of a national, independent evaluation of the DVPI will allow identification of successful evidence-based and practice-based programs that can be replicated across the Indian health system.

IHS is collaborating with other agencies working in the field of domestic violence and sexual assault. IHS and the Department of Justice (DOJ) Office for Victims of Crime (OVC) established an Interagency Agreement to provide training and technical assistance to address the needs of sexual assault victims. The OVC has established a coordinated, multidisciplinary project, the Sexual Assault Nurse Examiner and Sexual Assault Response Team AI/AN Initiative, which will involve IHS, the Bureau of Indian Affairs, the Federal Bureau of Investigation, and the DOJ

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[2] Centers for Disease Control and Prevention. (2008). Adverse health conditions and health risk behaviors associated with intimate partner violence-United States, 2005. *MMWR, 57*(05), 113-117. Retrieved March 2, 2010, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5705a1.htm

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

[4] Department of Justice, Bureau of Justice Statistics National Crime Database.

[5] Centers for Disease Control and Prevention. (2008). Adverse health conditions and health risk behaviors associated with intimate partner violence-United States, 2005. *MMWR, 57*(05), 113-117. Retrieved March 2, 2010, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5705a1.htm

Office on Violence Against Women. The overall goal of the initiative is to restore the dignity, respect, and mental and physical health of victims of sexual assault and ensure more effective and victim-centered investigations and prosecutions. The initiative will support victim recovery, satisfaction, and cooperation with the Federal criminal justice system, as well as support victims of sexual assault and Tribal communities' need for justice.

FUNDING HISTORY

Fiscal Year	Amount	
2009 Recovery Act	$85,000,000*	Health IT, P.L. 111-5
2009 Omnibus	$1,597,777,000	
2010 Enacted	$1,754,383,000	
2011 Enacted	$1,762,865,000	
2012 Enacted	$1,810,966,000	
2013 Continuing Resolution	$1,822,049,000	

* see HIT narrative (separate)

BUDGET REQUEST

The FY 2014 budget request for Hospitals and Health Clinics of $1,865,630,000 is an increase of $54,664,000 above the FY 2012 Enacted level. The increase will provide:

Current Services +$54,664,000

- Pay costs +$3,794,000 – to fund pay increases for Federal and Tribal employees.

- Additional Staffing for New Healthcare Facilities +$50,870,000
  There are 10 new and expanded healthcare facilities that are planned to open in FY 2014. The following healthcare facilities reflect the 401 additional staffing needs that IHS has determined as its minimum potential request for FY 2014. Seven of the ten facilities listed are Joint Venture Construction Program (JVCP) projects where the Tribe is fulfilling its responsibility under the JVCP agreement to fund the construction and equipment for the healthcare facility. IHS' responsibility is to request the funds for the additional staff and to operate the healthcare facility. Increases in H&HC funding are required for additional staffing since it is recurring funding to the facility in subsequent years.

Additional Staff for New Healthcare Facility – Minimum Need for FY 2014	Amount	Additional Positions to be Funded
Chickasaw Nation Health Clinic (JV), Ardmore, OK	$5,388,000	55
Cherokee Nation Health Center (JV), Vinita, OK	$599,000	6
Southcentral Foundation Valley Primary Care Center (JV), Wasilla, AK	$11,462,000	82
Tanana Chief Conference Interior Health Center (JV), Fairbanks, AK	$14,103,000	102
Norton Sound Regional Hospital, Nome, AK	$9,833,000	76
Chickasaw Nation Health Clinic (JV), Tishomingo, OK	$2,757,000	28
Copper River Health Clinic (JV), Tazlina, AK	$281,000	2
Kenaitze Tribe Dena'ina Health Clinic (JV), Kenai, AK	$508,000	4
Samuel Simmonds Hospital, Barrow, AK	$5,328,000	40
San Carlos Health Center, San Carlos, AZ	$611,000	6
Grand Total:	**$50,870,000**	**401**

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
5: Diabetes: Nephropathy Assessment: Proportion of patients with diagnosed diabetes assessed for nephropathy. IHS-All	FY 2012: 66.7% (Target Exceeded)	57.8%	65.0%	7.2%
5: Tribally Operated Health Programs	FY 2012: 57.6% (Target Exceeded)	45.4%	56.2%	10.8%
20: 100 percent of hospitals and outpatient clinics operated by the Indian Health Service are accredited (excluding tribal and urban facilities)	FY 2012: 100% (Target Met)	100%	100%	0
6: Diabetic Retinopathy: Proportion of patients with diagnosed diabetes who receive an annual retinal examination. IHS-All	FY 2012: 55.7% (Target Exceeded)	54.8%	57.8%	3.0%
6: Tribally Operated Health Programs	FY 2012: 52.6% (Target Exceeded)	49.9%	54.6%	4.7%
7: Pap Smear Rates: Proportion of eligible women who have had a Pap screen within the previous four years. IHS-All	FY 2012: 57.1% (Target Not Met)	59.5%	TBD	N/A (Baseline in FY 2013)
7: Tribally Operated Health Programs	FY 2012: 56.7% (Target Not Met)	60.0%	TBD	N/A (Baseline in FY 2013)
8: Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. IHS-All	FY 2012: 51.9% (Target Exceeded)	51.7%	50.6%	-1.1%
8: Tribally Operated Health Programs	FY 2012: 52.9% (Target Exceeded)	52.0%	51.6%	-0.4%
9: Colorectal Cancer Screening Rates: Proportion of eligible patients who have had appropriate colorectal cancer screening. IHS-All	FY 2012: 46.1% (Target Exceeded)	43.2%	TBD	N/A (Baseline in FY 2013)
9: Tribally Operated Health Programs	FY 2012: 46.9% (Target Exceeded)	45.2%	TBD	N/A (Baseline in FY 2013)
TOHP-2: Number of designated annual clinical performance goals met. (Outcome)	FY 2012: 13/17 (Target Met)	13/17	13/17	0
44: Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) population (Outcome) IHS-All	N/A	N/A	TBD	N/A
24: American Indian and Alaska Native Childhood Combined (4:3:1:3*:3:1:4) immunization rates: American Indian/Alaska Native patients aged 19-35 months, are immunized against preventable childhood diseases. IHS - All (Outcome)	FY 2012: 76.8% (Target Not Met but Improved)	77.8%	TBD	N/A (Baseline in FY 2013)

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
24: Tribally Operated Health Programs	FY 2012: 73.6% (Target Not Met but Improved)	74.1%	TBD	N/A (Baseline in FY 2013)
45: Hospital Admissions per 100,000 service population for long term complications of diabetes. (Efficiency) IHS-All	N/A	N/A	TBD	N/A
16: Domestic (Intimate Partner) Violence Screening: Proportion of women who are screened for domestic violence at health care facilities. IHS-All	FY 2012: 61.5% (Target Exceeded)	55.3%	60.0%	4.7%
16: Tribally Operated Health Programs	FY 2012: 56.3% (Target Exceeded)	46.1%	54.9%	8.8%
25: Adult Immunizations: Influenza: Influenza vaccination rates among adult patients aged 65 years and older. IHS-All	FY 2012: 65.0% (Target Exceeded)	63.4%	63.4%	0
25: Tribally Operated Health Programs	FY 2012: 61.6% (Target Exceeded)	59.7%	60.1%	0.4%
26: Adult Immunizations: Pneumovax: Pneumococcal vaccination rates among adult patients aged 65 years and older. IHS-All	FY 2012: 88.5% (Target Exceeded)	87.5%	86.3%	-1.2%
26: Tribally Operated Health Programs	FY 2012: 85.4% (Target Exceeded)	82.6%	83.3%	0.7%
33: HIV Screening: Proportion of pregnant women screened for HIV.	FY 2012: 85.8% (Target Exceeded)	81.8%	83.7%	1.9%
32: Tobacco Cessation Intervention**:** Proportion of tobacco-using patients that receive tobacco cessation intervention. IHS-All	FY 2012: 35.2% (Target Exceeded)	30.0%	TBD	N/A (Baseline in FY 2013)
32: Tribally Operated Health Programs	FY 2012: 31.5% (Target Exceeded)	26.9%	TBD	N/A (Baseline in FY 2013)
30: CVD Comprehensive Assessment: Proportion of IHD patients who have a comprehensive assessment for all CVD-related risk factors. IHS-All	FY 2012: 45.4% (Target Exceeded)	40.6%	36.6% (GPRAMA logic)	N/A
30: Tribally Operated Health Programs	FY 2012: 39.5% (Target Exceeded)	34.4%	31.5% (GPRAMA logic)	N/A
43: Breastfeeding Rates: Proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed.	FY 2012: 28.8% (Target Exceeded)	28.6%	TBD	N/A
H&HC 4: Inpatient Admissions - IHS Direct *(Output)*	FY 2011: 23,207 (Target Exceeded)	22,500	22,700	200
Domestic Violence Prevention Initiative				
H&HC 1: Percent of Domestic Violence Prevention Initiative-funded programs providing case management services to victims and children of victims *(Output)*	FY 2012: 84%	63.4%	84%	0

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
H&HC 2: Percent of sexual assault community developed model (SACDM) programs that have an active interdisciplinary Sexual Assault Response Team (SART) *(Output)*	FY 2012: 100%	84.6%	100%	0
H&HC 3: Percent of SANE/SART Programs with written sexual assault response policies and procedures *(Output)*	FY 2012: 100%	85.7%	100%	0

GRANTS AWARDS

H&HC funds support two grant programs: the Healthy Youth Lifestyle Grant, a $1 million limited cooperative agreement with the National Congress of American Indians, and the $500,000 National Indian Health Board Cooperative Agreement.

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request
Number of Awards	2	2	2
Average Award	$750,000	$750,000	$750,000
Range of Awards	$500,000-$1,000,000	$500,000-$1,000,000	$500,000-$1,000,000
Total Awards	**$1,500,000**	**$1,500,000**	**$1,500,000**

AREA ALLOCATION – Hospitals and Health Clinics *(dollars in thousands)*

Discretionary SERVICES	**FY 2012 Enacted**	**FY 2013 Cont. Resolution**	**FY 2014 Request**	**FY 2014 +/- FY 2012**
Aberdeen	$175,330	$172,904	$175,697	$367
Alaska	260,233	279,824	302,293	42,060
Albuquerque	80,522	78,823	80,690	169
Bemidji	102,775	99,302	102,991	215
Billings	66,334	65,353	66,473	139
California	73,492	71,983	73,646	154
Nashville	57,333	56,947	57,453	120
Navajo	234,032	231,222	234,522	490
Oklahoma	330,767	339,755	340,204	9,437
Phoenix	165,274	163,797	166,231	957
Portland	77,927	76,541	78,091	163
Tucson	20,650	20,515	20,693	43
Headquarters	166,297	165,084	166,645	348
Total, H&HC	**$1,810,966**	**$1,822,049**	**$1,865,630**	**$54,664**

Note: The allocation amounts are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Services: 75-0390-0-1-551

HOSPITALS AND HEALTH CLINICS

Epidemiology Centers

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$1,810,966	$1,822,049	$1,865,630	+$54,664
Epi Centers	*$4,679*	*$4,679*	*$4,679*	*$0*

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

FY 2014 Authorization.. Permanent

Allocation Method .... Cooperative Agreements

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

Operating within Tribal organizations, TECs are uniquely positioned to provide support to local Tribal disease surveillance and control programs, and assess the effectiveness of public health programs. All TECs monitor the health status of their constituent Tribes, produce reports annually or bi-annually, and 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 for planning the needs of their Tribal membership. Immediate feedback is provided to the local data systems and leads to improvements in Indian health data overall. TECs support national public health goals by working to improve data for GPRA, agency performance reports, and monitoring of the Healthy People 2020 objectives at the Tribal level. Health status reports across all TECs will lead to a more comprehensive picture of Indian health.

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

FUNDING HISTORY

Over 90 percent of the TEC Program budget is distributed through cooperative agreements. Up to $1,000,000 in funding for each TEC is authorized by the Indian Health Care Improvement Act. Initially, four Tribal organizations competed and received funding based on recommendations from an objective review panel in the amount of $155,000 each. In FY 2000,

the four original TECs plus two new centers received an average award of $220,000 over the next five years. In FY 2006, after another competitive 5-year cooperative agreement award the IHS TEC program expanded to 11 TECs with an average award of $380,000. In FY 2008, a TEC was established in the California Area and was funded through the Director's budget in the amount of $350,000 until the next 5-year cooperative agreement award cycle in FY 2011.

All 12 existing TECs now serve a major portion of the AI/AN population in 12 regions comparable to the IHS Administrative Area service population. In FY 2011, through another competitive 5-year cooperative agreement award process, all 12 TECs were again awarded and the average award has been $360,000.

Fiscal Year	Amount *
2009 Enacted	*$4,609,489*
2010 Enacted	*$4,686,346*
2011 Enacted	*$4,686,346*
2012 Enacted	*$4,678,847*
2013 Continuing Resolution	*$4,678,847*

** Funded under the H&HC budget.*

BUDGET REQUEST

The FY 2014 budget request for the Tribal Epidemiology Centers program of $4,678,847 is the same as the FY 2012 Enacted level.

The TEC program evaluation was conducted by an external company in FY 2010 for the time period each TEC received a cooperative agreement award, beginning in 1997, and the evaluation highlighted strengths and addressed weaknesses at each TEC. Comments from the TECs and their Tribal or Urban Indian health boards indicate the number one recommendation for strengthening the TEC Program Performance is to Increase Core Funding., It also recommends continuing to build on public health capacity, improve data collection and analysis, and provide services to assist Tribes.

FY 2014 Tribal Epidemiology Centers Allocation (Estimated)			
1	Alaska Native Tribal Health Consortium	Anchorage, AK	$360,000
2	Albuquerque American Indian Health Board	Albuquerque, NM	$360,000
3	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI	$360,000
4	Inter-Tribal Council of Arizona	Phoenix, AZ	$360,000
5	Montana/Wyoming Tribal Leaders Council	Billings, MT	$360,000
6	Navajo Nation Division of Health	Window Rock, AZ	$360,000
7	Northern Plains – Aberdeen Area	Rapid City, SD	$360,000
8	Northwest Portland Area Indian Health Board	Portland, OR	$360,000
9	Oklahoma City Area Inter-Tribal Health Board	Oklahoma City, OK	$360,000
10	Seattle Indian Health Board	Seattle, WA	$360,000
11	United South and Eastern Tribes, Inc.	Nashville, TN	$360,000
12	California Rural Indian Health Board	Sacramento, CA	$360,000
	Administrative and technical support	IHS Headquarters	$358,847
	TOTAL		**$**4,678,847

Addressing Agency Priorities:

1. Renew and strengthen our partnership with Tribes
   The TECs are fundamental to the IHS' partnership with Tribes by supporting epidemiology and public health functions critical to the delivery of healthcare services. Independent TEC goals are set as directed by their constituent Tribes and health boards. DEDP tracks these

goals and objectives as written in their cooperative agreements (i.e. surveillance of disease and control programs and collecting epidemiological data for use in determining health status of Tribal communities). DEDP sets a national outcome for each TEC to develop and disseminate regional health profiles for their constituent Tribes and communities.

2. Reform the IHS
   TECs represent an important link to IHS reform efforts through their efforts to build capacity in the Indian health system to evaluate and monitor the effectiveness of health programs.

3. Improve the quality of and access to care
   In the expanding environment of Tribally-operated health programs, epidemiology centers provide additional public health services, such as disease control and prevention programs, in areas such as sexually transmitted disease control, HIV, and cancer prevention. TECs assist Tribes with projects such as conducting behavioral risk factor surveys to establish baseline data for successfully evaluating intervention and prevention activities. The TEC program supports Tribal communities by providing technical training in public health practice and prevention-oriented research, and promoting public health career pathways for Tribal members. DEDP works with the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) to supplement the TECs, create stronger interagency partnerships, and prevent costly duplication of effort.

4. Ensure that our work is transparent, accountable, fair and inclusive
   The DEDP continues to make all our work transparent, accountable, fair and inclusive to IHS, Tribes, TECs, other Federal agencies, and the public through reports, meetings and the recent TEC program evaluation.

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

Outputs and Outcomes Table

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
EPI-1: Health Status & Monitoring* **Measured by surveys, assessments, reports (Output)*	FY 2011: 12 of 12 TECs (Target Met)	12 of 12 TECs	12 of 12 TECs	0
EPI-2: Provide regional health profiles *(Output)*	FY 2011: 12 of 12 TECs (Target Met)	12 of 12 TECs	12 of 12 TECs	0
EPI-3: Tribal support - technical training in public health practice *(Output)*	FY 2011: 12of 12 TECs (Target Met)	12 of 12 TECs	12 of 12 TECs	0

GRANTS AWARDS

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request
Number of Awards	12	12	12
Average Award*	$360,000	$360,000	$360,000
Range of Awards	$350,000 - $500,000	$350,000 - $500,000	$350,000 -$500,000

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

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$1,810,966	$1,822,049	$1,865,630	$54,664
HIT	*$172,149*	*$172,149*	*$172,149*	*$0*

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

FY 2014 Authorization... Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Indian Health Service (IHS) Health Information Technology (HIT) program uses secure information technology (IT) to improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions consistent with the Department of Health and Human Services (HHS) enterprise initiatives. The IHS HIT program provides support for the Indian Health Care system. IHS has nearly 30 years of experience with HIT as a major enabler of clinical care that supports the goal of achieving health equity and improving clinical outcomes for the American Indian and Alaska Native (AI/AN) population. Continued investment in HIT has the ongoing potential to transform health care delivery by lowering costs and improving quality. HIT funding increases continue to improve the quality of the care that physicians and other caregivers provide and ensure patient safety within the Indian health system.

The IHS HIT Program is dedicated to providing the most innovative, effective, and cost-efficient HIT system in the federal government. The IHS HIT program is comprised of three major IT strategic investments that are fully integrated with the Agency's programs and critical to carrying out the IHS mission and priorities: 1) the Resource and Patient Management System (RPMS); 2) Infrastructure, Office Automation, and Telecommunications (IOAT); and 3) the National Patient Information Reporting System (NPIRS).

1) **RPMS** is the key IHS enterprise health information system that underlies the clinical, practice management and revenue cycle business processes at IHS, Tribal, and Urban (I/T/U) facilities across the country. RPMS is used at approximately 400 Indian health care facilities and includes a Certified Electronic Health Record (EHR), which is in use at over 325 of these locations with continued deployment activities underway. The IHS-wide adoption of RPMS provides substantial savings to IHS by lowering the cost of providing health care, eliminating unnecessary health care services, and improving the quality of care.
2) **IOAT** provides the technical infrastructure for IHS healthcare facilities and is the foundation upon which RPMS is delivered. The IOAT investment includes a highly available and secure wide area network, a national e-mail and telecommunications capability, and supporting hardware including servers and end-user devices. The IHS IT infrastructure incorporates

government and industry standards for the collection, processing, storage, and transmission of information and is poised to respond to new and innovative opportunities.

3) **NPIRS** is an enterprise-wide data warehouse environment that produces reports required by statute and regulation and provides a broad range of clinical and administrative information, and associated analytical tools, to managers at all levels of the Indian health system. This investment is evolving to become the data source for agency-level quality measurement, performance reporting, and enterprise analytics, residing in a cloud computing environment.

In addition, the IHS HIT Program includes mature Information Security, Capital Planning and Investment Control (CPIC), and Enterprise Architecture programs that support the three major IT strategic investments and serve to promote compliance with federal laws and mandates and to improve the efficiency and security of the IHS HIT Program.

FY 2012 Accomplishments

The IHS Office of Information Technology achieved numerous accomplishments during FY 2011 and 2012, including the following examples:

- IHS is proud as a federal agency to have achieved certification of its health information system for the Meaningful Use of an Electronic Health Record program authorized by the Health Information Technology for Economic and Clinical Health (HITECH) Act. The RPMS suite was certified as a Complete EHR for both Ambulatory and Inpatient settings in April 2011. By the third quarter of 2012, 14 IHS Eligible Hospitals and 527 IHS Eligible Providers have registered with the Centers for Medicare and Medicaid Services (CMS) signifying their intent to participate in the Meaningful Use incentive programs. Many other IHS EH and EP are preparing for Meaningful Use. In addition, a large number of Tribally-operated hospitals and Tribally-employed providers are also benefitting from the MU incentive programs using IHS-supplied EHR technology.
- IHS was the first HHS agency to implement Continuous Monitoring as an effective IT security strategy.
- IHS completed migration to the new federally compliant Citrix Virtual Private Network for remote access users.
- Full disk encryption has been implemented for all IHS laptop computers.
- IHS consolidated the NPIRS help desk system with the OIT help desk system to simplify user support and gain efficiencies. The OIT Help Desk has a 95% satisfaction rating.
- The NPIRS successfully completed a pilot demonstration of the ability to produce aggregated performance measures from the National Data Warehouse in preparation for the expansion of NPIRS to include national performance and quality measurement capabilities.

IHS has continued to expand its support for telehealth through improvement of the infrastructure and network expansion required for telehealth delivery. This support helps ensure that the backbone of the network can remain adequate for the timely transmission of telehealth consultations. Telehealth enables a “best practice” model of specialist health care delivery. This model of enhanced access, improved clinical quality, and increased organizational cost-efficiency is possible through the integration of emerging technical and clinical innovations, such as expert teleconsultation and remote patient monitoring/care coordination.

Collaboration with other federal agencies is a key initiative within the IHS HIT Program. IHS works closely with the Office of the National Coordinator for HIT, 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 its 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 considers the RPMS suite to be a public utility, making it available without cost to all interested parties.

The IHS HIT Program makes use of all available resources to implement critically important initiatives that are aimed at meeting federal mandates and improving the overall delivery of care that IHS provides, while upgrading its systems and infrastructure to meet the technology and security demands of the 21st century.

FUNDING HISTORY

Fiscal Year	Amount *
2009 Recovery Act	*$10,985,000*
2009 Omnibus	*$114,506,000*
2010 Recovery Act	*$74,015,000*
2010 Enacted	*$172,405,000***
2011 Enacted	*$169,024,509*
2012 Enacted	*$172,149,000*
2013 Continuing Resolution	*$172,149,000*

*This represents the total cost of HIT within IHS. The majority is from the Hospitals & Health Clinics budget line with a small amount from Direct Operations for federal personnel and travel.
** The increase of $57,899,000 from 2009 Omnibus to 2010 Enacted includes a $16,251,000 program increase for HIT and $41,648,000 increase which reflects a change in reporting requirements to include field IT related expenses that were previously reported program operation budgets only.

Immediate Priorities and Challenges

The IHS HIT Program will face increased workload and costs in FY 2014. The principal priorities in FY 2014 will be completion of the system-wide transition to version 10 of the International Classification of Diseases (ICD-10) and developing EHR enhancements that will be required in preparation for Meaningful Use (MU), with additional priorities as shown below:

- IHS must complete implementation of the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) in time for the expected new compliance date of October 1, 2014. This effort includes extensive RPMS updates affecting more than 60 software applications, as well as changes to all analytical and reporting systems and processes that rely on diagnostic coding. Retraining of all coders, billers, and other staff including clinicians who interact with ICD codes will be required as well.
- At the same time, IHS must continue to support Stage 1 MU adoption throughout Indian country, complete development for 2014 EHR certification in preparation for Stage 2 MU, and simultaneously analyze technical and business process changes required for Stage 3 MU when those rules are published. The ONC/CMS roadmap for Meaningful Use will necessitate significant additional changes to IHS HIT systems to address Stage 3 requirements. These changes will affect not just the RPMS health information system but enterprise services such as Health Information Exchange and the Personal Health Record.
- The IHS network continues to require upgrades in order to achieve the necessary bandwidth and reliability recommended by the Federal Communications Commission (FCC) in order to support robust health information exchange and expanding telehealth initiatives.
- IHS HIT will be expected to respond in a timely way to new security threats, regulatory mandates for government IT systems, and industry standards and best practices.
- IHS HIT will be expected to support numerous provisions of the Affordable Care Act (ACA) that call for new data or data systems to implement new business processes or reporting

requirements. Many of these requirements are still evolving in the regulatory process so their impacts on IHS HIT are not fully known.

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

BUDGET REQUEST

The FY 2014 budget request for Health Information Technology of $172,149,000 is the same as the FY 2012 Enacted level.

HIT in IHS is an instrument to support health care efficiency and quality. The IHS HIT Program has made substantial strides in the past few years by using innovative solutions to improve the IHS' infrastructure and to provide healthcare providers with the tools and information they need to make life-saving decisions at the point of care. The FY 2014 budget request will allow the IHS HIT Program to maintain current gains in HIT and complete basic development work on ICD-10, which is critical to maintaining the revenue streams for IHS, Tribal and Urban health care facilities.

The IHS request includes funding to support the President's information technology initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process.

IHS Investments

(Dollars in Thousands)

Program Name	IT Investment Title	UPI	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request
Hospitals & Health Clinics	IHS Resource and Patient Management System – Maintenance & Enhancements	009-17-01-02-01-1010-00	$94,876	$101,625	$ 96,625
Hospitals & Health Clinics	IHS National Patient Information and Reporting System – Maintenance & Enhancements	009-17-01-02-01-1020-00	$9,000	$9,285	$9,448
Hospitals & Health Clinics	IHS Infrastructure, Office Automation, & Telecommunications (IOAT)	009-17-02-00-01-1040-00	$54,578	$55,858	$56,218
Hospitals & Health Clinics	Non-major Investments including Security and Enterprise Architecture Programs	N/A	$9,255	$9,707	$8,077

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
RPMS-2: Derive all clinical measures from RPMS and integrate with EHR (Clinical Measures/Areas) (RPMS Program Assessment)	FY 2012: 73/12 (Target Exceeded)	69/12	73/12	4/0

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

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$159,440	$160,416	$168,225	$8,785
FTE**	699	699	699	0

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

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

FY 2014 Authorization...Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The purpose of the Dental Program is to raise the oral health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level through the provision of quality preventive and treatment services, at both community and clinic sites. The Dental Program is a service-oriented program providing basic dental services (e.g., diagnostic, emergency, preventive, and basic restorative care). Approximately 90 percent of the dental services provided fall into the basic dental services category. In FY 2012, the dental program provided a total of 3,345,873 documented basic dental services. More complex rehabilitative care (e.g., root canals, crown and bridge, dentures, and surgical extractions) is provided where resources allow and account for the additional 179,375 dental services provided in FY 2012.

By age eight, 90 percent of AI/AN children suffer from dental caries, while only 50 percent of the U.S. population has experienced cavities. In addition to this disparity in prevalence, there is a significant disparity in severity of dental disease. AI/AN children ages 2-5 exhibit an average of six decayed teeth, while the same age group in the U.S. population averages one decayed tooth. Thus, the demand for dental treatment remains high due to the high incidence of dental caries in AI/AN children. A continuing emphasis on community oral health promotion/disease prevention is essential in order to address the current high prevalence, reduce the severity of oral disease and improve the oral health of AI/AN people. Prevention activities reduce both the amount and the cost of subsequent dental care and improve oral health.

The dental program maintains data and tracks three key program objectives: 1) increase the number of dental sealants placed; 2) increase the number of patients who receive at least one topical fluoride application; and 3) increase access to care. The Dental Program met all three annual targets for the Government Performance and Results Act (GPRA) year ending June 2012. While final performance data for the GPRA year ending June 2013 is not yet available, progress reports throughout this most recent GPRA year suggest the Dental Program will again meet all annual targets. Topical fluorides and dental sealants are extensively researched and documented in the dental literature as safe and effective preventive interventions to reduce tooth decay. The

high prevalence of sealants represents a notable accomplishment for the IHS Dental Program as significant numbers of susceptible tooth surfaces are now protected by dental sealants. Access to dental services is a prerequisite to the control of oral disease in susceptible or high-risk populations.

In recent years, the IHS Dental Program has utilized field dental programs in conjunction with its Dental Clinical and Preventive Support Centers (DSC) to achieve national performance objectives and IHS Area initiatives. The DSCs were designed and implemented in FY 1999 and FY 2000 to augment the dental public health infrastructure necessary to best meet the oral health needs of the AI/AN community. Currently there are eight DSCs, four funded by program awards and four through grants. The primary purpose of a DSC is to provide technical support, training, and assistance in clinical and preventive aspects of dental programs providing care to the AI/AN community. As a direct result of the advocacy efforts of the DSCs, the number of key preventive procedures has increased significantly in recent years. For example, the number of dental sealants placed per year has tripled in the last decade, and the number of patients receiving topical fluoride treatments has more than doubled in the last five years.

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

- All centers advocated for an appropriate focus on the Dental GPRA performance objectives to increase specific clinical services.
- All centers provided continuing education opportunities to enhance the quality of care delivered.
- Several centers provided on-site clinical and community based program reviews to enhance the quality of care assuring that field programs maintained a high level of expertise with respect to challenges such as infection control, Joint Commission Accreditation and Certification preparedness, and patient scheduling practices aimed at maximizing access to care.
- Several centers provided an array of health education materials or designed materials customized to the specific needs of the IHS Areas they serve. These materials have increased the quality of IHS oral health education efforts throughout Indian Country.
- Several centers provided direct clinical services that otherwise would not have been provided.

The aggregate accomplishments of the DSCs have resulted in an increase in clinical preventive care, an increase in overall clinical services, and an enhancement of the quality of clinical and community based care delivered by the dental field programs.

The targeted percentage of patients receiving dental services was exceeded during FY 2012, as were the number of patients receiving at least one topical fluoride application and number of sealants placed. The IHS Dental program will continue its efforts to recruit and retain dental providers to improve dental access and to meet all annual performance objectives.

FUNDING HISTORY

Fiscal Year	Amount
2009 Omnibus	$141,936,000
2010 Enacted	$152,634,000
2011 Enacted	$152,634,000
2012 Enacted	$159,440,000
2013 Continuing Resolution	$160,416,000

BUDGET REQUEST

The FY 2014 budget request for Dental Services of $168,225,000 is an increase of $8,785,000 over the FY 2012 Enacted level.

The increase will provide:

Current Services +$8,785,000

- Pay costs +$415,000 – to fund pay increases for Federal and Tribal employees.

- Additional Staffing/Operating Costs for New Healthcare Facilities + $8,370,000
The following healthcare facilities reflect the additional staffing needs that IHS has determined is a minimum request for FY 2014. Seven of the ten healthcare facilities listed are Joint Venture Construction Program (JVCP) projects where the Tribe is fulfilling its responsibility under the JVCP agreement to fund the construction and equipment for the healthcare facility. IHS' responsibility is to request the funds for additional staff and to operate the healthcare facility. Increases in Dental Health funding are required for additional staffing since it is recurring funding to the facility in subsequent years.

Additional Staff for New Healthcare Facility – Minimum Need for FY 2014	Amount	Additional Positions to be Funded
Chickasaw Nation Health Clinic (JV), Ardmore, OK	$1,143,000	12
Cherokee Nation Health Center (JV), Vinita, OK	$508,000	5
Southcentral Foundation Valley Primary Care Center (JV), Wasilla, AK	$2,051,000	17
Tanana Chief Conference Interior Health Center (JV), Fairbanks, AK	$2,190,000	17
Norton Sound Regional Hospital, Nome, AK	$1,109,000	9
Chickasaw Nation Health Clinic (JV), Tishomingo, OK	$611,000	6
Copper River Health Clinic (JV), Tazlina, AK	$125,000	1
Kenaitze Tribe Dena'ina Health Clinic (JV), Kenai, AK	$135,000	1
Samuel Simmonds Hospital, Barrow, AK	$405,000	3
San Carlos Health Center, San Carlos, AZ	$93,000	1
Grand Total:	**$8,370,000**	**72**

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
12: **Topical Fluorides:** Number of American Indian and Alaska Native patients receiving at least one topical fluoride application.	FY 2012: 169,083 (Target Exceeded)	161,461	TBD	N/A (new rate-based measure in FY 2013)
13: **Dental Access:** Percent of patients who receive dental services.	FY 2012: 28.8% (Target Exceeded)	26.9%	27.8%	0.9%
14: **Dental Sealants:** Number of sealants placed per year in AI/AN patients.	FY 2012: 295,734 (Target Exceeded)	276,893	TBD	N/A (new rate-based measure in FY 2013)

GRANTS AWARDS

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request
Number of Awards	4	4	4
Average Award	$249,998	$249,998	$249,998
Range of Awards	$249,996-250,000	$249,996-250,000	$249,996-$250,000
Total Awards	**$1,000,000**	**$1,000,000**	**$1,000,000**

AREA ALLOCATION – Dental Services *(dollars in thousands)*

Discretionary SERVICES	**FY 2012 Enacted**	**FY 2013 Cont. Resolution**	**FY 2014 Request**	**FY 2014 +/- FY 2012**
Aberdeen	$17,479	$16,900	$17,524	$45
Alaska	19,061	21,837	25,126	6,065
Albuquerque	8,505	8,269	8,527	22
Bemidji	4,356	4,235	4,367	11
Billings	7,610	7,399	7,630	20
California	1,999	1,943	2,004	5
Nashville	2,881	2,801	2,888	7
Navajo	30,046	29,214	30,124	78
Oklahoma	34,773	37,544	37,126	2,353
Phoenix	13,723	13,343	13,852	129
Portland	7,790	7,574	7,810	20
Tucson	1,894	1,842	1,899	5
Headquarters	9,324	7,515	9,348	24
Total, DENTAL	**$159,440**	**$160,416**	**$168,225**	**+$8,785**

Note: The allocation amounts are estimates.

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$75,589	$76,052	$79,873	$4,284
FTE**	216	216	216	0

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

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

FY 2014 Authorization..Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

The MH/SS addresses the Agency's priorities and works to integrate behavioral health into primary care. Tribal contracting and compacting has enabled behavioral health programs to transition from IHS to local community control. As a result, over half the Tribes now administer and deliver their own mental health programs. The IHS MH/SS program assists Tribes in bringing programs and program collaborations to their own communities.

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

- Serious psychological distress;
- Feelings of sadness, hopelessness, and worthlessness;
- Feelings of nervousness or restlessness; and
- Suicide.

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

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

Suicide Prevention: Overall, suicide mortality is 73 percent greater in AI/AN populations in IHS service areas compared to U.S. all races.[1] In AI/AN youth ages 15-24, suicide mortality rates have increased from 45.9 per 100,000 population in years 1999- 2001 to 55.2 per 100,000 population in years 2003-2005. In fact, suicide is the second leading cause of death behind unintentional injuries for Indian youth ages 15-24 residing in IHS service areas and is 3.5 times higher than the national average.

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

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

Child/Family Protection: Child abuse and the cycle of repeat abuse in adulthood are well documented in the AI/AN literature. Family violence affects all members of the community, but AI/AN women and children are particularly vulnerable to abuse. To help victims of violence, IHS provides direct services, advocacy, interagency consultation, and collaboration with other Federal agencies to provide AI/AN child and family protection services.

Partnerships: IHS has devoted considerable effort to develop and share effective programs throughout the Indian health system. The Agency believes developing programs that are collaborative, community driven, and nationally supported offer the most promising potential for

[1] Unpublished data, Office of Public Health Support. Division of Program Statistics. Indian Health Service.

long term success and sustainment. Through partnership and consultation, IHS and Tribes are working together to improve the health of AI/AN communities.

Strategies to address mental health and suicide include collaborations and partnerships with consumers and their families, Tribes and Tribal organizations, Urban Indian health programs, Federal, State, and local agencies, as well as public and private organizations. This effort seeks to establish effective long-term strategic approaches to address mental health and suicide prevention in Indian Country.

On September 10, 2010, Department of Health and Human Services Secretary Kathleen Sebelius and Department of Defense Secretary Robert M. Gates announced the creation of the National Action Alliance for Suicide Prevention. On September 10, 2012 the Action Alliance, along with the U.S. Surgeon General, Dr. Regina Benjamin, released the revised National Strategy for Suicide Prevention (NSSP). The revised strategy emphasizes the role every American can play in protecting their friends, family members, and colleagues from suicide. It also provides guidance for schools, businesses, health systems, clinicians and many other sectors that takes into account nearly a decade of research and other advancements in the field since the last strategy was published. The AI/AN Task Force was also formed to advance suicide prevention efforts in AI/AN communities.

The 2012 IHS National Behavioral Health Conference was held June 25-28 in Bloomington, Minnesota. The theme of the 2012 national conference, Mobilizing Partnerships to Promote Wellness, emphasized the importance of collaboration in working to improve the behavioral health status of American Indians and Alaska Natives. The 2012 conference was combined with the Methamphetamine and Suicide Prevention Initiative (MSPI) and the Domestic Violence Prevention Initiative (DVPI) annual meetings. In total, 657 participants attended the event, which included 225 MSPI participants and 106 DVPI participants, representing 186 Tribes located in 36 States. The conference included 11 half- to full-day preconference training sessions and 14 workshop tracks that provided intensive skill-building and continuing education on a wide range of mental health topics, including suicide prevention, veterans' health, traumatic brain injury, trauma-informed care, youth mental health, and post-traumatic stress disorder.

In FY 2014, IHS will continue to focus on integration of behavioral health into primary care. IHS supports changing the paradigm of mental health services from being episodic, fragmented, specialty, and/or disease focused to being a part of primary care and the medical home. The medical home is an accessible and patient-centered system of care that provides safe, timely, effective, efficient, and equitable care. This offers new opportunities for interventions that identify high-risk individuals before their actions or behavior becomes more clinically significant. There will continue to be a focus on a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors. This effort will continue to bring together multiple disciplines, perspectives, and resources to create an integrated system where services can be accessed across multiple settings. To help victims of violence, IHS provides direct services, advocacy, interagency consultation, and collaboration with other Federal agencies to provide child and family protection services to AI/AN children and families. Plans also include improving the RPMS to support clinical best practices and disease surveillance.

FUNDING HISTORY

Fiscal Year	Amount
2009 Omnibus	$67,748,000
2010 Enacted	$72,786,000
2011 Enacted	$72,786,000
2012 Enacted	$75,589,000
2013 Continuing Resolution	$76,052,000

BUDGET REQUEST

The FY 2014 budget request for Mental Health of $79,873,000 is an increase of $4,284,000 over the FY 2012 Enacted level.

The increase will provide:

Current Services +$4,284,000

- Pay Costs +$185,000 – to fund pay increases for Federal and Tribal employees.

- Additional Staffing/Operating Costs for New Healthcare Facilities +$4,099,000
  The following healthcare facilities reflect the 38 additional mental health staffing needs that IHS has determined as its minimum potential request for FY 2014. Seven of the ten facilities listed are Joint Venture Construction Program (JVCP) projects where the Tribe is fulfilling its responsibility under the JVCP agreement to fund the construction and equipment for the healthcare facility. IHS' responsibility is to request the funds for additional staff and to operate the healthcare facility. Increases in Mental Health funding are required for additional staffing since it is recurring funding to the facilities in subsequent years.

Additional Staff for New Healthcare Facility – Minimum Need for FY 2014	Amount	Additional Positions to be Funded
Chickasaw Nation Health Clinic (JV), Ardmore, OK	$559,000	6
Cherokee Nation Health Center (JV), Vinita, OK	$94,000	1
Southcentral Foundation Valley Primary Care Center (JV), Wasilla, AK	$1,083,000	9
Tanana Chief Conference Interior Health Center (JV), Fairbanks, AK	$815,000	7
Norton Sound Regional Hospital, Nome, AK	$420,000	4
Chickasaw Nation Health Clinic (JV), Tishomingo, OK	$562,000	6
Copper River Health Clinic (JV), Tazlina, AK	$94,000	1
Kenaitze Tribe Dena'ina Health Clinic (JV), Kenai, AK	$126,000	1
Samuel Simmonds Hospital, Barrow, AK	$250,000	2
San Carlos Health Center, San Carlos, AZ	$96,000	1
Grand Total:	**$4,099,000**	**38**

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
29. **Suicide Surveillance:** Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals.	FY 2012: 1,709 (Target Not Met)	1,807	1,668	-139
18. **Behavioral Health:** Proportion of adults ages 18 and over who are screened for depression. IHS-All	FY 2012: 61.9% (Target Exceeded)	56.5%	60.4%	3.9%
18. Tribally Operated Health Programs	FY 2012: 56.7% (Target Exceeded)	49.7%	55.3%	5.6%

During the past few years the program has experienced positive performance results. Depression screening for early detection, diagnosis, and treatment increased from 56.5% in FY 2011 to 61.9% in FY 2012. Depression screening improves detection of mental health needs. Depression is often an underlying component contributing to suicide, accidents, domestic/intimate partner violence, and alcohol and substance abuse. Early identification of depression allows providers to plan interventions and treatment to improve the mental health and well-being of AI/AN people who experience depression. Tools have been selected to assess depression, monitor response, and track the response over time. The screening tools and results are incorporated into the IHS Electronic Health Record. The system is now deployed and in operation in over 250 clinical sites across the country.

The suicide surveillance performance target was not met in FY 2012. The FY 2012 target was 1,807 completed forms; the FY 2012 actual results were 1,709 completed forms. This was due to a variety of factors. First, it was discovered during a routine internal data quality review that data exports received at the National Data Warehouse (NDW) from the IHS Areas may be comprised of duplicate suicide reporting forms. To address this issue, the IHS developed a procedure to identify duplicate records and a process to delete all duplicate exported records received by the NDW. As a result, the annual total number of forms submitted nationally was reduced. Second, one IHS Service Area informed IHS that they declined participation in suicide surveillance data collection. In consideration of Tribal data ownership and given the very sensitive nature of suicide, IHS no longer collects and reports on suicide surveillance data for that IHS Area.

To help ensure IHS meets its target in FY 2014, IHS will increase and improve awareness of the form and the importance of suicide surveillance activities among providers, facility and Area managers, and administrators. Similarly, RPMS Site Managers and Electronic Health Record Clinical Application Coordinators will be made aware of the suicide reporting form and the appropriate application set-up and exporting processes. As described in the narrative above, IHS serves on the National Action Alliance for Suicide Prevention, which recently released the revised National Strategy for Suicide Prevention. IHS will continue to work with its public and private partners to implement the Strategy's fourth strategic direction, which addresses suicide prevention surveillance, research, and evaluation activities.

Aside from the decrease in number due to one IHS Area declining participation, the results for FY 2012 represent a more accurate estimate of provider reporting of suicide and suicide-related events due to improved data quality processes. Data collected from the Suicide Reporting Form is beginning to provide a more detailed picture of who is completing or attempting suicide and identifies salient factors contributing to the events. Completion of forms should provide more detailed information about the incidence of suicidal ideation, attempts, and completions which will provide far more accurate and timely data and will allow interventions to be evaluated for effectiveness in ways not previously possible.

The FY 2014 depression target is 60.4% which is a 3.9% increase over FY 2012. The 2014 suicide surveillance target is 1,668 forms completed. The impact of absorbing current services will reduce access to behavioral health screening, diagnosis, and treatment. This may increase untreated depression and the morbidity burden on the individual, family, and community.

GRANT AWARDS – The program does not anticipate any grant awards for FY 2014.

AREA ALLOCATION – Mental Health *(dollars in thousands)*

Discretionary SERVICES	**FY 2012 Enacted**	**FY 2013 Cont. Resolution**	**FY 2014 Request**	**FY 2014 +/- FY 2012**
Aberdeen	$9,841	$9,541	$9,865	$24
Alaska	6,364	7,642	9,168	2,804
Albuquerque	4,426	4,310	4,436	11
Bemidji	2,321	2,260	2,327	6
Billings	3,934	3,830	3,943	10
California	2,034	1,981	2,039	5
Nashville	1,773	1,727	1,778	4
Navajo	14,635	14,251	14,671	36
Oklahoma	13,325	14,526	14,573	1,248
Phoenix	7,682	7,480	7,797	115
Portland	4,192	4,082	4,202	10
Tucson	1,485	1,446	1,488	4
Headquarters	3,577	2,976	3,586	9
Total, MENTAL HLTH	**$75,589**	**$76,052**	**$79,873**	**+$4,284**

Note: The allocation amounts are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Services: 75-0390-0-1-551

ALCOHOL AND SUBSTANCE ABUSE

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$194,297	$195,486	$196,405	$2,108
FTE**	189	189	189	0

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

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

FY 2014 Authorization..Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Alcoholism, addiction, and alcohol and substance abuse are among the most severe public health and safety problems facing American Indian and Alaska Native (AI/AN) individuals, families, and communities. The purpose of the Indian Health Service (IHS) Alcohol and Substance Abuse Program (ASAP) is to raise the behavioral health status of AI/AN communities to the highest possible level through a comprehensive array of preventive, educational, and treatment services that are community-driven and culturally competent. The ASAP addresses the Agency's priorities to renew and strengthen our partnership with Tribes, improve the quality of and access to care through these collaborative activities, and work to integrate behavioral health into primary care.

In general, AI/AN populations suffer disproportionately from substance abuse disorders compared with other racial groups in the United States. In a 2010 report from the National Survey on Drug Use and Health (NSDUH), the rates of past-month-binge alcohol use and illicit drug use were higher among AI/AN adults compared to national averages (30.6 vs. 24.5 percent and 11.2 vs. 7.9 percent, respectively) and the percentage of AI/AN adults who needed treatment for an alcohol or illicit drug use problem in the past year was nearly double the national average for adults (18.0 vs. 9.6 percent).[1]

Alcohol and substance abuse in AI/AN communities results in devastating intergenerational social, economic, physical, mental, and spiritual health disparities. Alcohol and substance abuse among AI/AN populations contribute to high rates of mortality from liver disease, unintentional injury, and suicide. AI/AN communities suffer from some of the highest rates of Fetal Alcohol Spectrum Disorders (FASD) in the nation, and the damaging effects of alcohol use to an unborn baby during pregnancy are permanent. Methamphetamine and other drug abuse are becoming

[1] Substance Abuse and Mental Health Services Administration, Office of Applied Studies (June 24, 2010). *The NSDUH Report: Substance Use among American Indian or Alaska Native Adults*, Rockville, MD.

more serious problems among AI/AN people, compounding the current adverse effects of alcohol and substance abuse. For example:

- The age-adjusted[2] alcohol related death rate for AI/ANs is 43.3 per 100,000 population (2003-2005) and is over six times the U.S. all races rate of 7.0 per 100,000 population (2004).[3]
- The age-adjusted drug related death rate for AI/ANs is 15.0 per 100,000 population (2002-2004) and is 1.5 times greater than the U.S. all races rate of 9.9 per 100,000 population (2003).[4]

Over the last 15 years, ASAP programs have transitioned from IHS Direct Care to local community control via Tribal contracting and compacting. In FY 2012, the majority of the ASAP programs were managed by Tribes. To support this trend, IHS is transitioning from direct service only to primarily direct service support to enable communities to plan, develop, and implement culturally-informed ASAP programming. Organized to develop programs and program leadership, the major ASAP activities and focus areas are:

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

Youth Regional Treatment Centers (YRTCs): There are 11 YRTCs which provide substance abuse and mental health treatment services to AI/AN youth. Congress authorized the establishment of these YRTCs in each of the 12 IHS Areas, with two (northern and southern) specifically authorized for the California Area. Some Tribes within certain IHS Areas (e.g., Bemidji and Billings) elected not to construct YRTCs but to contract for similar services. The Alaska Area divided their funds to provide residential treatment services for two programs.

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

Methamphetamine and Suicide Prevention Initiative (MSPI): The MSPI is a nationally-coordinated demonstration/pilot program, focusing on providing targeted methamphetamine and suicide prevention and intervention resources to communities in Indian Country with the greatest need for these programs. The $16.3 million annual appropriation supports 125 pilot projects that promote the establishment of innovative practice-based and evidence-based interventions developed and administered by the communities themselves. These model programs are connected to the entire national network of recipients to share program, service, and evaluation information. All MSPI pilot programs are community developed and delivered and represent the

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2. Rates have been adjusted to compensate for misreporting of AI/AN race on state death certificates.
3 Unpublished data. Office of Public Health Support, Division of Program Statistics, Indian Health Service (2003-2005 AI/AN age-adjusted rates based on 2000 census with bridged – race categories.)
4 U.S. Department of Health and Human Services. Indian Health Service. Trends in Indian Health, 2002-2003 Edition. Washington: Government Printing Office, Released October 2009. ISSN 1095-2896. p. 195.

growing support from IHS to help communities address the dual crises of methamphetamine abuse and suicide in Indian Country.

Telebehavioral Health: The ASAP program incorporates telebehavioral health technology as a means to increase access to behavioral health services. Over 50 IHS and Tribal facilities in eight IHS Areas have incorporated telebehavioral health as part of their services. In FY 2012, more than 1,700 behavioral health encounters were delivered via telehealth platforms. Established in 2008, the TeleBehavioral Health Center of Excellence (TBHCE) in Albuquerque provides a range of behavioral health services, technical assistance, and training opportunities via televideo. For example, clinical services were provided to the Nashville Area Youth Regional Treatment Center and Catawba Service Unit and technical support was provided to a number of sites implementing telehealth technology. In partnership with the University of New Mexico, the TBHCE conducted webinar training for over 100 participants on the following topics: Introduction to Addiction; Opiate Dependence; Introduction to Medication Assisted Treatments for Opiate Dependence: Screening for Addiction and Monitoring for Aberrant Behavior in Patients with Chronic Pain; and a three part series on Traditional and Biomedical Approaches to Screening, Assessment, Diagnosis, and Treatment for Co-occurring Disorders. In FY 2012, the TBHCE began providing clinical services in the Billings Area, provided technical assistance to the Phoenix Area, and offered educational opportunities via televideo on pain management and prescription drug abuse, screening for developmental disorders and fetal alcohol spectrum disorders among children, among other behavioral health topics.

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

Partnerships: IHS has devoted considerable effort to develop and share effective programs throughout the Indian health system. The Agency believes developing programs that are collaborative, community driven, and nationally supported offer the most promising potential for long term success and sustainment. Through partnership and consultation, IHS and Tribes are working together to improve the health of AI/AN communities.

IHS is collaborating with other agencies working in the field of substance disorders such as the Substance Abuse and Mental Health Services Administration (SAMHSA), Veterans Health Administration, Health Resources and Services Administration, Office of National Drug Control Policy, and Centers for Medicare and Medicaid Services to ensure that the best available information, training, protocols, evaluations, performance measures, data needs, and management skills are incorporated and shared with all agencies and organizations working on substance use disorders.

The Department of the Interior (DOI) through the Bureau of Indian Affairs (BIA) and the Bureau of Indian Education (BIE) and the IHS have a memorandum of agreement (MOA) on Indian alcohol and substance abuse prevention. Through this MOA, BIA, BIE, and IHS will coordinate

and implement plans in cooperation with Tribes, which have the primary responsibility for protecting and ensuring the well-being of their members. The MOA emphasizes assisting Tribal governments in their efforts to address behavioral health issues. The MOA includes coordination of data collection, resources, and programs of IHS, BIA, and BIE.

The Tribal Law and Order Act (TLOA) requires a significant amount of interagency coordination and collaboration among HHS (IHS and SAMHSA), DOI (BIA/BIE), Department of Justice (DOJ) (Office of Justice Programs/Office of Tribal Justice), and the Office of the Attorney General. The leverage and coordination of Federal efforts and resources will assist in determining both the scope of alcohol and substance abuse problems as well as effective prevention and treatment programs. The MOA required by Section 241 of the TLOA was signed on July 29, 2011 by the Secretaries of the Departments of Health and Human Services and the Interior and the Attorney General to: 1) determine the scope of the alcohol and substance abuse problems faced by Tribes; 2) identify and delineate the resources each entity can bring to bear on the problem; 3) set standards for applying those resources to the problems; and 4) coordinate existing agency programs with those established under the 1986 Act.

In FY 2014, the ASAP will continue to focus on integration of behavioral health into primary care. IHS supports changing the paradigm of mental health services from being fragmented, episodic, stigmatized, specialty, and disease-focused to being a part of primary care and the medical home. The medical home is an accessible and patient-centered system of care that provides safe, timely, effective, efficient, and equitable care. This paradigm offers new opportunities for interventions that identify high-risk individuals before their actions or behavior become more clinically significant. IHS will continue to promote the ASBI as an integral part of a primary care based behavioral health program. IHS will provide support to YRTCs in meeting the needs of youth. There will continue to be a focus on the MSPI pilot program, which provides methamphetamine and suicide prevention and intervention resources to communities in Indian Country with the greatest need for these programs. Plans also include ongoing improvements for the RPMS to support clinical best practices and disease surveillance in collaboration with Tribal and Federal partners.

FUNDING HISTORY

Fiscal Year	Amount
2009 Omnibus	$183,769,000
2010 Enacted	$194,409,000
2011 Enacted	$194,409,000
2012 Enacted	$194,297,000
2013 Continuing Resolution	$195,486,000

BUDGET REQUEST

The FY 2014 budget request for Alcohol & Substance Abuse of $196,405,000 is an increase of $2,108,000 over the FY 2012 Enacted level.

The increase will provide:

Current Services +$2,108,000

- Pay costs +$415,000 – to fund pay increases for Federal and Tribal employees.

- Additional Staffing/Operating Costs at New Healthcare Facilities +$1,693,000
  The following healthcare facilities reflect the sixteen additional staffing needs that IHS has determined as its minimum potential request for FY 2014. Under the Joint Venture Construction Program (JVCP), Tribes are fulfilling its responsibility under the JVCP agreement to fund the construction and equipment for the healthcare facility. IHS' responsibility is to request the funds for the additional staff and to operate the healthcare facility. Increases in ASAP funding are required for additional staffing since it is recurring funding to the facility in subsequent years.

Additional Staff for New Healthcare Facility – Minimum Need for FY 2014	Amount	Additional Positions to be Funded
Chickasaw Nation Health Clinic (JV), Ardmore, OK	$273,000	3
Cherokee Nation Health Center (JV), Vinita, OK	$91,000	1
Southcentral Foundation Valley Primary Care Center (JV), Wasilla, AK	$400,000	4
Tanana Chief Conference Interior Health Center (JV), Fairbanks, AK	$257,000	2
Norton Sound Regional Hospital, Nome, AK	$96,000	1
Chickasaw Nation Health Clinic (JV), Tishomingo, OK	$273,000	3
Samuel Simmonds Hospital, Barrow, AK	$211,000	1
San Carlos Health Center, San Carlos, AZ	$92,000	1
Grand Total:	**$1,693,000**	**16**

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
10. **YRTC Improvement/ Accreditation:** Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more)	FY 2012: 91% (Target Not Met)	100%	100%	0
11. **Alcohol Screening (FAS Prevention):** Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients. IHS-All	FY 2012: 63.8% (Target Exceeded)	58.7%	61.9%	3.2%
11. Tribally Operated Health Programs	FY 2012: 59.3% (Target Exceeded)	50.1%	57.6%	7.5%
Methamphetamine and Suicide Prevention Initiative (MSPI)				
ASA – 1: The number of identified meth using patients who enter methamphetamine treatment program *(Output)*	FY 2012: 2,177 (Target Exceeded)	1,240	2,177	937
ASA – 2: The number of youth (ages 6 – 21) who participate in evidence-based and/or promising practice prevention or intervention programs *(Output)*	FY 2012: 133,970 (Target Exceeded)	42,895	133,970	91,075

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
ASA – 3: The number of individuals trained in suicide crisis response *(Output)*	FY 2012: 2,857 (Target Exceeded)	674	2,857	2,183
ASA – 4: Increase Telebehavioral health encounters** *(Output)*	FY 2012: 3,094 (Target Exceeded)	617	3,094	2,477

* Number of individuals trained has been reported instead of teams trained due to inconsistencies around definitions. Both measures will be collected in progress reporting for 2011.
** Many programs did not have their telebehavioral health equipment operational until the final months of the base year resulting in fewer encounters than would be expected from a full year of telebehavioral health data reporting.

The accreditation measure for Youth Regional Treatment Centers reflects an evaluation of the quality of care associated with accreditation status by either the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities (CARF), State certification, or regional Tribal health authority certification. The actual performance measure was not met in FY 2012 as a result of internal infrastructure challenges with one YRTC program. IHS is committed to providing the necessary technical assistance needed in order to assist this facility in obtaining CARF accreditation. The FY 2014 performance target for the YRTCs is 100 percent accreditation and certification status.

Heavy drinking during pregnancy can cause significant birth defects including Fetal Alcohol Syndrome (FAS). FAS is the leading known, and preventable, cause of mental retardation. Rates of FAS are higher among American Indians and Alaska Natives than the general population. Screening with intervention has been shown to be effective in reducing alcohol misuse during pregnancy and to reduce the incidence of FAS.

In FY 2012, the 58.7 percent target for FAS Prevention was exceeded. In FY 2014, the target is 61.9 percent for the proportion of women screened for alcohol to prevent FAS. There have been significant increases in results since FY 2005, due to increased provider awareness, and an agency emphasis on behavioral health screening. IHS anticipates absorption of current services will impact the FAS Prevention result as there may be reduced access to alcohol screening, diagnosis, and treatment. This reduced access will in turn increase untreated alcohol and substance abuse and the morbidity burden on the individual, family, and community.

GRANT AWARDS

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget
Number of Awards	15	15	15
Average Award	$100,000	$100,000	$100,000
Range of Awards	n/a	n/a	n/a
Total Awards	$1,500,000	$1,500,000	$1,500,000

AREA ALLOCATION – Alcohol and Substance Abuse *(dollars in thousands)*

Discretionary SERVICES	FY 2012 Enacted	FY 2013 Cont. Resolution	FY 2014 Request	FY 2014 +/- FY 2012
Aberdeen	$14,417	$14,427	$14,448	$31
Alaska	31,328	31,857	32,359	1,031
Albuquerque	12,543	12,551	12,569	27
Bemidji	10,357	10,364	10,379	22
Billings	11,418	11,426	11,442	24
California	11,245	11,253	11,269	24
Nashville	9,077	9,083	9,096	19
Navajo	19,476	19,490	19,518	42
Oklahoma	15,758	16,515	16,428	671
Phoenix	17,090	17,102	17,219	129
Portland	16,698	16,710	16,734	36
Tucson	3,218	3,221	3,225	7
Headquarters	21,671	21,487	21,718	46
Total, A&SA	**$194,297**	**$195,486**	**$196,405**	**+$2,108**

Note: The allocation amounts are estimates.

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$843,575	$848,739	$878,575	+$35,000
FTE**	0	0	0	0

**Purchased/Referred Care funds are not used to support Federal FTEs.

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

FY 2014 Authorization...Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Congress has requested the title of the Contract Health Services program be changed to the Purchased/Referred Care Program to more accurately reflect its true purpose.

Purchased/Referred Care (PRC) funds are used to purchase services from private health care providers in situations where (1) no IHS direct care facility exists, (2) the direct care element is not capable of providing required emergency and/or specialty care, (3) the direct care element has an overflow of medical care workload, and (4) supplementation of alternate resources is required (i.e., Medicare, private insurance) to provide comprehensive care to eligible Indian people.

The annual allocation of PRC funds is based on each Area's established funding base for the prior year and increases for inflation and population growth are distributed among the Area or Tribes base. New PRC funds are distributed to the IHS Areas using a formula that consists of three basic integrated factors: (1) active user population, (2) relative cost of purchasing health care services within a geographic area, and (3) access to care, specifically lack of availability of inpatient care.

The PRC program uses the PRC eligibility criteria and the IHS medical priority system in order to determine priorities for purchasing services, and uses the Medicare-Like Rate to purchase all inpatient health care services, while utilizing alternate resources to ensure IHS is the payor of last resort. Tribes manage about 54 percent of the PRC budget and must adhere to the same regulations as the IHS-managed PRC programs.

PRC is consistently the top budget priority of Tribes during both the budget formulation process and in numerous meetings with IHS and Tribes.

Accomplishments

Purchased/Referred Care -- The rising cost of health care services and transportation, and the increased need for PRC services has led to increased demand for PRC. Medical inflation,

providing care to an aging population, and State Medicaid reforms/reductions in services also increase demand for PRC resources. In FY 2012 PRC denied an estimated 186,353 services needed by eligible American Indians and Alaska Natives (AI/AN). Since Tribally managed programs are not required to report on denials, it is difficult to provide a verifiable and complete measure of total unmet need for the entire system; the denied services estimate is based on actual data from Federal programs and estimated Tribal data. At current funding levels, most programs are approving only medically emergent referrals (Priority One or life or limb care) and less urgent, routine and/or preventive care is deferred or denied pending additional appropriations. Because of recent PRC appropriations increases since FY 2010, some of the IHS and Tribally managed PRC programs have been able to approve referrals in other priority categories, which increases access to more patient care services including some preventive care services.

Catastrophic Health Emergency Fund (CHEF) -- The PRC budget also includes $51.5 million for the CHEF, which provides funding to reimburse costs for high cost cases (after meeting a threshold amount of payment) such as burn victims, motor vehicle accidents, high risk obstetrics, and cardiology. CHEF is centrally managed at IHS Headquarters and is available to IHS and Tribally managed PRC programs. Funding from the CHEF program helps reduce the impact of an unexpected, high-cost case on limited PRC funding.

In FY 2012, 1,879 high cost cases were reimbursed from CHEF funds on a rolling basis at a total cost of $51,500,000; however, there were 641 submitted cases that were not reimbursed by the CHEF program at a total cost of $13,664,304. It is estimated that more cases may qualify for CHEF reimbursement but were not reported by the local IHS and Tribally managed PRC programs due to the depletion of CHEF before the end of FY 2012. .

The PRC program maximizes its annual resources by contracting with Blue Cross/Blue Shield of New Mexico as its fiscal intermediary (FI). The FI assists the IHS by ensuring PRC payments are made in accordance with IHS's payment policy and coordinates benefits with other payers to maximize the PRC resources. All IHS managed PRC programs and some Tribally managed PRC programs utilize the FI to ensure the use of Medicare-Like Rates.

An important trend in IHS's healthcare facility construction underscores the importance of PRC funding to IHS and Tribal healthcare facilities. Five hospitals have been or are planned to be replaced by ambulatory health centers with no inpatient services because the workload does not necessitate full service hospitals. To maintain the same level of services, these new ambulatory health centers will be required to purchase inpatient care from the private sector, which will increase demand for PRC inpatient funding.

Based on input that improving the PRC program is a top Tribal priority, the IHS Director established a Tribal workgroup in FY 2010 to review and make recommendations on improving the business practices of the program. A technical subcommittee was created to evaluate and make recommendations on how to improve calculations of the total current need and estimated future need. Work sessions were held at all twelve Areas in FY 2011 and FY 2012 where recommendations on specific measurable changes to improve the business of the program were developed. IHS staff and Tribes continue to work together on further implementation of the approved recommendations to improve business practices over the next few years. A core curriculum with nine learning modules was developed and is available for hard copy use and is scheduled to be available online by April 2013. The online version will be available to federal and tribal PRC staff. The PRC chapter of the IHS Manual has been revised and is in the review process.

The PRC program is also involved in case management and best practice activities to ensure AI/AN patients receive quality patient care when referred to private providers and that all third party payers are identified prior to utilizing PRC funds. These activities directly relate to the Agency's priority to improve the quality of and access to care and improve how the Agency does business. Both IHS and Tribally managed PRC programs are also developing training and education for patients and outside providers. The IHS Director posted a six-part blog on the IHS website entitled "Understanding the CHS [PRC] Program" in 2011 that provided education on the PRC program for the general public and staff.

FUNDING HISTORY

Fiscal Year	PRC	CHEF	TOTAL
2009 Omnibus	$603,477,366	$31,000,000	$634,477,000
2010 Enacted	$731,347,000	$48,000,000	$779,347,000
2011 Enacted	$731,927,000	$48,000,000	$779,927,000
2012 Enacted	$792,075,000	$51,500,000	$843,575,000
2013 Continuing Resolution	$797,239,,000	$51,500,000	$848,739,000

BUDGET REQUEST

The FY 2014 budget request for Purchased/Referred Care of $878,575,000 is an increase of $35,000,000 above the FY 2012 Enacted level.

+$35,000,000 will cover inflationary costs to maintain purchasing the current level of services.

The recurring base of PRC budget provides the following services:

- $51,500,000 for CHEF high cost cases
- $792,075,000,000 to purchase:
    - 33,361Inpatient admissions
    - 1,245,961 Outpatient visits
    - 45,881 one-way patient travel trips

The Purchased/Referred Care program impacts the Agency's third priority to improve the quality of and access to care while improving customer service for patients and providers. These services are critical and provide needed care to thousands of patients who would otherwise not have access.

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

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
CHS-1: Average Days between Service End and Purchase Order (PO) Issued *(outcome)*	FY 2012: 68.8 days (Target Exceeded)	78 days	74 days	0 days

AREA ALLOCATION – Purchased/Referred Care *(dollars in thousands)*

Discretionary SERVICES	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request	FY 2014 +/- FY 2012
Aberdeen	$84,711	$85,870	$88,225	$3,515
Alaska	82,025	82,467	85,429	3,403
Albuquerque	40,572	40,462	42,256	1,683
Bemidji	57,175	56,985	59,547	2,372
Billings	60,574	61,776	63,087	2,513
California	44,946	44,370	46,811	1,865
Nashville	32,553	32,816	33,904	1,351
Navajo	92,342	92,485	96,173	3,831
Oklahoma	104,298	103,670	108,625	4,327
Phoenix	68,526	68,612	71,369	2,843
Portland	89,887	90,559	93,616	3,729
Tucson	18,101	18,485	18,852	751
Headquarters	67,866	70,182	70,681	2,816
Total, PRC	**$843,575**	**$848,739**	**$878,575**	**+$35,000**

Note: The allocation amounts are estimates.

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$147,023	$147,923	$152,463	+$5,440
FTE**	274	274	274	0

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

SUMMARY OF THE BUDGET REQUEST

The FY 2014 budget request for Preventive Health of $153,363,000 is an increase of $5,440,000 above the FY 2013 Continuing Resolution level.

- The FY 2014 budget request for **Public Health Nursing** (PHN) of $71,194,000 is an increase of $4,562,000 above the FY 2012 Enacted level. The increase will be used for pay increases and staffing new/replacement facilities. The PHN base funding supports prevention-focused nursing care interventions for individuals, families, and community groups as well as improving health status by early detection through screening and disease case management. The PHN program home visiting service provides primary, secondary, and tertiary prevention focused health interventions.
  - *Primary prevention* targets healthy populations and activities are aimed at preventing the onset of disease in high risk populations through education, health awareness, immunizations, and risk reduction. For example, the PHNs provide childhood obesity prevention activities through breastfeeding promotion to the prenatal patient and during the postpartum time in home visits to mother and baby after hospital discharge.
  - *Secondary prevention* detects and treats problems in the early stages of illness or disease. These interventions target disease before complications arise and before signs or symptoms appear and include health screening for diabetes and hypertension, fall risk assessments, and school health assessments.
  - *Tertiary prevention* reduces further complications from a disease or illness and restores the individual to their optimum level of health. Interventions include chronic disease care, self-management education, medication management, and care coordination. For example, a PHN may make a home visit after a patient is discharged from a hospital to help reduce preventable complications and hospital readmissions.

- The FY 2014 budget request for **Health Education** of $17,677,000 is an increase of $620,000 above the FY 2012 Enacted level. The increase will be used for pay increases and staffing new/replacement facilities. The Health Education base funding will be used to support the provision of community health, school health, worksite health promotion, and patient education. The Health Education program standardizes, coordinates, and integrates education initiatives within IHS, including health literacy for AI/AN individuals and communities, provision of professional education and training, and developing educational materials for staff, patients, families, and communities.

- The FY 2014 budget request for **Community Health Representatives** (CHRs) of $61,661,000 is an increase of $254,000 above the FY 2012 Enacted level. IHS will use the

funds for pay increases and staffing new/replacement facilities. The base funding helps to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained indigenous community members. CHRs use local community knowledge to help integrate and disseminate basic information about health promotion/ disease prevention and self-management support to patients. With more pilot sites participating in the Agency's Improving Patient Care and Partnership for Patients efforts, several are reporting how valuable the input and services provided by CHRs are to improving patient care.

- The FY 2014 budget request for **Hepatitis B and Haemophilus Immunization Programs (Alaska)** of $1,931,000 is an increase of $4,000 above the FY 2012 Enacted level. The increase will be used for pay increases. The base funding will continue the provision of vaccines for preventable diseases, immunization consultation/ education, research, and liver disease treatment and management through direct patient care, surveillance, and education. The Hepatitis B and Haemophilus Immunization Programs (Alaska) budget supports these priorities through direct patient care, surveillance, and educating AI/AN patients.

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

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$66,632	$67,040	$71,194	+$4,562
FTE**	241	241	241	0

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

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

FY 2014 Authorization...Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS Public Health Nursing (PHN) Program is a community health nursing program that focuses on the goals of promoting health and quality of life, and preventing disease and disability.

The PHN Program provides quality, culturally sensitive health promotion and disease prevention nursing care services through primary, secondary and tertiary prevention services to individuals, families, and community groups.

- *Primary prevention interventions* include health education for health promotion, risk reduction, and immunizations.
- *Secondary prevention interventions* detect and treat problems in their early stages. Examples include health screening of high-risk populations, screening for diabetes and hypertension, fall risk assessments, and school health assessments.
- *Tertiary prevention interventions* prevent or limit complications and disability in persons with an existing disease. Other interventions include chronic disease care, self-management education, medication management, and care coordination.

PHNs play a critical role in the surveillance of communicable diseases. The PHN expertise in communicable disease assessment, outreach, investigation, surveillance and monitoring interventions helps to manage and prevent the spread of disease in communities. The PHNs contribute to the agency's primary prevention efforts by providing community immunization clinics and immunizations to homeward bound AI/ANs.

PHN home visiting nursing services include services for:

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

The PHN Program awarded 10 grants and 5 program awards in calendar year (CY) 2012 with continuation funding through CY 2017. These grants and program awards provide funding to increase local nursing services through public health nursing case management programs for high risk and vulnerable patients and families. The intent of this project is to make available an array of PHN Best Practices/Promising Practices to support a PHN Case Management Program through the cooperative agreement grant & program award process for 5 years (2012-2017).

A PHN data improvement project exists to evaluate PHN data and identify training needs to improve documentation and health care service. The PHN Data Mart captures data related to clinical and quality improvement activities; and, these reports are used to determine demands for PHN services as well as to report accountability and transparency as the program aligns with Agency priorities. PHN specific performance activities can be extracted from the data base as needed to measure or report outcome of service. The data quality improvement project began in 2009 and demonstrated increased performance in FY 2010. In 2011, PHN programs began to utilize the Electronic Health Record, coding and documentation was a concern; therefore, in March 2012, PHN documentation and coding training was held to support the PHN electronic health record documentation process. The FY 2012 result for the PHN performance measure was 435,848 encounters. This is the total number of primary, secondary and tertiary prevention activities provided by the PHN to individuals, families and community groups.

FUNDING HISTORY

Fiscal Year	Amount
2009 Omnibus	$59,885,000
2010 Enacted	$64,071,000
2011 Enacted	$63,943,000
2012 Enacted	$66,632,000
2013 Continuing Resolution	$67,040,000

BUDGET REQUEST

The FY 2014 budget request for Public Health Nursing of $71,194,000 is an increase of $4,562,000 above the FY 2012 Enacted level. The increase includes:

Pay Costs +$179,000 to fund pay increases for Federal and Tribal employees.

Additional Staffing/Operating Costs for New Healthcare Facilities +$4,383,000
There are 10 new and expanded healthcare facilities that are planned to open in FY 2014. The following healthcare facilities reflect the 33 additional staffing needs that IHS has determined as its minimum potential request for FY 2014. Seven of the 10 facilities listed are Joint Venture Construction Program (JVCP) projects where the Tribe is fulfilling its responsibility under the JVCP agreement to fund the construction and equipment for the healthcare facility. IHS' responsibility is to request the funds for the additional staff and to operate the healthcare facility. Increases in PHN funding are required for additional staffing since it is recurring funding to the facility in subsequent years.

Additional Staff for New Healthcare Facility – Minimum Need for FY 2014	Amount	Additional Positions to be Funded
Chickasaw Nation Health Clinic (JV), Ardmore, OK	$720,000	6
Cherokee Nation Health Center (JV), Vinita, OK	$121,000	1

Additional Staff for New Healthcare Facility – Minimum Need for FY 2014	Amount	Additional Positions to be Funded
Southcentral Foundation Valley Primary Care Center (JV), Wasilla, AK	$1,247,000	9
Tanana Chief Conference Interior Health Center (JV), Fairbanks, AK	$884,000	6
Norton Sound Regional Hospital, Nome, AK	$640,000	5
Chickasaw Nation Health Clinic (JV), Tishomingo, OK	$486,000	4
Samuel Simmonds Hospital, Barrow, AK	$165,000	1
San Carlos Health Center, San Carlos, AZ	$120,000	1
Grand Total:	**$4,383,000**	**33**

With the FY 2014 budget request, the PHN program will continue working towards achieving its performance targets of:

1. Providing approximately 425,679 health activities and services to AI/AN patients in FY 2014;
2. Continuing to support national measures of maternal-child health, such as childhood immunizations, prenatal visits, postpartum visits, childhood obesity prevention through breastfeeding promotion, and domestic violence screening through collaboration with related Federal, state, local, and private programs;
3. Integrating PHN Case Management best practices into the 2012 cooperative agreement grant and program awards; and
4. Implementing best practices identified as a result of participating in the President's Partnership for Patients initiative by reducing hospital readmissions by 20 percent by the end of calendar year (CY) 2013 as compared to 2010.

The PHN program will continue to coordinate and collaborate with related Federal, state, local and private programs to promote efforts to expand and improve maternal and child-health services. Home visiting is a long-standing, well-known prevention strategy used by States and communities to improve the health and well-being of women, children, and families, particularly those who are at risk. Early investments in home visiting programs have been shown to reduce costs caused by foster care placements, hospitalizations and emergency room visits, unintended pregnancies, and other more costly interventions.[1]

The PHN program will also continue its focus on case management to include the client, family, and other members of the health care team. Quality of care, continuity, and assurance of appropriate and timely interventions are also crucial.[2] In addition to reducing the cost of health care, case management, "has proven its worth in terms of improving rehabilitation, improving quality of life, increasing client satisfaction and compliance by promoting client self-determination."[3]

All PHN programs will report on new clinical performance measures for hospital readmissions that will be aligned with national quality measurements, such as the measurements stated in the

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[1] Deanna S. Gomby, Paul L. Culross, and Richard E. Behrman, issue eds., "Home Visiting: Recent Program Evaluations," (published by The David and Lucille Packard Foundation) The Future of Children 9, no. 1 (Spring/Summer 1999); David Olds, Charles Henderson, Charles Phelps, Harriet Kitzman, and Carole Hanks, "Effect of prenatal and infancy nurse home visitation on government spending," Medical Care 31, no. 2 (1993): 155–174.

[2] Deanna S. Gomby, Paul L. Culross, and Richard E. Behrman, issue eds., "Home Visiting: Recent Program Evaluations," (published by The David and Lucille Packard Foundation) The Future of Children 9, no. 1 (Spring/Summer 1999).

[3] Reel SJ, Morgan-Judge T, Peros DS, and Abraham IL. School-based rural case management: a model to prevent and reduce risk. J Am Acad Nurse Pract. 2002. Jul; 14(7):291–6. [PubMed].

President's Partnership for Patients initiative: by the end of CY 2013, preventable complications during a transition from one care setting to another will decrease, thereby reducing all hospital readmissions by 20 percent (compared to 2010). Achieving this goal would mean, on a national level, more than 1.6 million patients would recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.[4]

The IHS PHN Program works closely with other Federal agencies to foster high-quality, well-coordinated home visiting programs for AI/AN families in at-risk communities. Local PHN programs take advantage of opportunities to partner with other programs, such as the Maternal, Infant and Early Childhood Home Visiting Program and other programs funded under the Affordable Care Act.

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
23: **Public Health Nursing:** Total number of public health activities captured by the PHN data system; emphasis on primary, secondary and tertiary prevention activities to individuals, families and community groups.	FY 2012: 435,848 (Target Exceeded)	424,203	425,679	1,476

The FY 2012 target for the PHN performance measure was 424,203 encounters. The final result of 435,848 encounters exceeded the target by 11,645 encounters, a 2.7 percentage increase. In 2011, all PHN programs began to use the Electronic Health Record and many programs identified coding and documentation issues. Such issues as miscoding of the PHN provider code, PHN clinic codes, and location codes were identified as significant coding concerns. In March 2012, PHN documentation and coding training was held to improve and standardize PHN electronic health record documentation practices. In addition, the PHN Documentation and Coding manual was updated to include documentation guidance and standardized coding charts. IHS is committed to providing the necessary technical assistance to improve documentation practices to assure accuracy.

GRANTS AWARDS

	FY 2012 Enacted	FY 2013 Request	FY 2014 Request
Number of Awards	15	15	15
Average Award	$150,000	$150,000	$150,000
Range of Awards	$150,000	$150,000	$150,000

[4] Smith DS. Standards of practice for case management. J Care Manage. 1995. Oct; 1(3):7
Jencks, Stephen F., Williams, Mark V., and Coleman, Eric A. 2009. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. *N Engl J Med* 360 (14):1418-1428; Benbassat, J., Taragin, M. 2000. Hospital readmissions as a measure of quality of health care: advantages and limitations. *Archives of Internal Medicine* 160 (8):1074-1081.

AREA ALLOCATION – Public Health Nursing *(dollars in thousands)*

Discretionary SERVICES	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request	FY 2014 +/- FY 2012
Aberdeen	$9,462	$9,010	$9,488	$25
Alaska	3,873	5,472	6,820	2,946
Albuquerque	3,469	3,332	3,478	9
Bemidji	2,218	2,131	2,224	6
Billings	4,277	4,109	4,288	11
California	938	901	941	3
Nashville	1,083	1,040	1,086	3
Navajo	13,564	13,031	13,601	36
Oklahoma	12,437	13,734	13,797	1,360
Phoenix	7,190	6,907	7,329	139
Portland	3,002	2,884	3,010	8
Tucson	1,035	994	1,038	3
Headquarters	4,085	3,493	4,095	11
Total, PHN	**$66,632**	**$67,040**	**$71,194**	**+$4,562**

Note: The allocation amounts are estimates.

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$17,057	$17,161	$17,677	+$620
FTE**	26	26	26	0

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

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

FY 2014 Authorization..Permanent

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 to educate American Indian/Alaska Native (AI/AN) clients and communities about their health. The program continues to focus on the importance of educating AI/AN clients in a manner that empowers them to make better choices in their lifestyles and how they utilize health services. Good patient care includes the provision of education, but, more importantly, accreditation requirements specifically require the provision of and documentation of education.

Health Education funds support approximately 75 Tribal Health Education staff. These health educators possess the expertise to assist non-education staff to provide standardized health education that is consistent with validated learning principles and practices. To support the Health Educators, Headquarters leadership is provided to the 23 IHS full-time field positions located throughout the Indian health system.

Continued investment in the IHS Health Education program demonstrates IHS' commitment to integrate education and prevention services with clinical services to improve healthcare services for AI/AN people. The IHS Health Education program continues to meet, and in some cases exceed, its performance measures as documented in the outputs and outcomes table. Educational services provided by IHS, Tribal and Urban staff demonstrate a steady increase in the number of AI/AN clients that have a documented educational encounter. The number of visits in which education was provided has increased from approximately 777,000 visits in FY 2004, to 2,953,473 as of November 2012, a 280 percent increase in visits.

The Health Education program partners with other IHS disciplines and programs to ensure the education of IHS clients continues to occur, even at those sites without a full-time health educator. The Headquarters Health Education program provides the technical assistance and guidance on educational issues to all disciplines and programs. All education encounters are documented and coded in the Resource and Patient Management System (RPMS). Health Education provides leadership in the integration of Healthy People 2020 Objectives with goals

that integrate plain language, health literacy, patient-provider communications and electronic health information opportunities for our clients.

The IHS Health Education program demonstrates accountability through the development of the Patient Education Protocols and Codes (PEPC), which is an IHS-wide reporting system providing local, on-demand education data reports documenting a broad range of clinical and administrative information to managers at all levels of the Indian health system. The PEPC is the basic infrastructure supporting the provision of health education. The IHS Health Education program makes use of all available resources to implement critically important initiatives that are focused on meeting accreditation requirements, patient safety, and Healthy People 2020 Objectives, all of which assist in improving the overall delivery of care provided by IHS.

Preventive health services include health education and prevention. In 2011, Health Education expanded injury prevention and behavioral health (BH) education protocols to include domestic and sexual violence/assault, suicide prevention, child/elder abuse and neglect, mental health, and alcohol and substance abuse. The expansion of existing BH education protocols for I/T/U healthcare delivery systems was included in the new Behavioral Health RPMS Reporting system.

In July 2011, the Health Education program partnered with the Alaskan Tanana Chiefs Council Community Health Aide Program (CHA-P) to integrate into RPMS the documentation and coding of all education provided to AI/ANs by the Community Health Aides in rural Alaska. The Alaskan CHA-P will now be able to report to governing bodies, as needed, with data on education. The Community Health Aide Program Patient Education Codes and Protocols will now be deployed to multiple Tribes/Tribal clinics throughout Alaska thus improving patient care and helping to unify the patient record.

The Health Education program maintains data tracking of a key program objective: The number of clients who received health education services. See Outputs and Outcomes Tables (below) for more information.

IHS Health Education maintains IHS-wide statistics on educational encounters. Examples of data available from educational encounters include: 1) the number of clients who received health education services, 2) provider type delivering the health education, 3) where the education took place, 4) what information the patient was provided, 5) the amount of time spent providing this education, 6) whether the patient understood the education provided, and 7) whether the patient set a behavior goal change. These IHS statistics are currently available from the RPMS system. In partnership with all IHS programs, disciplines and staff, the Health Education Program staff continues to:

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

The Health Education Program has identified the following areas of emphasis for FY 2014:

- Continue to strengthen the development of standardized, nationwide patient and health education programs through the integration of the IHS Patient Education Protocols into all IHS software packages including the Patient Care Component (PCC) and the electronic health record, with the continued provision of ongoing training to IHS and Tribal staff on the documentation and coding of patient and health education. This effort assists IHS to meet accreditation requirements as well as *Healthy People* objectives to improve consumer access to health information and to improve health communications to our clients.

- Increase focus on the area of *Healthy People* through health communications:
  - Increase the proportion of AI/ANs with access to health information;
  - Improve the health literacy of AI/ANs with inadequate or marginal literacy skills;
  - Increase the health information contained on www.ihs.gov, ensuring that information disclosed is quality-assured and culturally appropriate for AI/AN clients;
  - Improve patient-provider communication skills; and
  - Improve the use of plain language in written health communications materials.

FUNDING HISTORY

Fiscal Year	Amount
2009 Omnibus	$15,723,000
2010 Enacted	$16,682,000
2011 Enacted	$16,649,000
2012 Enacted	$17,057,000
2013 Continuing Resolution	$17,161,000

BUDGET REQUEST

The FY 2014 budget request for Health Education of $17,677,000 is an increase of $620,000 above the FY 2012 Enacted level. The increase includes:

- Pay Costs +$40,000 – to fund pay increases for Federal and Tribal employees.
- Additional Staffing/Operating Costs for New Healthcare Facilities +$580,000
  The following healthcare facilities reflect the 6 additional staffing needs that IHS has determined as its minimum potential request for FY 2014. Seven of the 10 facilities listed are Joint Venture Construction Program (JVCP) projects where the Tribe is fulfilling its responsibility under the JVCP agreement to fund the construction and equipment for the healthcare facility. IHS' responsibility is to request the funds for the additional staff and to operate the healthcare facility. Increases in Health Education funding are required for additional staffing since it is recurring funding to the facility in subsequent years.

Additional Staff for New Healthcare Facility – Minimum Need for FY 2014	Amount	Additional Positions to be Funded
Chickasaw Nation Health Clinic (JV), Ardmore, OK	$91,000	1
Southcentral Foundation Valley Primary Care Center (JV), Wasilla, AK	$114,000	1
Tanana Chief Conference Interior Health Center (JV), Fairbanks, AK	$218,000	2
Norton Sound Regional Hospital, Nome, AK	$96,000	1
Chickasaw Nation Health Clinic (JV), Tishomingo, OK	$61,000	1
Grand Total:	**$580,000**	**6**

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
Number of Visits with Health/Patient Education *(Output)*	FY 2012: 2,953,473 (Target Exceeded)	2,722,160	2,874,290	152,130

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

AREA ALLOCATION – Health Education *(dollars in thousands)*

Discretionary SERVICES	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request	FY 2014 +/- FY 2012
Aberdeen	$1,969	$1,937	$1,974	$5
Alaska	1,904	2,107	2,336	432
Albuquerque	1,224	1,204	1,227	3
Bemidji	634	624	636	1
Billings	1,229	1,209	1,232	3
California	258	254	258	1
Nashville	518	509	519	1
Navajo	2,348	2,309	2,353	6
Oklahoma	2,737	2,908	2,896	158
Phoenix	1,824	1,794	1,829	4
Portland	952	936	954	2
Tucson	222	219	223	1
Headquarters	1,237	1,152	1,240	3
Total, HEALTH ED	**$17,057**	**$17,161**	**$17,677**	**+$620**

Note: The allocation amounts are estimates.

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$61,407	$61,783	$61,661	+$254
FTE**	7	7	7	0

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

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

FY 2014 Authorization..Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Community Health Representatives (CHRs) are a critical part of the Indian health system as they link available health programs to the American Indian and Alaska Native (AI/AN) patients and communities. This is accomplished by utilizing indigenous community members as health paraprofessionals to expand lay health education services, support patient self-management efforts, and initiate community change. CHRs provide health education, health promotion, and disease prevention services to Indian communities and Tribal members. Funds are distributed through Area allocations to the Tribes that employ approximately 1,600 CHRs.

CHRs provide a critical link in the continuity of care across settings that support patient care and monitoring, and self-management, especially important in geographically remote and rural reservations. These services help prevent avoidable hospital readmissions and emergency department visits. Training is a key tool to provide laypersons with the comprehensive health education, skills, and competencies needed to perform the wide variety of culturally sensitive job responsibilities the various Tribes assign to their CHRs. Training improves public health workforce skills and equips CHRs with the skills needed to provide 16 categories of services that patients report make a difference in their lives and that contribute to Agency performance measures. Research indicates that community health workers such as CHRs improve patient access to quality health care and contribute to greater patient satisfaction with health services.

Program accomplishments during FY 2012 include:

1) 245 CHRs trained in the IHS Resource Patient and Management System (RPMS) CHR Patient Care Component (PCC); 60 CHRs trained in Basic and Refresher courses;
2) Enhanced collaboration with various disciplines and offices such as: a) the Improving Patient Care Initiative which focuses on patient-centered care in a medical home model and incorporates community based programs and services; b) sample training curricula from Federal and non-governmental organizations (NGO) as resources to incorporate into existing curriculum; c) Tribes and Area staff for technical assistance; d) management of the IHS CHR website and listserv; and e) other federal agencies and NGOs to leverage resources
3) Revising Chapter 16, Community Health Representatives in the *Indian Health Manual* to

include revised standards of CHR practice such as scope of practice, core competencies, and reporting requirements.

4) Enhancements to the IHS Resource Patient and Management System (RPMS) CHR Patient Care Component (PCC) data application was beta tested and completed in FY 2012-13. Additional functionality and enhancements are being identified in different IHS Areas by local CHRs and OIT staff to identify and address the challenges of dual entry into two different programs.

For FY 2012, data from 40 percent of reporting CHR Programs on types of services provided by CHRs showed that over 21 percent was direct Patient Care (taking vital signs, providing foot care, providing emotional support); over 16 percent was Case Finding/Screening; over 16 percent was Case Management; over 11 percent was Monitored Patients; over 10 percent was Health Education; over 9 percent was Transportation; and over 4 percent was Other Patient Services.

FUNDING HISTORY

Fiscal Year	Amount
2009 Omnibus	$57,796,000
2010 Enacted	$61,628,000
2011 Enacted	$61,505,000
2012 Enacted	$61,407,000
2013 Continuing Resolution	$61,783,000

BUDGET REQUEST

The FY 2014 budget request for Community Health Representatives of $61,661,000 is an increase of $254,000 above the FY 2012 Enacted level. The increase includes:

- Pay Costs +$134,000 to fund pay increases for Federal and Tribal employees.
- Staffing and Operating Costs for New/Replacement Facilities +$120,000
  The following healthcare facilities reflect the two additional staffing needs that IHS has determined as its minimum potential request for FY 2014. Seven of the 10 facilities listed are Joint Venture Construction Program (JVCP) projects where the Tribe is fulfilling its responsibility under the JVCP agreement to fund the construction and equipment for the healthcare facility. IHS' responsibility is to request the funds for the additional staff and to operate the healthcare facility. Increases in Community Health Representatives funding are required for additional staffing since it is recurring funding to the facility in subsequent years.

Additional Staff for New Healthcare Facility – Minimum Need for FY 2014	Amount	Additional Positions to be Funded
Cherokee Nation Health Center (JV), Vinita, OK	$120,000	2
Grand Total:	**$120,000**	**2**

The total funding for Community Health Representatives will be used to provide:

- $59.4 million for Self-Determination contracts and compacts with Tribes for direct health care, health promotion and disease prevention services in homes and other community-based settings as identified in Tribal funding agreements and scopes of work to 2.2 million AI/AN population throughout 12 Areas.

- $2.1 million for training, information technology costs, and special projects. However, approximately two-thirds of this amount represents Tribally-administered funds. Remaining Federally retained funds will support the following plans for FY 2014, but are not limited to:
    - Training CHRs nationally on the CHR PCC data application;
    - Providing onsite CHR basic and refresher training using appropriate adult education techniques and paying registration, travel, and per diem for CHRs from Tribes leaving Headquarters shares for training;
    - Apportioning funds to pay for online training development, testing, implementation and maintenance;
    - Providing administrative and logistical, training, web management, listserv, and other program assistance;
    - Refining the CHR curriculum for cost-effective training through online training modules and training in person;
    - Continuing investments in health information technology development, refinement, and data support to enhance the CHR data application in RPMS;
    - Enhancement of the national CHR web-based tracking system to improve data reporting by Tribal and Federal CHR programs to IHS and by IHS to Congress at the national level;
    - Continuing efforts to provide CHR education on the Improving Patient Care Initiative and Model for Improvement; testing and refinement of an assessment tool to identify improvements for CHR programs; and dissemination of information related to CHR involvement and integration into each patient's health care team and medical home; and
    - Updating the CHR Resources and Requirements Methodology (RRM) module, part of the system IHS uses to prepare staffing estimates based on workload information for each discipline to Congress and Tribes.

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
CHR-2: CHR patient contacts for Chronic Disease Services (1), (2), (3)	FY 2012: 201,575 (Target Exceeded)	196,396	195,815	-581
CHR-1: Number of patient contacts (3), (4)	FY 2012: 2,098,704 (Target Exceeded)	1,836,168	2,038,729	202,561
CHR-3: Number of CHRs trained (5)	FY 2012: 333 (Target Not Met)	780	414	-366

[1, 3]110 of 290, about 38 percent, CHR Programs assigned Program Codes reported in RPMS CHR PCC during FY 2012, the only way IHS Headquarters can track CHR data (47 per cent reported in FY 2011; 42 percent reported in 2009; 55 percent in 2008; 33 percent in 2007). 193,706 service hours were extrapolated from 47 percent reporting.
[2]The Program Performance target above represents an effort by the IHS national CHR Program to obtain specific number of patient contacts provided in the categories of diabetes, heart, hypertension, nutrition, cancer, other chronic, dialysis, obesity, depression, renal failure, and liver disease related to IHS GPRA indicators and drawn from the CHR PCC software application.
[3]Training conducted on CHR PCC suggests that CHRs routinely under-report the services they provide. Typically they report 2-3 services, but when queried further they identify 5-7 additional services that regularly are unreported (checking homes for hazards as part of injury prevention efforts, providing homemaker services, providing health information on/checking medications, coordinating appointments, interpreting/translating, health education).
[4]Patient contacts are the number of services multiplied by number served.
[5]The CHR National Education Training usually attended by 300 CHRs was postponed and not held in 2012. Only 59 CHRs attended the CHR Basic & Refresher training courses (80 slots were available).

With the budget proposed for FY 2014, the CHR program will maintain the level of services provided in FY 2013 and continue to address the following challenges:

1) Development of an appropriate online training system to the extent practicable with available funding while maintaining training requirements.
2) Coordinating data validations - currently, RPMS CHR PCC is the only data system by which IHS can furnish data for budget purposes or program management. With Tribes having the option of another data source, data validation coordination is essential.
3) Improving connectivity for remote sites.
4) Ensuring necessary Federal security requirements for Tribal members to request and maintain access to RPMS.

GRANTS AWARDS -- No grant awards are anticipated for FY 2014.

AREA ALLOCATION – Community Health Representatives *(dollars in thousands)*

Discretionary SERVICES	**FY 2012 Enacted**	**FY 2013 Continuing Resolution**	**FY 2014 Request**	**FY 2014 +/- FY 2012**
Aberdeen	$7,291	$7,321	$7,307	$15,910
Alaska	4,435	4,453	4,445	9,678
Albuquerque	3,521	3,536	3,529	7,684
Bemidji	4,840	4,860	4,850	10,561
Billings	4,479	4,497	4,489	9,773
California	2,014	2,023	2,019	4,396
Nashville	3,481	3,496	3,489	7,597
Navajo	6,927	6,955	6,942	15,116
Oklahoma	9,001	9,163	9,141	140
Phoenix	6,285	6,311	6,299	13,715
Portland	4,709	4,729	4,719	10,276
Tucson	1,978	1,986	1,982	4,316
Headquarters	2,444	2,454	2,450	5,334
Total, CHR	**$61,407**	**$61,783**	**$61,661**	**+$254**

Note: The allocation amounts are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Services: 75-0390-0-1-551

HEPATITIS B AND HAEMOPHILUS IMMUNIZATION PROGRAMS (ALASKA)

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$1,927	$1,939	$1,931	+$4
FTE**	0	0	0	0

**The program is operated by Tribal staff.

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

FY 2014 Authorization..Permanent

Allocation Method .... Self-Governance Compact

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Hepatitis B Program and Immunization (Hib) Program of the Alaska Native Tribal Health Consortium in collaboration with partners within the Alaska Tribal Health Care System provide clinical expertise and consultation, trainings, research, evaluation and surveillance.

Hepatitis B Program

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

Hepatitis and other liver disease continues to be a health disparity in American Indian and Alaska Native (AI/AN) people. To address this disparity, the Program provides:

- Regular medical monitoring and clinical care follow-up of chronic liver disease patients;
- Consultation on immunization and hepatitis issues;
- Follow-up of persons with autoimmune and non-alcoholic fatty liver disease; and
- Follow-up of large cohorts of persons vaccinated with hepatitis A and B vaccine to determine duration of immunity and if booster doses will be needed in the future.

The Program uses computer-based applications that integrate laboratory and other clinical data into a series of reports that allows program clinicians to follow a large number of patients with chronic hepatitis and other liver disease. The Program follows patients Statewide with chronic hepatitis B with the goal of reducing the lifetime risk of death from liver cancer or cirrhosis from 25 percent to less than 10 percent by early detection and removal of hepatocellular cancer and treatment with antiviral medications.

In 2012, at least 60 percent of AI/ANs with chronic hepatitis B or C infection were screened for liver cancer and for liver aminotransferase levels (60 percent and 73 percent of the population,

respectively) to detect liver inflammation and potential treatment candidates at least once during the year. In 2012 targets for chronic hepatitis B and C screening were exceeded. We continue to see an increase in newly diagnosed hepatitis C cases which may be due in part to the CDC recommendation to screen (without assessment of risk) all “baby boomers” (persons born 1945-65) for hepatitis C infection. The program is increasing patient outreach by establishing a Hepatitis C Support Group which holds regular meetings and be attended by clinical staff from the Program. A continuing challenge is to determine good candidates for antiviral therapy, especially with the advent and approval of several new potent and more effective antiviral agents. Within the next 5 to 10 years, an estimated 25–33 percent of persons with chronic hepatitis C will need therapy for Hepatitis C.

Immunization (Hib) Program

The Immunization (Haemophilus Influenza; Hib) Program started in 1989 with a targeted Haemophilus Influenzae type b prevention project in the Yukon Kuskokwim Delta and now maintains high vaccine coverage by providing resources, training, and coordination to Tribal facilities throughout Alaska. The Program conducts activities through e-mail, phone consultation, onsite training, teleconferences, web-based trainings, written guidelines, presentations, and site visits. Regular meetings are held with regional Immunization Coordinators, Clinical Directors, Community Health Aide Program (CHAP), IHS Immunization Coordinators, and the State of Alaska Immunization Program. The Program works with Tribal public relations to address parental immunization hesitancy and highlight the importance of vaccines. Statewide Alaska Native immunization coverage rates are reported to IHS headquarters for infants 3-27 months, 19-35 months, adolescents and older adults and flu vaccine among all ages.

In 2011-2012, the Program accomplished the following:

- Immunization Coverage for 19-35 month olds was 73%, compared to the 2011 national GPRA target of 74.6 percent for child vaccine coverage with 4:3:1:3:3:1:4 series (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1Var, 4 PCV). The target was not met because PCV4 was added to the series requiring 4 additional immunizations.
- Pneumococcal vaccine coverage in elders ≥ 65 years (92%) greatly exceeded the 2011 national GPRA objective of 79.3 percent.
- Administered human papillomavirus (HPV) vaccine 1+ dose coverage in 82% percent of Alaska Native females 13-17 years olds, which is much higher than the US all races coverage (47%).
- Achieved coverage with Haemophilus influenza type b (Hib) (94%) which is much higher than the US races.
- Achieved high coverage with 13 valent pneumococcal conjugate vaccine (PCV13) (96%) resulting in decrease in invasive pneumococcal disease.
- Consulted on RPMS immunization package, interface between tribal facilities and State Immunization Information System, and implementation of new electronic health records at tribal facilities.
- Achieved immunization rate of 74% for health care workers in all tribal facilities.
- Published articles (5) on lower respiratory infection hospitalization rates, empyema in American Indian/Alaska Native people, risk factors for respiratory hospitalization, and impact of PCV13 in peer-reviewed journals.
- Collaborating with several agencies in a Healthy Homes study to evaluate the impact of reducing indoor air pollution from woodstoves and improper ventilation on respiratory visits and symptoms in high risk Alaska Native children.

- Addressed the Alaska pertussis outbreak by promoting Tdap vaccine. Alaska Native adults 19-64 years have a rate of Tdap vaccination of 61% compared with the US adult estimate (2010) of only 8%.
- Collaborated with Tribal facilities to develop a strong teen vaccination program resulting in 13-17 year old Tdap vaccination rate of 90% and 1 HPV vaccination rate in females of 77%.

Immunization Measure	Age Group	Alaska Native coverage 3/31/2011
4:3:1:3:3:1:4	19-35 mo	74%
4:3:1:3:3:1	19-35 mo	82%
3 Hib vaccines doses		94%
3 PCV (pneumococcal conjugate vaccine)	19-35 mo	96%
1+ HPV	13-17 years female	77%
Pneumococcal vaccine	65+ years	93%
Tdap	19-64 yrs	61%

FUNDING HISTORY

Fiscal Year	Amount
2009 Enacted	$1,823,000
2010 Enacted	$1,934,000
2011 Enacted	$1,930,000
2012 Enacted	$1,927,000
2013 President's Budget	$1,927,000

BUDGET REQUEST

The FY 2014 budget request for Immunization AK of $1,931,000 is an increase of $4,000 above the FY 2012 Enacted level.

Pay Costs +$4,000 to fund pay increases for Tribal employees.

Base Funding of $1,927,000 would continue to provide:

Activities associated with this funding include the coordination of vaccine coverage reporting for Tribal facilities, training of Tribal immunization coordinators, and clinic staff in vaccine recommendations and documentation, and consultation in the migration to Electronic Health Records, and regular notification to hepatitis patients of the need to complete liver function screenings so that program clinicians can identify serious liver disease or liver cancer when it is at an early and treatable stage.

Hepatitis B Program
The Program conducts three days of outpatient clinics at the Alaska Native Medical Center (ANMC) and also travels to regional health centers to conduct outpatient clinics (13 site visits/year). Outpatient clinic time was added given an increasing number of Hepatitis C patients, as they require intensive workup and those who are on treatment require case management to ensure compliance and healthy outcomes.

As many of the patients that are monitored and their primary care provider resides outside of Anchorage, in FY 2012 the Program continues its implementation of a venue for the education/ training of providers utilizing an established web-based application for video-conferencing

(Adobe Connect) that is accessible to our statewide Alaska Tribal Health System (ATHS) audience. The objective of the Program's "LiverConnect" is to provide relevant clinical information to assist in the care and management of hepatitis and liver disease patients. The Program maintains and works to grow partnerships with Tribes throughout the ATHS. Annual field clinics (13 visits/yr) are conducted across Alaska to provide direct patient care, clinical updates to ATHS staff, and to recruit and conduct follow-up on participants enrolled in the Program's research.

The Program strives to achieve quality of and access to care by recruiting and retaining the highest level of clinical and support staff. To increase access to care, the Program is always on the lookout for new cases through the utilization of regular electronic health care records reviews and a statewide referral system. The Program strives to make all work accountable, transparent, fair and inclusive through systematic reporting of upcoming clinical screenings to ATHS clinics and the notification of screening and subsequent report of results to the provider and patients. The Program ensures accountability by using customer satisfaction surveys and maintains flexibility in scheduling to accommodate programmatic and customer needs that might arise.

Immunization (Hib) Program
The budget request will be used for staff travel to provide program support for regional Tribal programs and limited printing of media materials. Funding of these activities allows maintenance of current program support of Alaska Tribal immunization activities, statewide and national immunization advocacy and technical support, and Area reporting to IHS Headquarters.

The Program supports the HHS Strategic Plan:

- Preventing disease through immunization
- Improving maternal and infant health
- Planning and preparing for public health emergencies by providing an infrastructure to maintain high immunization coverage for basic vaccines and have a rapid response to emergencies such as pandemic flu

Outputs during FY 2014 will include:

- The activities listed above under Program Description
- Technical support to Tribal agencies developing Electronic Health Records (EHR)
- Networking with other departments and agencies for Emergency Preparedness

New strategies include:

- Collaboration with other agencies such as CDC in developing media materials
- Network with IHS and other agencies to provide technical assistance regarding EHRs
- Obtain grant funding and technical assistance to support uncovered program activities such as emergency preparedness

The future challenge of the diversity of EHRs employed by Tribal agencies that may result in a temporary loss or delay of Area-wide reporting of immunization coverage will continue to be addressed through coordinated technology efforts by IHS and Tribes.

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
Hepatitis Program (Targeted/Known Cases = T and Screened = S)				

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
Sum of Hepatitis Patients Targeted for Screening	FY 2012: 3222 (Target Not Met but Improved)	3231	3300	69
AK-1: Chronic Hepatitis B Patients Screened/Targeted	FY 2012: T=1090 S=658 (T Target Not Met and S Target Exceeded)	T=1100 S=693	T=1060 S=628	T= -40 S= -65
AK-2: Chronic Hepatitis C Patients Screened/Targeted	FY 2012: T=1515 S=1103 (T Target Not Met but Improved and S Target Exceeded)	T=1531 S=900	T=1625 S=1135	T= +94 S= +235
AK-3: Other Liver Disease Patients Screened/Targeted**	FY 2012: T=617 S=451 (T Target Exceeded and S Target Not Met but Improved)	T=600 S=456	T=667 S=501	T= +67 S= +45
AK-4: Hepatitis A/B vaccinations***	FY 2012: HepA=91%; HepB=97% (Targets Exceeded)	90%	90%	0

* Decline in hepatitis B cases due to an aging cohort and their deaths; discovery of new cases is rare given hepatitis B vaccinations.
** Other liver disease includes autoimmune hepatitis, primary biliary cirrhosis, and nonalcoholic fatty liver disease.
***Hepatitis A/B Immunization rates for Alaska Native children who achieve Hepatitis A 1-dose completion and Hepatitis B 3-dose completion aged 19-35 months are compiled and reported throughout the Alaska Native Tribal Health System on a quarterly basis. The rates reported herein represent an average for the reporting period. The established target immunization rate for each vaccine is 90%.
All data reported is that which is available to the Alaska Native Tribal Health Consortium.

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

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$42,984	$43,247	$43,049	+$65
FTE**	6	6	6	0

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

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

FY 2014 Authorization...Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Urban Indian Health Program (UIHP) was established in 1976 to provide affordable and accessible health care for the underserved urban American Indian/Alaska Native (AI/AN) population. IHS provides funding through limited, competing contracts and grants with 33 urban Indian 501(c)(3) non-profit organizations to provide health care in 40 sites throughout the U.S. Urban Indian Health Organizations (UIHO) define their scopes of work and services based upon the documented unmet needs of the urban AI/AN community they serve. Each UIHO is governed by a Board of Directors of whom at least 51 percent are AI/AN.

UIHOs provide primary medical care and public health case management wrap-around services for approximately 51,000 urban AI/ANs who do not have access to the resources offered through IHS and tribally operated health care facilities. Urban Indian primary care clinics and case management programs provide high quality, culturally accessible, affordable, and accountable health services. The services include ambulatory health care, health assessment, health promotion, disease education, child abuse prevention, immunizations, and behavioral health services. The UIHOs fulfill IHS data reporting requirements including the IHS Government Performance and Results Act (GPRA) report and the Diabetes Non-Clinical Audit report. Eight programs participate in the IHS Improving Patient Care program.

The UIHOs report on the amounts and purposes for which funding is used, including the number of eligible urban AI/ANs for whom services are provided and the number and type of services provided to urban AI/ANs. Information contained in the 2011 Uniform Data System (UDS) report, the most recent year for which data is available, indicated that the UIHO served a population that was 41 percent AI/AN.
The UIHOs have policies requiring supporting documentation of the eligibility of a particular individual included in their Title V reports.

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

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

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

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

As of May 2012, eleven programs have implemented IHS Resource and Patient Management System (RPMS)/Electronic Health Record (EHR), eight have fully implemented IHS RPMS and are working on transitioning to RPMS/EHR, eight programs are working to implement RPMS, and six programs have non-RPMS electronic systems. The RPMS data provides detailed health and utilization information for individuals, including comprehensive encounter data not otherwise collected through surveys.

The 2011 national measure reporting cycle (July 1, 2010 – June 30, 2011) was successful for the UIHOs. Areas of greatest accomplishment included: (1) 100 percent of the UIHO reported on 20 of the 20 performance measures, and (2) 24 UIHO reported through CRS, while 10 reported using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records). The goal is to transition to 100 percent electronic reporting for the UIHO using RPMS, and, once the data is stabilized, advocate for inclusion in the IHS national clinical performance measure reporting.

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

FUNDING HISTORY

Fiscal Year	Amount
2009 Omnibus	$36,189,000
2010 Enacted	$43,139,000
2011 Enacted	$43,053,000
2012 Enacted	$42,984,000
2013 Continuing Resolution	$43,247,000

BUDGET REQUEST

The FY 2014 budget request for Urban Health of $43,049,000 is an increase of $65,000 above the FY 2012 Enacted Level. The increase includes:

Pay Costs +$65,000 to fund pay increases for Federal and Grantee employees.

The program funding and accomplishments will strengthen and enhance implementation of the HHS Strategic Plan for Fiscal Years 2010-2015. In particular it will address Goal 1: Strengthen Health Care by:

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

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
UIHP-2: Percent of AI/AN patients with diagnosed diabetes served by urban health programs that achieve good blood sugar control. (Outcome)	FY 2012: 31.9% (Target Not Met)	36.1%	TBD	N/A (Baseline in FY 2013)
UIHP-3: Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher (Outcome[1])	FY 2012: 16.4%	no annual target	Develop a new process measure	N/A
UIHP-6: Increase the number of diabetic AI/ANs that achieve ideal blood pressure control (Outcome)	FY 2012: 41.9% (Target Exceeded)	41%	40.9%	-0.1%
UIHP-7: Number of AI/ANs served at Urban Indian Clinics. (Outcome)	FY 2011: 50,511 (Target Exceeded)	51,167	51,425	+258

[1] *Long-term measure, reportable in 2010 and 2013.*

Grant Awards – Funding for the Urban Indian health programs for FY 2012 came from the FY 2012 appropriations for both the grants and contracts awarded to the programs.

GRANTS AWARDS

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request
Number of Awards	33	33	33
Average Award	$227,856	$227,856	$227,856
Range of Awards	$122,832 - $626,765	$122,832 - $626,765	$122,832 - $626,765

AREA ALLOCATION – Urban Health *(dollars in thousands)*

Discretionary SERVICES	**FY 2012 Enacted**	**FY 2013 Cont. Resolution**	**FY 2014 Request**	**FY 2014 +/- FY 2012**
Aberdeen	$1,529	$1,529	$1,531	$2,312
Alaska	0	0	0	0
Albuquerque	2,426	2,439	2,429	3,668
Bemidji	4,494	4,437	4,501	6,796
Billings	2,285	2,277	2,288	3,455
California	6,562	6,521	6,572	9,923
Nashville	944	922	945	1,427
Navajo	722	720	723	1,092
Oklahoma	2,070	2,061	2,073	3,130
Phoenix	2,483	2,486	2,487	3,755
Portland	5,536	5,554	5,544	8,371
Tucson	516	517	517	781
Headquarters	13,418	13,783	13,438	20,290
Total, Urban Health	**$42,984**	**$43,247**	**$43,049**	**+$65**

Note: The allocation amounts are estimates.

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$40,596	$40,844	$40,602	+$6
FTE**	26	26	26	0

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

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

FY 2014 Authorization..Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

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

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

Sections 103 and 104 of the Scholarship Program – Section 103 includes the preparatory and pre-graduate scholarship programs that prepare students for health profession training programs. Graduate students and junior- and senior-level undergraduate students are given priority for funding for programs under section 103, unless the section specifies otherwise. Section 104 includes the Health Professions Scholarship Program, which provides financial support for AI/AN students from Federally recognized Tribes enrolled in health profession or allied health profession programs. Students accepting funding for programs under section 104 incur service obligations and payback requirements.

In 2013, the IHS Scholarship Program provided retention metrics for inclusion in a system design guide for the revision of the Scholarship Management System. When completed, the system will

provide annual reports on retention of scholars employed by IHS beyond the obligated service period.

Students in the following disciplines received funding during FY 2012 school year:

Section 103 Preprofessional - 14 students				
Pharmacy	5		Medical Technology	0
Nursing	5		Occupational Therapy	0
Clinical Psychology	3		Social Work	1
Physical Therapy	0			
Section 103 Pregraduate - 17 students				
Medicine	12		Optometry	0
Dentistry	4		Podiatry	1
Section 104 Health Professions - 264 students				
Physician (DO and MD)	41		Dental Hygienist	0
Nurse (ADN, BS and MS)	75		Dietitian	0
Pharmacist	25		Occupational Therapist	2
Dentist	20		Chemical Abuse Counseling	2
Physical Therapist	11		Health Care Administration	0
Physician Assistant	13		Health Education	0
Clinical Psychologist	13		Health Records	2
Optometrist	5		Nurse Anesthetist	1
Nurse Practitioner	20		Podiatrist	0
X-Ray Technology	9		Respiratory Therapist	0
Engineer	0		Sanitarian	0
Medical Technology	4		Women's Health Nursing	1
Social Work	19		BioMedical Engineering	1

Loan Repayment Program (Section 108): The Loan Repayment Program is an invaluable tool for recruiting and retaining healthcare professionals and offers these professionals the opportunity to reduce their student loan debts and places them in Indian health programs with critical staffing needs. Applicants agree to serve two years at an Indian health program in exchange for up to $20,000 per year in loan repayment funding and up to an additional $4,000 per year to offset tax liability. Loan repayment recipients with more than $40,000 in loan debt can extend their initial two-year contract on an annual basis and receive up to an additional $20,000 per year, plus up to $4,000 for taxes, until their original loan debt is paid.

In February 2013, the IHS LRP was assigned a Web Application Developer to develop an LRP retention measuring tool which will be used to report the average retention period for loan repayment recipients beyond their required service obligation.

The IHS Health Professions Scholarship and IHS Loan Repayment Programs are very similar to other programs that receive preferred tax treatment, and should therefore receive similar tax treatment. Currently, benefits awarded through IHS in the form of loan repayment and scholarships are regarded as Federal taxable income to the recipient; however, the same benefits offered under the National Health Service Corps (NHSC) are not taxable. This disparate tax treatment of IHS-funded scholarship and loan repayment awards increases the overall tax bracket for the participants and creates a financial

disincentive for those otherwise willing to serve American Indian and Alaska Native (AI/AN) patients by working in Indian health facilities.

The ability to exempt scholarship and loan repayment funds from gross income would make this recruitment and retention tool more attractive to potential participants. Thus, the IHS would be better able to increase the number of healthcare providers entering and remaining within the IHS to provide primary healthcare and specialty services for AI/AN patients.

Applicants who apply for funding and do not receive it, are identified as either "matched unfunded" and "unmatched unfunded". The "matched unfunded" are employed in an Indian health program, while those who decline job offers because they do not receive loan repayment funding are deemed "unmatched unfunded". Applicants denied funding can also include those without suitable assignments. It is estimated that an additional $3.5 million would be needed to fund the 68 matched but unfunded applicants from FY 2012.

In FY 2012, the IHS LRP made loan repayment awards to the following disciplines:

Awards by Profession	**Total Awards****	**New Awards**	**Contract Extensions**	**Matched Not Awarded**
Nurses	194	170	24	29
Dental*	107	42	65	1
Pharmacists	195	97	98	9
Physicians	87	44	43	2
PA/APN	64	46	18	4
Behavioral Health	44	30	14	7
Optometrists	37	9	28	0
Podiatrists	16	4	12	0
Rehabilitative Services	27	15	12	1
Other Professions	49	47	2	15
TOTAL	**820**	**504**	**316**	**68**

* Includes Dentists and Dental Hygienists
**Includes awards funded with Hospital and Clinic funds

Other Professions	**Total Awards**	**Matched Not Awarded**
Medical Lab Scientist	13	4
Dietician	12	6
Medical Technician	3	1
Engineer	8	2
Sanitarian	2	1
Respiratory Therapist	4	0
Chiropractor	4	1
Audiology	**1**	**0**
Health Records Tech	**2**	**0**
TOTAL	**49**	**15**

By Pay System	**Awards**
Tribal Employees	391
Civil Service	268
Commissioned Corps	150
Urban Health Employees	11
Total	**820**

<u>Grant Programs</u> - The IHP administers three grant programs which fund colleges and universities to train students for health professions: Indians into Nursing (Section 112); Indians into Medicine (Section 114); and Indians into Psychology (Section 217).

FUNDING HISTORY

Fiscal Year	Amount
2009 Omnibus	$37,500,000
2010 Enacted	$40,743,000
2011 Enacted	$40,661,000
2012 Enacted	$40,596,000
2013 Continuing Resolution	$40,844,000

BUDGET REQUEST

The FY 2014 budget request for Indian Health Professions of $40,602,000 is an increase of $6,000 above the FY 2012 Enacted Level. The increase includes:

Pay Costs +$6,000 to fund pay increases for Federal employees.

The table below specifies the expected performance of each budget request by section.

Section	Title	FY 2012 Enacted	FY 2014 Request	FY 2014 +/- FY 2012	Expected *Performance
103	Health Professions Preparatory and Pre-Graduate Scholarships	$3,840,096	$3,573,186	-$266,910	53 continuing and 18 new student agreements
104	Health Professions Scholarship	$10,546,886	$10,719,560	+$172,674	167 continuing and 45 new student contracts
105	Extern Program	$1,181,932	$1,181,932	$0	168 temporary clinical assignments
108	Loan Repayment Program	$21,338,884	$21,439,120	+$100,236	174 contract extensions and 389 new contracts.
112	Quentin N. Burdick American Indians Into Nursing Program	$1,768,497	$1,768,497	$0	5 grants
114	Indians into Medicine (INMED) Program	$1,162,319	$1,162,319	$0	3 grants
217	American Indians Into Psychology Program	$757,386	$757,386	$0	3 grants
	TOTAL	**$40,596,000**	**$40,602,000**	**+6,000**	

*Expected performance does not include awards funded with Hospital and Health Clinics funds.

In FY 2012, the IHS LRP received $5,153,716 of Hospitals and Health Clinics (H&HC) funds, which continues the funding support for loan repayment awards first appropriated in FY 2001. Based on IHS staffing needs, along with number of FY 2012 “matched unfunded” as described previously, the IHS LRP awarded funded 116 new LRP contracts to various health professionals, including nurses, dentists, pharmacists, and mid-level practitioners from HH&C.

For FY 2014, the IHS LRP will continue to use the additional H&HC funds to meet IHS priority staffing needs.

Outputs and Outcomes

Measure	Most Recent Result	FY 2012	FY 2014	FY 2014 +/- FY 2012
42: Scholarships: Proportion of Health Professionals Scholarship recipients placed in Indian health settings within 81 days of graduation.	FY 2011: 61.2% Target:78% (Target Not Met)	78%	78%	0
Number of Scholarship Awards – Total				
IHP-1: Section 103 *(Outputs)*	FY 2012: 31 (Target NotMet)	49	45	-4
IHP-2: Section 104 *(Outputs)*	FY 2012: 264 (Target Exceeded)	223	245	22
IHP—3: Number of Externs (Section 105) *(Outputs)*	FY 2012: 151 (Target Exceeded)	135	135	0
Number of Loan Repayments Awarded – Total (Section 108)a/ *(Outputs)*	FY 2012: 820 (Target Exceeded)	685	685	0
IHP-4: New Awards (2 Year Awards)(Outputs)	FY 2012: 504 (Target Exceeded)	425	400	25
IHP-5: Contract Extensions (1 Year Awards)(Outputs)	FY 2012: 316 (Target Exceeded)	260	250	10
IHP-6: Continuation Awards (Funded in Previous Fiscal Year)(Outputs)	FY 2012: 425 (Target Exceeded)	176	407	231

a/ Loan repayment figures include awards funded with Hospital and Health Clinics funds.
(100 new two-year awards anticipated in FY 2014).

The IHS performance goal is to place scholars within 90 days from when they complete their health profession degree or training. The IHP works with scholarship recipients as well as specific healthcare professional subject matter experts to place them in Indian health system hospitals and clinics. IHS has made notable progress in reducing hiring times from approximately 140 days to approximately 90 days to hire a health care professional (from the time the completed request is submitted to the Department's Capital HR program to when the person enters on duty). IHS will continue to focus on best practices to ensure that Departmental and health-professional licensure requirements are carried out so that a scholar can be placed within 90 days. The FY 2014 placement goal remains the same as FY 2012. IHS hiring reforms and improved tracking of placements should result in improved performance and meeting the objective.

GRANTS AWARDS

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request
Indians into Nursing (Section 112)			
Number of Awards	5	5	5
Average Award	$336,186	$336,186	$336,186
Range of Awards	$300,000 - $350,000	$300,000 - $350,000	$300,000 - $350,000
Indians Into Medicine(Section 114)			
Number of Awards	3	3	3
Average Award	$356,083	$356,083	$356,083
Range of Awards	$170,000 - $728,250	$170,000 - $728,250	$170,000 - $728,250

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request
Indians Into Psychology (Section 217)			
Number of Awards	3	3	3
Average Award	$252,462	$252,462	$252,462
Range of Awards	$300,000-$350,000	$300,000-$350,000	$300,000-$350,000

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$2,577	$2,593	$2,577	$0
FTE**	0	0	0	0

** Tribal Management Grant funds are not used to support FTEs.

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

FY 2014 Authorization...Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Tribal Management Grant (TMG) Program was authorized in 1975 under Sections 103(b)(2) and 103(e) of Public Law (P.L.) 93-638, Indian Self-Determination and Education Assistance Act (ISDEAA), as amended. It was established to assist Tribes and/or Tribal organizations (T/TO) to plan and prepare for assumption of all or part of existing Indian Health Service (IHS) programs, functions, services, and activities (PFSA) under the authority of the ISDEAA and to further develop and enhance their health program management capability and capacity. The TMG Program provides discretionary competitive grants to T/TO to establish goals and performance measures for current health programs, assess current management capacity to determine if new components are appropriate, analyze programs to determine if T/TO management is practicable, and develop and/or enhance infrastructure systems to manage or organize PFSA.

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

The TMG funds are distributed primarily for direct grant awards. Approximately three percent of the appropriated funding is used for overall administration of the program; these funds provide program requirements training, grant writing workshops and general technical assistance. These efforts assist T/TO in developing proposals that fully address the TMG project cycle and are responsive to the program announcement. Past performance has demonstrated that T/TO who

participate in TMG training and technical assistance sessions score higher in the objective review than those with no grant training.

The TMG Program offers four project types with three different award amounts and project periods:

1) Planning and 2) Evaluation Study projects are funded up to $50,000 with project periods not to exceed 12 months.
   - The Planning Project allows T/TO to establish goals and performance measures for current health programs or to design their health programs and management systems.
   - An Evaluation Study Project determines the effectiveness and efficiency of a program or if new components are needed to assist the T/TO improve its health care delivery system.

3) Feasibility studies are funded up to $70,000 with project periods not to exceed 12 months. A feasibility study analyzes programs to determine if T/TO management is practicable.

4) Health Management Structure (HMS) grants are funded up to $300,000 with project periods not to exceed 36 months. HMS projects include the design and implementation of systems to manage PFSA, such as electronic health records systems or billing and accounting systems as well as correction of audit material weaknesses.

FUNDING HISTORY

Fiscal Year	Amount
2009 Omnibus	$2,586,000
2010 Enacted	$2,586,000
2011 Enacted	$2,581,000
2012 Enacted	$2,577,000
2013 Continuing Resolution	$2,593,000

BUDGET REQUEST

The FY 2014 budget request for Tribal Management Grants of $2,577,000 is the same as the FY 2012 Enacted Level.

Base funding is necessary to maintain Tribal Management Grant progress including:

- The building of health management infrastructure for tribes and tribal organizations including but not limited to electronic health records conversion, third-party billing, and health accreditation, all of which impactsthe provision of health care.
- Increasing the tribes' and tribal organizations' ability to compete for other grant programs as the management capability of the applicant organization plays an important role in securing federal funding from other federal agencies on a broader scale.
- Enhancement of a tribe's ability to assume Programs, Functions, Services and Activities (PFSAs) from the IHS under the Indian Self Determination and Education Assistance Act (ISDEAA), P.L. 93-638 contracts.
- The assimilation of newly federally-recognized or federally-restored tribes for IHS assistance and consideration to provide technical assistance and develop their management capacity and capability to achieve and eventually exercise their government-to-government relationship as

sovereign nations under the ISDEAA and eventually assume PFSAs should they so choose to do so.

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
Planning Grants	FY 2012: 2 (Target Exceeded)	1	2	1
Health Management Structure (HMS) Grants	FY 2012: 26 (Target Exceeded)	22	28	6

GRANTS AWARDS

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request
Number of Awards[1]	$2,577,000 11 Noncompeting Continuations and 17 New	$2,593,000 10 Noncompeting Continuations and 18 New	$2,577,000 10 Noncompeting Continuations and 17 New
Average Award	$95,185	$95,185	$89,300
Range of Awards	$50,000-$150,000	$50,000 - $150,000	$50,000 - $150,000

[1] Includes partial awards

AREA ALLOCATION – Tribal Management

Discretionary SERVICES	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request	FY 2014 +/- FY 2012
Headquarters	2,577,000	2,593,000	2,577,000	0
Total, TM	**$2,577,000**	**$2,593,000**	**$2,577,000**	**$0**

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

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$71,653	$72,092	$71,845	+$192
FTE**	290	290	290	0

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

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

FY 2014 Authorization...Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The IHS Headquarters provides Agency-wide leadership, oversight, and executive direction to ensure that comprehensive health care services are provided to American Indians and Alaska Natives (AI/ANs). In addition, Headquarters administers the Agency in the context of President and HHS goals and IHS mission and priorities while simultaneously maintaining the special Tribal-Federal relationship based in treaty and law. The Direct Operations budget provides critical support in the overall administration and delivery of health programs and services throughout the IHS and its funding is allocated to IHS Headquarters, 12 Area Offices, and Tribal Shares.

The IHS Headquarters authorities and operations are set forth by statute and administrative requirements by the Department of Health and Human Services (HHS), the Administration, and Congress. The IHS Headquarters provides general program direction and oversight for the 12 IHS Areas and 163 Service Units; formulates policy and distributes resources; provides technical expertise to all components of the Indian health care system, which includes IHS direct, Tribally operated programs, and urban Indian health programs (I/T/U); maintains national statistics and public health surveillance; identifies trends; and projects future needs. The IHS Headquarters actively works with HHS to formulate and implement national health care priorities, goals, and objectives for AI/ANs. The IHS Headquarters works with HHS to formulate the annual budget and necessary legislative proposals. In addition, it responds to congressional inquiries and interacts with other governmental entities to enhance and support health care services for AI/ANs.

By delegation from the IHS Director, the 12 Area Offices distribute resources, monitor and evaluate the full range of comprehensive health care and community oriented public health programs, and provide technical support to local Service Units and I/T/U staff. They ensure the delivery of quality health care through the 163 Service Units and participate in the development and demonstration of alternative means and improvement techniques of health services

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

The Direct Operations budget supports the leadership, overall management, and inherent federal functions and activities of the IHS to ensure effective support for the IHS mission. This includes oversight of human resources, financial resources, facilities, information technology and administrative support resources and systems' accountability. With approximately half of the IHS budget managed by Tribes, the IHS continues to function as a large, comprehensive, primary health care system that benefits from many efficiencies through common administrative systems and consistent business practices.

Overall leadership and direction is focused on the Agency's four priorities:

1. To renew and strengthen the partnership with Tribes and improve the Tribal consultation process.
2. To reform the IHS.
3. To improve the quality of and access to care for patients who are served by the IHS.
4. To be as transparent, accountable, fair, and inclusive as possible in the work performed.

Agency priority number one is largely addressed through Tribal consultation, which is a fundamental part of how IHS is changing and improving. One example of recent accomplishments is implementation of a total of eleven recommendations from Tribes to improve the Tribal consultation process by the end of FY 2012. The IHS consulted with Tribes on numerous issues that were indicated as Tribal priorities. In August 2012, the IHS Director provided an update to Tribal Leaders on Tribal consultation activities and included a Tribal Consultation Activities Summary that provided the follow-up and outcomes by consultation topics since June 2009. Furthermore, Tribal consultations results in better decisions for the future of IHS and help to improve patient care. For example, significant work has been accomplished through a Tribal workgroup on improving the Purchased/Referred Care (formerly known as Contract Health Services) program (PRC) that resulted in recommendations and sharing of best practices to improve management of IHS operated PRC programs and third-party collections.

The IHS continues comprehensive improvements, reforms and oversight in management and administration of key Agency-wide systems, including financial management, property management, performance management, and hiring reforms, which includes improved suitability determinations for new hires and ongoing oversight and improvements in healthcare provider credentialing and facility accreditation. These reforms are a part of corrective actions in response to the Senate Committee on Indian Affairs investigation of the IHS Aberdeen Area, as well as a part of the Agency's overall internal reform, Area management reviews, and program integrity activities. One example of a recent improvement is that IHS is now ensuring that employment and background verification requirements are fully met prior to bringing employees on board. The IHS now checks the Office of Inspector General's exclusion list for all its employees and has standard security pre-clearance language for use in IHS solicitations that involve contractor access to IHS facilities and systems. Another example of an improvement specific to the Aberdeen Area is that IHS has reduced the number of pharmacy discrepancies from more than 3,600 in 2010 to fewer than 100 in 2012. This improvement demonstrates that the Area is more accountable for the security of medications that patients need. A final example of improvement is IHS working closely with HHS on maintaining progress and completion of addressing the major audit findings for cash management and suspense reconciliations. The most recent focus is on

refining and formalizing processes to ensure routine accomplishment of cash and suspense reconciliations. In FY 2011, the IHS achieved its most effective accounting of fund balances since implementing the Unified Financial Management System. As a result of the 2011 audit, the IHS achieved a clean opinion on the portion in which IHS participates. The Agency had only two IHS-specific findings on the 2011 audit compared to 20 in FY 2010. Also, the IHS continues to maintain 100 percent accreditation/certification for IHS-operated hospitals, ambulatory clinics, and regional youth treatment centers and works in collaboration with national healthcare organizations to remain accredited/certified.

The Direct Operations budget supports leadership and oversight for the accomplishment of the Agency's program performance. Direction includes specific focus on the Secretary's Key Initiatives and priorities and the HHS Strategic Plan for Fiscal Years 2010-2015. The IHS exceeded both of its FY 2012 targets for its Agency-specific performance goals− depression screening and improving the Tribal consultation process − that are tracked as a part of the implementation of the HHS Strategic Plan.

Direct Operations includes a critical focus on program integrity and accountability, ensuring that appropriated funds are effectively and efficiently expended to obtain the highest quality of outcomes for the Agency mission. This focus includes the establishment of an oversight component to provide continuous and special monitoring of all financial, human resources, acquisitions, grants and information technology management systems at all levels of the Agency. This oversight component will provide regular and special reports on the performance of administrative and management systems that support the delivery of health care throughout the Indian health system. Program integrity is a priority for IHS and includes responsiveness to key stakeholders (Administration, Congress, Tribal partners) in a transparent and timely manner.

The improvement of the Human Resource Management and Servicing systems are a high priority for the IHS and include the following:

- The IHS is working on specific activities to improve and streamline the hiring process by making use of standardized position descriptions and improving use of the web-based hiring system. In FY 2011, the IHS reduced its average overall hiring time from 140 days to 81 days by making improvements in the processes it uses to hire employees. The FY 2013 performance goal for IHS executives across the IHS is to have an IHS average overall hiring time of fewer than 80 days.
- The Agency is working on improvements in pay systems and strategies to improve more timely recruitment and retention because it has been historically difficult for IHS to recruit and retain healthcare providers, due to remote locations and noncompetitive salaries.
- The collaborative work IHS continues with the Health Resources and Services Administration (HRSA) has resulted in approval of 588 IHS, Tribal and urban Indian health care delivery sites for placement of NHSC health care providers, and the number of placements has increased to 305 providers in FY 2012. The progress was made possible by the IHS and HRSA's NHSC working collaboratively to develop a process for a pre-approved method for site eligibility.
- IHS continues to make improvements in its training of supervisors and performance management processes to ensure an effective workforce that is accountable to the IHS mission and that demonstrates progress in IHS reforms.

Priorities for improvements in Direct Operations also include ongoing oversight and implementation of the Affordable Care Act and the Indian Health Care Improvement Act within

the IHS. The IHS is collaborating with HHS and other federal agencies on implementation of provisions in the ACA that impact American Indians and Alaska Natives and also is the lead on implementation of the new permanent authorities of the IHCIA. IHS is consulting with Tribes on an ongoing basis regarding implementation of ACA and IHCIA provisions and provides updates on implementation progress. Implementation continues to focus on preparations for the expansion of health insurance and Medicaid coverage for patients served by IHS as well as planning for enhanced business office and health care delivery system improvements necessary to fully implement ACA and IHCIA provisions in the IHS.

FUNDING HISTORY

Fiscal Year	Amount
2009 Omnibus	$65,345,000
2010 Enacted	$68,720,000
2011 Enacted	$68,583,000
2012 Enacted	$71,653,000
2013 Continuing Resolution	$72,092,000

BUDGET REQUEST

The FY 2014 budget request for Direct Operations of $71,845,000 is an increase of $192,000 above the FY 2012 Enacted Level. The increase includes:

Pay Costs +$192,000 to fund pay increases for Federal and Tribal employees.

FY 2014 Direct Operations $71,845,000

Direct Operations will continue to fund system-wide administrative, management and oversight priorities at the discretion of the IHS Director that include:

- Continuing investments to maintain improvements and reforms made to date and to continue enhancements in the IHS' capacity for providing comprehensive oversight and accountability in key administrative areas such as: human resources, property, financial management, performance management and PRC program improvements developed through PRC consultation recommendations on improving business practices related to PRC and third party reimbursements.
- Addressing recent Congressional oversight and reports issued by the General Accountability Office (GAO) and the Office of Inspector General (OIG) to make improvements in management of IHS programs, such as the PRC program.
- Addressing requirements for national initiatives associated with privacy requirements, facilities, and personnel security.
- Improving responsiveness to external authorities such as Congress, GAO, OIG on questions related to oversight recommendations and the implementation and continuing accountability for new permanent authorities of the reauthorization of the IHCIA. The IHS has placed a high priority on the issues raised in the Senate Committee on Indian Affairs investigation of the IHS Aberdeen Area, and, in addition to implementing a corrective action plan to address findings in the Aberdeen Area, IHS established a schedule to conduct comprehensive reviews of all IHS Areas to ensure that the findings of the investigation are not global IHS issues. In December 2012, the IHS completed management reviews of all 12 IHS Areas on schedule. IHS will continue to implement and monitor improvements and corrective actions related to the findings of the Area reviews.

Direct Operations Headquarters and Area Office – Estimated Distribution

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

	FY 2012 Enacted	FY 2013 CR	FY 2014 Request
Headquarters (56.5%)	$40,483,945	$40,731,855	$40,592,425
Title I Contracts (non-add)	*2,150,072*	*2,183,530*	*2,183,530*
Title V Compacts (non-add)	*6,069,403*	*6,163,850*	*6,163,850*
Area Offices (12) (43.5%)	31,169,055	31,360,145	31,525,575
Title I Contracts (non-add)	*912,603*	*926,804*	*926,804*
Title V Compacts (non-add)	*9,276,264*	*9,420,613*	*9,420,613*
BA	**$71,653,000**	**$72,092,000**	**$71,845,000**

AREA ALLOCATION – Direct Operations *(dollars in thousands)*

Discretionary SERVICES	**FY 2012 Enacted**	**FY 2013 Pres. Budget**	**FY 2014 Request**	**FY 2014 +/- FY 2012**
Aberdeen	$2,556	$2,692	$2,563	$7
Alaska	4,931	5,192	4,944	13
Albuquerque	1,366	1,438	1,369	4
Bemidji	1,465	1,543	1,469	4
Billings	2,341	2,465	2,348	6
California	1,547	1,628	1,551	4
Nashville	1,783	1,877	1,787	5
Navajo	3,211	3,381	3,219	9
Oklahoma	3,743	3,941	3,753	10
Phoenix	3,200	3,370	3,209	9
Portland	2,698	2,840	2,705	7
Tucson	712	750	714	2
Headquarters	42,100	40,977	42,213	113
Total, Direct Ops	**$71,653**	**$72,092**	**$71,845**	**+$192**

Note: The allocation amounts are estimates.

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$6,044	$6,081	$6,049	+$5
FTE**	11	11	11	+0

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

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

FY 2014 Authorization..Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

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

Since 1993, the IHS, in cooperation with Tribal representatives, developed formula methodologies for identification of Tribal shares for all Indian Tribes. Tribal shares are those program and administrative funds that Tribes are eligible to assume through self-determination contracts and self-governance compacts.[1] As of November 2012, the IHS negotiated a total of 82 self-governance compacts and 107 funding agreements with Indian Tribal governments and

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

Tribal organizations. In FY 2013, approximately $1.5 billion, or one-third of the total IHS budget appropriation, will be transferred to Tribes to support 87 ISDEAA Title V compacts and 112 funding agreements.[2]

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

The Self-Governance budget strengthens and renews partnerships with Tribes through several activities:

- Develops and oversees the implementation of Tribal Self-Governance legislation and authorities in the IHS.
- Reviews eligibility requirements for Tribes to participate in the Tribal Self-Governance Program and applications for Self-Governance Planning and Negotiation Cooperative Agreements.
- Provides resource and technical assistance to Tribes and Tribal organizations for the implementation of Tribal Self-Governance.
- Provides Tribal Self-Governance Trainings to Tribes, Tribal organizations and Tribal groups.
- Arranges national Tribal Self-Governance meetings, including an annual conference in partnership with the Department of the Interior, to promote the participation by all American Indian and Alaska Native Tribes in IHS Tribal Self-Governance activities and program direction.
- Develops, publishes, and presents information related to the IHS Tribal Self-Governance activities to Tribes, Tribal organizations, state and local governmental agencies and other interested parties.
- Coordinates Self-Governance Tribal Delegation Meetings for HHS, IHS Headquarters and Area Senior officials.

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

- Overseeing the negotiations of Tribal Self-Governance compacts and funding agreements with participating Tribes;
- Supporting new authorities available to Tribes under the Indian Health Care Improvement Act; and

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[2] Tribes who exercise Self-Governance authority under Title V of the ISDEAA must meet statutory requirements, including (a) successfully completes the planning phase; (b) has requested participation in self-governance by resolution or other official action by the governing body of each Indian tribe to be served; and (c) has demonstrated, for three fiscal years, financial stability and financial management capability (25 U.S.C. 458aaa–2; 42 C.F.R. Part 137, Subpart C).
For FY 2014, the IHS estimates an additional five Tribes entering into Title V ISDEAA compacts and funding agreements. The IHS offers Self-Governance Planning and Negotiation Cooperative Agreements where the criteria for funding mirror the statutory eligibility requirements. Approximately, five negotiation cooperative agreements are available each fiscal year. For this pool, an average estimate of $5 million per Tribe is used to project estimates for Tribes entering into a Title V ISDEAA compact and funding agreement.

- Providing support for projects that improve tribally-operated health programs, GPRA reporting, and facility accreditation.

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

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

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

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

FUNDING HISTORY

Fiscal Year	Amount
2009 Omnibus	$6,004,000
2010 Enacted	$6,066,000
2011 Enacted	$6,054,000
2012 Enacted	$6,044,000
2013 Continuing Resolution	$6,081,000

BUDGET REQUEST

The FY 2014 budget request for Self-Governance of $6,049,000 is an increase of $5,000 above the FY 2012 Enacted Level. The increase includes:

Pay Costs +$5,000 to fund pay increases for Federal employees.

The Self-Governance budget is necessary to sustain valuable programs and maintain improvements made in Tribally-operated Health Programs performance measures in recent years.

Additionally, this funding will support further implementation of the IHS Tribal Self-Governance Program to federally recognized Indian Tribes and Tribal organizations under Title V of the ISDEAA; continue funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to enter into the IHS Tribal Self-Governance Program; continue to fund performance projects; and fund Tribal shares needs in IHS Areas and Headquarters for any Indian Tribe(s) that have decided to participate in self-governance**.**

Outputs and Outcomes Table

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
TOHP-1: Percentage of TOHP clinical user population included in GPRA data.[1]	FY 2012: 55.3% (Target Not Met)	70.3%	55.3%	-15.0%
TOHP-SP: Implement recommendations from Tribes annually to improve the Tribal consultation process.	FY 2012: 4 (Target Exceeded)	3	3	0

[1] Several Tribal Health Organizations did not submit performance reports in FY 2012.

AREA ALLOCATION – Self Governance

Discretionary SERVICES	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request	FY 2014 +/- FY 2012
Headquarters	6,044,000	6,081,000	6,049,000	5,000
Total, SELF-GOV	**$6,044,000**	**$6,081,000**	**$6,049,000**	**+$5,000**

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

	FY 2012 Actual	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
Medicare:				
Federal	$137,743,000	$140,455,000	$140,455,000	+$2,712,000
Tribal [1]	6,986,000	6,986,000	6,986,000	$0
Tribal [2]	57,244,000	57,244,000	57,244,000	$0
Subtotal:	201,973,000	204,685,000	204,685,000	+$2,712,000
Medicaid:				
Federal	$520,289,000	$537,063,000	$611,712,000	+$91,423,000
Tribal [1]	22,217,000	22,217,000	25,305,000	+$3,088,000
Tribal [2]	124,203,000	124,203,000	141,466,000	+$17,263,000
Subtotal:	666,709,000	683,483,000	778,483,000	+$111,774,000
Medicare/Medicaid Total:	868,682,000	888,168,000	983,168,000	+$114,486,000
Private Insurance	85,370,000	85,370,000	90,370,000	+$5,000,000
TOTAL:	**$954,052,000**	**$973,538,000**	**$1,073,538,000**	**+$119,486,000**
FTE**	6,088	6,110	6,110	22

[1] Represents CMS Tribal collection estimates.
[2] Represents estimates of Tribal collections due to direct billing that began in FY 2002.
** FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

Authorizing Legislation…………………….. Indian Health Care Improvement Act, Pub. L. 94-437, as amended by Pub. L. 111-148, title X, §10221(a), Mar. 23, 2010, 124 Stat. 935); and the Economy Act (31 U.S.C. 1535).

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Public and private collections are a significant part of the IHS and Tribal budgets, and provide increased access to quality health care services for American Indians and Alaska Natives (AI/AN). In furtherance of the provisions authorized by the Indian Health Care Improvement Act, as amended, IHS places the highest priority on meeting all accreditation standards for its healthcare facilities. Medicare and Medicaid (M&M) reimbursements continue to be used to support and maintain facility accreditation and improve the delivery and access to health care for AI/AN people.

IHS has had legislative authority to bill M&M since 1976. The collection of third party revenue is essential to maintaining facility accreditation and standards of health care through the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Health Care. Collections are also used to maintain the certification required by the Centers for Medicare and Medicaid Services (CMS) for participation in the M&M programs.

A recent accomplishment has been the development and implementation of a data system that IHS is currently using to identify deficiencies and monitor the third-party collections process for IHS operated facilities. This online data tool provides necessary information for local managers and Headquarters staff to monitor compliance with applicable policies and procedures so they can take necessary corrective actions and improve overall program activity.

Area Directors and Service Unit Chief Executive Officers now have access to improved online data reports that assist them with managing and making program improvements for IHS operated facilities. Over the past year, the Agency has had 100 percent of all IHS facilities participate in completing the online tool.

Medicare/Medicaid -- The FY 2014 estimates total $983,168, 000, an increase of $114,486,000 over FY 2012... This increase includes $19,486,000 related to impact of the CY 2012 M&M rate increases and a $95,000,000 increase estimated as a result of Medicaid expansion under the Affordable Care Act (ACA). In participating states, Medicaid coverage will expand to cover all individuals with incomes below 133 percent of the Federal Poverty Level, which will increase Medicaid collections. IHS staff will work with each state Medicaid agency to maximize enrollment and collections during FY 2014.

The FY 2013 M&M collection estimates total $888,168,000, an increase over FY 2012 of $19,486,000 related to CY 2012 rate increases. The FY 2013 collection estimate for Medicare totals $204,685,000, and includes an increase of $2,712,000 over FY 2012. The FY 2013 collection estimate for Medicaid totals $683,483,000, and includes an increase of $16,774,000 over FY 2012.

All M&M rate changes are calculated utilizing the IHS Medicare cost reports submitted to CMS. Accurate and complete cost reports will continue to be a priority since they provide valuable information in setting the Agency's future M&M rates.

During FY 2014, IHS will continue to place a priority on development of a third-party interface with the Unified Financial Management System and to develop and enhance systems and processes to meet new legislative requirements for IHS operated facilities.
The program will also work on initiatives such as the electronic health record and implementing ICD-10 codes. The IHS will continue to strengthen its business office policies and management practices, including internal controls, patient benefits coordination, provider documentation training, certified procedural coding training, and electronic claims processing. Priority efforts include the continued development of modifications to third-party billing and accounts receivable software to improve effectiveness and to ensure system integration with its business processes and compliance with M&M regulations. These improvements for IHS operated facilities will be coordinated with concurrent improvements in Purchased/Referred Care business practices related to alternate resources.

In addition, IHS is working to incorporate legislative rules and regulations that impact third-party collections directly and indirectly. Some rules such as meaningful use of the electronic health records by providers and facilities will have a direct impact on improving availability of data used in revenue generation over the next few years. IHS has formed a number of workgroups to maximize impact for all IHS, Tribal, and Urban Indian health care facilities.

IHS will continue to work with CMS and the State Medicaid agencies to identify patients who are eligible to enroll in M&M and SCHIP programs and in the implementation of provisions in ARRA, CHIPRA, ACA and the IHCIA. IHS works with CMS and the Tribes on a number of issues, including implementation of recent legislative changes, third-party coverage, claims processing, denials, training and placement of State Medicaid eligibility workers at IHS and Tribal sites to increase the enrollment of Medicaid eligible AI/AN patients. IHS is coordinating outreach, education, and training efforts in order to avoid duplication of efforts. IHS has partnered with CMS to provide a number of training sessions for Tribal and IHS employees,

focusing on outreach and accessing M&M programs. Also, IHS continues to train staff in the areas of accounts receivable, UFMS, coding and monitoring program activities. In April 2012, the IHS held its 13th Annual Partnership training conference where over 50 sessions were provided to over 500 IHS, Tribal, and Urban Indian organization staff on all aspects of the revenue cycle.

Private Insurance Collection -- For FY 2014 an increase of $5 million is estimated as a result of the ACA. The ACA subsidizes the cost of health insurance for AI/ANs with incomes up to 400 percent of the Federal Poverty Level and thus more individuals will choose to enroll in private insurance plans that can be billed through the Indian health system. During FY 2014, IHS will continue to work to enhance each IHS operated facility's capability to identify patients who have private insurance coverage and improve claims processing, particularly by utilizing a more robust program to monitor and follow up on outstanding bills. This initiative will maintain current collections efforts notwithstanding various reports that the downturn in the economy has affected private insurance coverage for AI/ANs. The local Service Units utilize the funds collected to improve services, such as the purchase of medical supplies and equipment, and to improve local Service Unit business management practices. The IHS continues to make use of private contractors to pursue collections on outstanding claims from private payers.

The following table shows how Medicare, Medicaid and private insurance collections are used.

Type of Obligation	FY 2012 Actual	FY 2013 Continuing Resolution	FY 2014 President's Budget
Personnel Benefits & Compensation	$382,657,000	$383,254,000	$386,620,000
Travel & Transportation	4,477,000	4,695,000	5,635,000
Non-Patient Transportation	4,062,000	4,256,000	5,112,000
Comm./Util./Rent	19,435,000	20,434,000	24,409,000
Printing & Reproduction	306,000	317,000	360,000
Other Contractual Services	151,540,000	159,549,000	191,192,000
Supplies	150,117,000	157,917,000	189,719,000
Equipment	16,782,000	17,661,000	21,497,000
Land & Structures	3,253,000	3,386,000	4,052,000
Grants	10,426,000	11,053,000	13,515,000
Insurance / Indemnities	347,000	366,000	426,000
Interest/Dividends	0	0	0
Subtotal	$743,402,000	$762,888,000	$842,537,000
Tribal Collections (est.)	$210,650,000	$210,650,000	$231,001,000
Total Collections	**$954,052,000**	**$973,538,000**	**$1,073,538,000**

Department of Veterans Affairs Reimbursements - In 2012, IHS and the Department of Veterans Affairs (VA) signed the VA IHS National Reimbursement Agreement. This agreement, which will facilitate reimbursement by the VA to the IHS for direct health care services provided to eligible American Indian and Alaska Native veterans in IHS facilities, is a significant step forward in ensuring implementation of Section 405 of the Indian Health Care Improvement Act. The agreement represents a positive partnership to support improved coordination of care between IHS and the VA. IHS estimates that the VA payments will increase health reimbursements by approximately $52 million in FY 2014. However, estimating the increase in IHS collections for FY 2014 is uncertain given the lack of information about the number of American Indians and Alaska Natives who will be eligible for VA benefits. This estimate will likely be revised as the agreement is fully implemented in the coming year. This agreement also paves the way for future agreements negotiated between VA and tribal health programs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Services: 75-3920-0-1-551
CONTRACT SUPPORT COSTS

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$471,437	$474,322	$477,205	+$5,768
FTE*	0	0	0	0

* Contract Support Costs funds are not used to support FTEs.

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

FY 2014 Authorization..Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The 1975 Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, provides Indian Tribes and Tribal organizations (T/TO) the authority to contract with the Federal government to operate programs serving eligible persons and to receive not less than the amount of program funding that the Secretary would have otherwise provided for the direct operation of the program. The 1988 amendments to the Act identified Contract Support Costs (CSC) be paid in addition to the program amount. CSC are defined as reasonable costs for activities that T/TO must carry out but that the Secretary either did not carry out in her direct operation of the program or provided from resources other than those under contract. In FY 2012, approximately $2.570 billion of the IHS appropriations was contracted through the ISDEAA by T/TO.

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

The IHS CSC policy was established in 1992 and amended in 2007 to provide guidance in the administration of CSC, and was developed through extensive consultation and participation of Tribes. The IHS continuously reviews the soundness of its CSC allocation policy to assure that CSC provided to T/TO is in accordance with the IHS CSC Policy and does not duplicate other funding provided by IHS. Upon revision in 2007, the policy was established as a permanent Chapter within the IHS Manual (Part 6, Chapter 3, TN-2007-05).

In FY 2011 and FY 2012, IHS made significant improvements to the IHS business practices associated with the CSC policy, which include:

- Ensuring a fair and consistent application of the CSC policy, its guidance and its stated procedures.
- Improved internal Agency understanding of the CSC Policy principles and its application;
- Utilization of key Area Office and Headquarters staff for Tribal data verification, funds certification and allocations.
- Completion and submission of the 2010 and 2011 CSC Funding Needs Reports to Congress by the Secretary, HHS and completion of the 2012 CSC Funding Needs Report by the Agency, which is currently in the clearance process, for submission to Congress in the near future.

FUNDING HISTORY

Fiscal Year	Amount
2009 Omnibus	$282,398,000
2010 Enacted	$398,490,000
2011 Enacted	$397,693,000
2012 Enacted	$471,437,000
2013 Continuing Resolution	$474,322,000

BUDGET REQUEST

The FY 2014 budget request for Contract Support Costs of $477,205,000 is an increase of $5,768,000 above the FY 2012 Enacted level.

+$5,768,000 – This increase will be used to address shortfall in CSC for ongoing tribal contracts and compacts.

Appropriations Language

In its June 18, 2012 ruling in Salazar v. Ramah Navajo Chapter, the United States Supreme Court held that "not to exceed" language in past appropriations was not sufficient to limit contract support costs. The Court identified legislative remedies, ranging from amending the authorizing statute, to changing payments for contract support costs, to enacting line-item appropriations for each contract, to appropriating full funding for CSC. To balance the priorities of all tribes with the available appropriations, and in accordance with the Supreme Court's decision, the Administration proposes new appropriations language for both IHS and the Bureau of Indian Affairs to provide a specific amount for contract support costs funding for each Indian Self-Determination and Education Assistance Act contract. Due to fiscal constraints, funding for CSC must be balanced with funding for direct health care services for tribes. The Administration looks forward to working with tribes and Congress to develop a balanced, long-term solution.
See page CJ-xxx for additional information on proposed language.

Outcomes and Outputs

Measure	Year and Most Recent Result/ Target for Recent Result/ (Summary of Result)	FY 2012 Enacted Level	FY 2014 Target	FY 2014 PB +/- FY 2012 Enacted Level
Total annual CSC need	FY 2010: $515,955,386	$556-$566M	$576M	--

AREA ALLOCATION – Contract Support Costs *(dollars in thousands)*

Discretionary SERVICES	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request	FY 2014 +/- FY 2012
Aberdeen	$15,844	$15,833	$16,038	$194
Alaska	149,227	153,107	151,053	1,826
Albuquerque	13,053	14,280	13,213	160
Bemidji	29,026	29,149	29,381	355
Billings	11,308	11,962	11,446	138
California	45,790	45,572	46,351	560
Nashville	19,415	20,673	19,653	238
Navajo	44,996	36,452	45,547	551
Oklahoma	71,648	75,162	72,524	877
Phoenix	22,049	21,446	22,318	270
Portland	46,862	48,199	47,435	573
Tucson	2,219	2,496	2,247	27
Headquarters	0	0	0	0
Total, CSC	**$471,437**	**$474,332**	**$477,205**	**+$5,768**

Note: The allocation amounts are estimates.

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$440,346	$443,040	$448,139	+$7,793
M&I	*$53,721*	$54,050	$53,721	$0
Sanitation	*$79,582*	$80,069	$79,582	$0
HCFC	*$85,048*	$85,568	$85,048	$0
FEHS	*$199,413*	$200,633	$207,206	+$7,793
Equipment	*$22,582*	$22,720	$22,582	$0
Quarters	$7,500	$7,500	$7,500	$0
FTE**	1,191	1,191	1,191	0

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

SUMMARY OF THE BUDGET REQUEST

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

BUDGET AUTHORITY

The FY 2014 budget submission for Facilities of $448,193,000 is an increase of +$7,793,000 above the FY 2012 Enacted level. IHS will be able to provide additional staffing for new healthcare facilities and provide pay costs for the Facilities and Environmental Health Support line item.

Maintenance & Improvement – The budget request for M&I of $53,721,000 is the same as the FY 2012 Enacted level. These funds provide for maintenance, repair, and improvement of health care facilities. Specific objectives and program priorities to address the condition of facilities include:

- Providing routine maintenance and repairs to upkeep facilities at their current conditions;
- Achieving compliance with buildings and grounds accreditation standards of the Joint Commission or other applicable accreditation bodies;
- Providing improvements to facilities for enhanced patient care through larger M&I projects to reduce the Backlog of Essential Maintenance, Alteration and Repair (BEMAR), currently is estimated at over $462 million for all IHS and reporting Tribal facilities;
- Ensuring that health care facilities meet building codes and standards; and
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., sustainability, energy conservation, seismic, environmental, handicapped accessibility, and security.

Sanitation Facilities Construction - The budget request for Sanitation Facilities Construction of $79,582,000 is the same as the FY 2012 Enacted level. These funds provide for essential water supply, sewage disposal, and solid waste disposal facilities, including:

- Projects to serve new or like-new housing, such as Indian homes being constructed or rehabilitated by the BIA-Home Improvement Program (HIP), Tribes, individual homeowners, or other nonprofit organizations;
- Projects to serve existing housing; and
- Special projects (studies, training, or other needs related to sanitation facilities construction), and emergency projects.

Health Care Facilities Construction – The budget request for Health Care Facilities Construction of $85,048,000 is the same as the FY 2012 Enacted level. These funds provide funding for continued progress on construction of replacement healthcare facilities in progress. The FY 2014 request will be allocated to the following projects:

- Kayenta Health Center, Kayenta, AZ to continue construction of the healthcare facility and begin construction of the staff quarters.
- San Carlos Health Center, San Carlos, AZ, to complete construction of the staff quarters.
- Southern California Youth Regional Treatment Center, Hemet, CA to complete construction of the treatment center.

Facilities and Environmental Health Support – The budget request for Facilities and Environmental Health Support (FEHS) is an increase of $7,793,000 above the FY 2012 Enacted level. The Agency is able to provide additional staffing at newly constructed healthcare facilities. FEHS funds provide for:

- Personnel who provide facilities and environmental health services and for operating costs associated with provision of those services and activities.

Equipment - The budget request for Equipment of $22,582,000 is the same as the FY 2012 Enacted level. These funds provide for:

- Routine replacement medical equipment to over 1,500 Federally and Tribally-operated health care facilities allocated on workload using a standard formula;
- New medical equipment in tribally-constructed health care facilities; and
- TRANSAM, a program under which IHS acquires and distributes surplus Department of Defense medical equipment, and ambulance programs.

COLLECTIONS

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

Quarters - The FY 2014 budget request of collections for Quarters of $7,500,000 is the same as the FY 2012 Enacted level for anticipated collections. Collected funds are to be used for:

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

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$53,721	$54,050	$53,721	$0
FTE	0	0	0	0

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

FY 2014 Authorization..Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Maintenance and Improvement (M&I) funds are the primary source of funding to maintain, repair, and improve existing IHS and Tribal healthcare facilities which are used to deliver and support healthcare services. M&I funding goes to federal, government-owned buildings and Tribally-owned space where healthcare services are provided pursuant to contracts or compacts executed under the provisions of the Indian Self-Determination and Education Assistance Act (P.L. 93-638). M&I funds are necessary to achieve and maintain accreditation, to meet building codes and standards, to maintain and repair the physical condition of healthcare facilities, to modernize existing healthcare facilities to meet changing healthcare delivery needs, and to implement mandated requirements; e.g., energy conservation, seismic, environmental, handicapped accessibility, security, etc. Efficient and effective buildings and infrastructure are vital to deliver healthcare in direct support of the IHS mission and priorities.

Maintaining reliable and efficient buildings is increasingly challenging as existing healthcare facilities age and additional space is added into the real property inventory. The average age for IHS-owned healthcare facilities is 33 years, whereas the average age including recapitalization of private-sector hospital plant is 9 to 10 years. The 'average age of plant' measures the average age of the facility including capital improvements, replacement of built-in equipment and modernization. Many IHS and Tribal healthcare facilities are old, operate at or beyond capacity, and are not designed to be utilized efficiently in the context of modern healthcare delivery. As existing healthcare facilities continue to age, they can become less efficient and the operational and maintenance costs increase. The IHS has not had the resources to recapitalize healthcare facilities on a routine basis.

The physical condition of IHS-owned and many Tribally-owned healthcare facilities is evaluated through a series of condition surveys. These surveys, together with routine observations by facilities personnel, identify facility, fire-life-safety, and program deficiencies that make up the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). The BEMAR is a measure of the condition of healthcare facilities and establishes priorities for larger M&I projects. Adequate M&I funding is essential to correct the deficiencies and keep the BEMAR to an

acceptable level. The current BEMAR for all IHS and reporting Tribal healthcare facilities as of October 1, 2012 is $462 million.

M&I Funds Allocation Method

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

- Routine Maintenance Funds - These funds support activities that are generally classified as those needed for maintenance and minor repair to upkeep the healthcare facility in its current condition. Funding allocation is formula based. The Building Research Board of the National Academy of Sciences (NAS) (*Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings, 1990*) has determined that approximately two to four percent of current replacement value of supported buildings is required to maintain (i.e., 'sustain') facilities in their current condition.

- M&I Project Funds - These funds are used for major projects to reduce the BEMAR and make improvements necessary to support healthcare delivery. Funding allocation is formula based. Under the Budget Request, no funds will be formula allocated as 'project funds' because there is only enough funding for routine maintenance.

- Environmental Compliance Funds - These funds are used to address findings and recommendations from environmental audits, to improve energy efficiency and water efficiency, to increase renewable energy usage, to reduce consumption of fossil-fuel generated electricity, and to implement other sustainability initiatives. These funds are available to Federal and Tribal healthcare facilities on a national basis.

- Demolition Funds - The IHS has a number of Federally-owned buildings that are vacant, excess, or obsolete. Demolition funds are used to dispose of these excess assets. These funds may be augmented with Environmental Compliance Funds as available for demolition and disposal to the extent that the proposed action reduces hazards, environmental concerns, or liability to IHS.

FUNDING HISTORY

Fiscal Year	Amount
2009 Recovery Act	$100,000,000
2009 Omnibus	$53,915,000
2010 Enacted	$53,915,000
2011 Enacted	$53,807,000
2012 Enacted	$53,721,000
2013 Continuing Resolution	$54,050,000

BUDGET REQUEST

The FY 2014 budget request for Maintenance and Improvement of $53,721,000 is the same as the FY 2012 Enacted level.

- Approximately $51.3 million will be allocated to sustain the condition of federal and tribal healthcare facilities buildings.

- $2 million will be allocated for environmental compliance projects and $500,000 for demolition projects.
- No funding will be formula allocated for projects to improve the condition of the healthcare facilities or make improvements to support healthcare delivery.

This level of funding will enable the IHS to maintain the condition of the IHS real property portfolio at, or slightly below the existing level. The healthcare facilities are stressed with increasing patient workload, high infrastructure demands to support technology advances in medical delivery, and changes in the delivery of 21st century healthcare. Alternately, the array of benefits achieved through timely investments in healthcare facilities repair and improvement includes effective mission attainment, compliance with regulations, improved healthcare facility condition, efficient operations and patient flow, better recruitment of healthcare professionals, and implementing stakeholder-driven initiatives.

Further, the FY 2014 Budget Request does not provide for the expected increase in health care facility space. Health care space increases by approximately three percent annually with the construction of new and expanded Federal and Tribal healthcare facilities. Consequently as new space becomes eligible for M&I funds, the overall funding per square meter of supported space is reduced and some necessary maintenance and repair work may need to be curtailed. Curtailing maintenance, routine repairs, and major repair projects lead to more costly repairs in the future and potentially catastrophic failure of major equipment (e.g., failure of boiler) that may affect the delivery of healthcare services and the current accreditation status of IHS-operated hospitals and major health centers.

Adequate funds are also not available to fully achieve the goals of the Energy Policy Act of 2005; Executive Order 13423, "Strengthening Federal Environmental, Energy, and Transportation Management"; the Energy Independence and Security Act of 2007; and Executive Order 13514, "Federal Leadership in Environmental, Energy and Economic Performance." The Office of Management and Budget (OMB) rates Agencies on their progress in achieving the sustainability/green targets established by these Laws and Executive Orders. Without adequate funding, the IHS will not meet all the targets and OMB may score HHS below the 'Standard for Success'.

OUTPUTS AND OUTCOMES - This program has no Output or Outcomes.

GRANT AWARDS – This program has no grant awards.

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$79,582	$80,069	$79,582	$0
FTE**	156	156	156	0

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

Authorizing Legislation ....25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; 42 U.S.C. 2004a, Indian Sanitation Facilities Act; 25 U.S.C. 1632, Indian Health Care Improvement Act (IHCIA), as amended 2010

FY 2014 Authorization...Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Sanitation Facilities Construction (SFC) is an integral component of the Indian Health Service (IHS) disease prevention activities. The IHS has carried out the program since 1959 using funds appropriated for SFC to provide potable water and waste disposal facilities for American Indian and Alaska Native (AI/AN) people. As a result, the rates for infant mortality, the mortality rate for gastroenteritis and other environmentally-related diseases have been reduced by about 80 percent since 1973. 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. It is important to note that 11.7 percent, or over 47,000 AI/AN homes, are without access to safe water or adequate wastewater disposal facilities and those individuals who live in the homes are still at an extremely high risk for gastrointestinal disease and respiratory disease at rates similar to developing countries. Many of these homes without service are very remote and may have limited access to health care which increases the importance of improving environmental conditions in the home as part of a comprehensive public health program.

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

SFC projects can be managed by the IHS directly (Direct Service) or they can be managed by Tribes that elect to use the Title I or Title V authorization under P.L. 93-638, the Indian Self-

Determination and Education Assistance Act. Sanitation facilities projects are carried out cooperatively with the Tribes who are to be served by the facilities. Projects start with a Tribal Project Proposal and are funded and implemented through execution of an agreement between the Tribe and IHS. In these agreements the Tribes also agree to assume ownership responsibilities, including operation and maintenance. The overall SFC goals, eligibility criteria, and project funding priorities remain the same, regardless of the delivery methods chosen by a Tribe. More than 70 percent of all sanitation facilities construction is performed by Indian Tribes/firms.

The Indian Health Care Improvement Act (Title III, Section 302(g) 1 and 2 of P.L.94-437) directs the IHS to identify the universe of sanitation facilities needs for existing Indian homes by documenting deficiencies and then proposing projects to address those needs. These projects include providing new and existing homes with first time services such as water wells and onsite waste water systems or connecting homes to community water and waste water facilities. The universe of need also includes projects to upgrade existing water supply and waste disposal facilities and projects to improve sanitation facilities operation and maintenance capabilities in Indian country. As of November 2012, the list of all projects to correct documented sanitation project deficiencies totaled almost $2.9 billion with those projects considered economically and technically feasible totaling almost $1.64 billion. Typically, projects with exceptionally high capital costs are considered economically infeasible if their cost per home exceeds an established allowable unit cost per home for a particular geographical area. Technical feasibility relates to operability and sustainability of the proposed system.

As of the end of FY 2012, there were about 240,000 or approximately 60 percent of AI/AN homes in need of sanitation facilities, including 7.45 percent or nearly 30,273 AI/AN homes without potable water. Maximum health benefits will be realized by addressing existing sanitation needs identified in the backlog and by providing sanitation facilities for new homes when they are constructed.

In 2012, the IHS provided service to 19,418 AI/AN homes. Projects that provide sanitation facilities to homes are selected for funding in priority order each year from the Sanitation Deficiency System (SDS) inventory of all needs in Indian Country. The SDS is an inventory of the sanitation deficiencies of AI/AN communities; those sanitation deficiencies include needed water, sewer, and solid waste facilities for existing AI/AN homes. Project selection is driven by objective evaluation criteria that include health impact, existing deficiency level, adequacy of previous service, capital cost, local Tribal priority, operations and maintenance capacity of receiving entity, availability of contributions from non-IHS sources, and other conditions that are locally determined. The SDS priority position of each unfunded project is reevaluated with the Tribes in each Area annually. In most years, the SFC program has exceeded all national performance measures, IHS, Departmental and program assessment performance measures.

An efficiency measure based on the average project duration is used in evaluating SFC expertise in advancing project discipline. The goal for SFC projects completed during calendar 2011 and the years thereafter is that the average project duration from the execution of the Project Memorandum of Agreement (MOA) to the Construction Completion date as tracked by the Sanitation Facilities Project Data System shall be 4 years or less.

Project duration is the average length of time to complete project construction from the time the project is funded and is a measure of actual performance since the project schedule is under a project manager's control. This time length had been slowly increasing from 2.5 years in 1993 to over 4 years at the end of 2007. Several factors have contributed to this growth in project duration including increased administrative requirements, more involved environmental reviews,

increased complexity of designs and decreases in staff resources. Reductions in the length of time a project takes to complete will yield cost savings in both construction inflation costs and project related staffing costs. In 2007, the average length of time to complete a project increased to 4.1 years but with the implementation of a robust project management program the time to complete projects has been reduced to 3.35 years by CY 2011. This decrease is a program success because it occurred at a time when construction budgets increased by 80 percent due to the American Recovery and Reinvestment Act (ARRA), and an increasing need for SFC. However in spite of this success at reducing durations while completing ARRA projects, the program is predicting slight increases in durations due to project completions of projects from annual appropriations that have been postponed to allow completion of ARRA projects.

FUNDING HISTORY

Fiscal Year	Amount
2009 Recovery Act	$68,000,000
2009 Omnibus	$95,857,000
2010 Enacted	$95,857,000
2011 Enacted	$95,665,000
2012 Enacted	$79,582,000
2013 Continuing Resolution	$80,069,000

BUDGET REQUEST

The FY 2014 budget request for Sanitation Facilities Construction of $79,582,000 is the same as FY 2012 Enacted level.

1) A portion of the total FY 2014 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)[1].

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

2) Up to $48,000,000 of the SFC appropriation in FY 2014 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 (AI/AN) homes without water supply or sewer facilities, or without both.

3) Up to $5,000,000 will be used for projects to clean up and replace open dumps on Indian lands pursuant to the Indian Lands Open Dump Cleanup Act of 1994.

[1] Homes in BIA/HIP Category A are considered existing homes. Category A homes needing service will be included in the SDS.

4) Up to $2,000,000 will be reserved at IHS Headquarters. Of this amount, $1,000,000 will be used for special projects and for distribution to all Areas as needed to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situations that require immediate attention to minimize potential threats to public health. Emergency and special funds remaining at the end of the fiscal year may be distributed to the Areas to address the Sanitation Deficiency System (SDS) priority list of needs. The remaining $1,000,000 is for funding special projects. Up to $500,000 will be used in 3 Areas a year to collect asset inventory data including life cycles, develop as-built drawings and develop rate studies for existing Tribal community water supply and waste water disposal systems to enhance the ability of Tribes to establish effective and sustainable operation and maintenance organizations. An amount up to $500,000 will be used for improving data collection systems, providing technical assistance and training for users, as well as for covering the costs of a national automated computer aided drafting contract and to fund an Alaska Native and American Indian Water Resource Center. The Water Resource Center will develop teaching materials and techniques for homeowners and communities to improve usage and support in a way that promotes health. The funding stream started in FY 2012 at $250,000 annually and will be funded for five years through FY 2016, in partnership with the Alaska Native Tribal Health Consortium to develop a teaching system that can be used IHS wide.

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

OUTPUTS AND OUTCOMES

Measure	**Most Recent Result**	**FY 2012 Target**	**FY 2014 Target**	**FY 2014 +/- FY 2012**
(35): Sanitation Improvement: Number of new or like-new and existing AI/AN homes provided with sanitation facilities.	FY 2012: 19,418 (Target Exceeded)	15,500	16,000	500
SFC-E: Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. *(Efficiency)*	FY 2011: 3.35 years (Target Exceeded)	4.0 years	4.0 years	0
SFC-3: Percentage of AI/AN homes with sanitation facilities	FY 2012: 88.2% (Target not met)	90%	89%	-1%

GRANT AWARDS – This program has no grant awards.

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$85,048	$85,568	$85,048	$0
Barrow, AK	$62,085	$0	$0	-$62,085
Kayenta, AZ	$9,984	$44,079	$57,048	+47,064
San Carlos, AZ	$9,984	$41,489	$12,500	+2,516
Southern California	$1,997	$0	$15,500	+13,503
Feasibility Study	$998	$0	$0	-$998
FTE	0	0	0	0

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

FY 2014 Authorization..Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

The construction and modernization of IHS infrastructure through the health care facilities construction program is essential to ensure the IHS commitment to the HHS Services Strategic goal, to strengthen health care. The health care facilities constructed by the IHS ensure access to quality, culturally competent care for one of the poorest and most vulnerable populations in the United States, American Indians and Alaska Natives (AI/AN). The focus of the IHS health service programs provided in these facilities is on prevention and the delivery of comprehensive primary care in a community setting.

Health care facilities construction is funded based on an IHS-wide list of priorities for construction projects. During FY 1990, in consultation with the Tribes, the IHS revised its Health Facilities Construction Priority System (HFCPS) methodology. The HFCPS ranks proposals using factors reflecting the total amount of space needed; age and condition of the existing facility, if any; degree of isolation of the population to be served in the proposed facility; and availability of alternate health care resources. The health facilities projects remaining on the HFCPS, including those partially funded, total approximately $2.2 billion.

The Joint Venture Construction Program (JVCP) allows IHS to enter into agreements with Tribes that construct their own health facilities. The funding for the construction of the health facility comes from the Tribe through their own resources, financing or other funding sources; IHS health care facility construction appropriations are not used for construction of facilities in the JVCP. Tribes apply for the JVCP during a competitive process and projects that are approved enter into agreements with IHS. Upon projected completion of construction by the respective Tribe, the IHS agrees to request Congressional appropriations for additional staffing and operations based on the Tribes' projected dates of completion, fully executed beneficial occupancy and opening.

Between FY 2001 and FY 2012, seventeen joint venture project agreements signed by IHS and Tribes were initiated and nine have been completed. The JVCP continues to receive strong support by Tribes based upon the 55 positive responses to the FY 2009 congressionally directed solicitation for the JVCP FY 2010-FY 2012 cycle.

FUNDING HISTORY

Fiscal Year	Amount
2009 Recovery Act	$227,000,000
2009 Omnibus	$40,000,000
2010 Enacted	$29,234,000
2011 Enacted	$39,156,000
2012 Enacted	$85,048,000
2013 Continuing Resolution	$85,568,000

BUDGET REQUEST

The FY 2014 budget request for Health Care Facilities Construction of $85,048,000 is the same as the FY 2012 Enacted level.

The FY 2014 budget request of $85,048,000 will be allocated to the following projects:

- Kayenta Health Center, Kayenta, AZ to continue construction of the health care facility and begin construction of the staff quarters.
- San Carlos Health Center, San Carlos, AZ, to complete the quarters which are integral to the construction of the health center project.
- Southern California Youth Regional Treatment Center, Hemet, CA to complete construction of the treatment center.

Kayenta Health Center, Kayenta, AZ $57,048,000

The under construction Kayenta replacement health center will provide space to support a modern and adequately staffed health care delivery program. The proposed 16,638 gross square meters (GSM) new health center has been planned for a projected user population of 19,253, generating approximately 54,000 primary care provider visits and 107,000 outpatient visits annually. This facility will ensure availability to the medical services needed to maintain and promote the health status and overall quality of life for the residents of the service area. The health care programs and services provided at this facility include a level III emergency and urgent care unit with the support of the Tribal emergency medical services (EMS); a 10-bed, short stay nursing unit that provides sub-acute care; and a three-bed low-risk birthing center, which will allow this health center to function as an IHS alternative rural hospital. Additionally, this health center will have comprehensive ambulatory care, ancillary services, preventive community health services, behavioral health services, service unit administration, and facility support services. The existing facility will be disposed of in accordance with established regulations and procedures after the replacement health center is operational. The FY 2014 funds will continue construction on the facility and begin the construction of the 129 new staff housing units. IHS expects to complete construction of the Kayenta Health Center by August 2014.

San Carlos Health Center, San Carlos, AZ $12,500,000

This under construction facility will provide an expanded level of health care services specifically designed to meet the health care needs of the San Carlos Service Unit's projected user population of 12,985, generating approximately 50,000 primary care provider visits and 128,000 outpatient visits annually (projections to 2015 based on actual FY 2008 population figures). The existing hospital at San Carlos is being replaced with a modern 16,721 gross square meters health center that will have alternative rural hospital capabilities. The replacement facility will be a modern, technologically advanced facility with the required staff to provide improved access to quality, culturally competent care. The health care programs and services provided include 8 low risk nursing care beds and two birthing beds for a total of 10 beds. New services provided by the facility will be a two-bed low risk birthing unit, physical therapy, telemedicine, podiatry, ultrasound, ambulatory procedures, CT Scanning, and mammography. The FY 2014 funds will complete the construction of this health care facility project which includes 43 new staff housing units.

Southern California Regional Youth Treatment Center, Hemet, CA $15,500,000

These funds will complete the construction of a 3,948 gross square meter (GSM) Youth Regional Treatment Center (YRTC). The proposed new YRTC will be located approximately 60 miles northwest of San Diego, in Hemet, California. The new facility will have 32 beds for routine general residential treatment, six beds for a close observation unit for youth who require crisis intervention, and five family suites. This facility will provide treatment of eligible American Indian and Alaska Native youth, ages 12 to 17, with substance abuse and/or dual diagnosis. Treatment includes a highly structured, culturally appropriate, therapeutic program based on an individual achievement level system. Congress provided design funds for this project in FY 2012 and the design will be completed prior to FY 2014 when funds are requested to construct the YRTC. Based on the location, construction will also require use of these funds to improve the county access road to accommodate transport of heavy equipment to the construction site. In accordance with congressional direction many years ago, the IHS has worked diligently in cooperation with the Tribes of California and Congress to acquire space for this initial YRTC exclusively serving AI/ANs in California. IHS expects to complete construction of the YRTC by April 2015.

OUTPUTS AND OUTCOMES

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
36 Health Care Facility Construction: Number of health care facilities construction projects completed.	FY 2012: 1 (Target Met)	1	1*	0
HCFC-E Health Care Facilities Construction: Energy consumption in Leadership in Energy and Environmental Design (LEED) certified IHS health care facilities compared to the industry energy consumption standard for comparable facilities.		Set Baseline	NA	NA

* The health care facility scheduled to be completed in FY 2014 is San Carlos, Arizona.

GRANTS AWARDS -- Program has no grants awards.

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

(Dollars in Thousands)

	FY 2012 Enacted		FY 2013 Continuing Resolution		FY 2014 President's Budget		FY 2014 +/- FY 2012	
	FTE**	Funds	FTE**	Funds	FTE**	Funds	FTE**	Funds
BA	1,035	$199,413	1,035	$200,633	1,035	$207,206	0	+$7,793
FS	416	$113,545	416	$114,204	416	$117,749	0	+$4,204
EHS	550	$69,703	550	$70,154	550	$72,589	0	+$2,886
OEHE	69	$16,165	69	$16,275	69	$16,868	0	+$703

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

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

FY 2014 Authorization...Permanent

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

SUMMARY OF PROGRAMS

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

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

1. Facilities Support (FS) provides funding for staff and management activities to support operation and maintenance of real property and building systems; medical equipment technical support; and planning design of new and replacement facilities projects.
2. Environmental Health Support (EHS) provides funding for staff and management activities in support of sanitation facilities construction, and environmental health services activities.
3. Office of Environmental Health and Engineering Support provides funding for headquarters management activities and for real property asset management across the IHS facilities and environmental health programs, including technical services and support for capital investments, construction contracting and management of new and replacement facilities, budget formulation, and long range planning, national policy development and

implementation and liaison with the Department of Health and Human Services (HHS), Congress, Tribes, and other Federal agencies.

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

FUNDING HISTORY

Fiscal Year	Amount
2009 Omnibus	$178,329,000
2010 Enacted	$193,087,000
2011 Enacted	$192,701,000
2012 Enacted	$199,413,000
2013 Continuing Resolution	$200,633,000

BUDGET REQUEST

The FY 2014 budget request for Facilities and Environmental Health Support of $207,206,000 is an increase of +$7,793,000 above the FY 2012 Enacted level. The increase will provide:

Pay Costs +565,000 – to fund pay increases for Federal and Tribal employees.

Additional Staffing/Operating Costs for New Healthcare Facilities +$7,228,000
There are 10 new and expanded healthcare facilities that are open or planned to open in FY 2014. The following healthcare facilities reflect the 32 additional staffing needs and operating costs that IHS has determined as its minimum potential request for FY 2014. Seven of the 10 facilities listed are Joint Venture Construction Program (JVCP) projects where the Tribe is fulfilling its responsibility under the JVCP agreement to fund the construction and equipment for the healthcare facility. IHS' responsibility is to request the funds for the additional staff. Increases in Facilities and Environmental Health Support funding are required for additional operating costs and staffing since it is recurring funding to the facility in subsequent years.

Additional Staff for New Healthcare Facility – Minimum Need for FY2014	Amount	Additional Positions to be Funded	
		Facilities Support	Environmental Health Support
Chickasaw Nation Health Clinic (JVCP), Ardmore, OK	$774,000	4	0
Cherokee Nation Health Center (JVCP), Vinita, OK	$220,000	1	0
Southcentral Foundation Valley Primary Care Center (JVCP), Wasilla, AK	$1,325,000	5	0
Tanana Chief Conference Interior Health Center (JVCP), Fairbanks, AK	$1,957,000	5	3
Norton Sound Regional Hospital, Nome, AK	$1,395,000	4	2
Chickasaw Nation Health Clinic (JVCP), Tishomingo, OK	$541,000	3	0
Kenaitze Tribe Dena'ina Health Clinic (JVCP), Kenai, AK	$231,000	1	0
Samuel Simmonds Hospital, Barrow, AK	$480,000	2	0
San Carlos Health Center, San Carlos, AZ	$305,000	1	1
Grand Total:	**$7,228,000**	**26**	**6**

In FY 2014, the program anticipates absorbing current services costs. As costs continue to increase and without funding for current services, Federal and Tribal healthcare administrators may choose not to fill vacant positions, hire lower grade or less experienced (i.e., lower salaried) staff, reduce the hours of service to lower utility costs, not fund critical support services, reduce oversight and inspection of contract actions, etc.

1) FACILITIES SUPPORT

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Facilities Support provides funding for Area and Service Unit staff for facilities-related management activities, operation and maintenance of real property and building systems, medical equipment technical support, and planning and construction management support for new and replacement health facilities projects. The sub-activity directly supports the Agency's priorities including: (1) renewing and strengthening our partnership with Tribes, (2) improving the quality of and access to care, and (3) making all our work accountable, transparent, fair and inclusive.

The IHS owns approximately 947,000 square meters of facilities (buildings and structures) and 733 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 160 years with an average age greater than 33 years. A professional and fully-staffed workforce is essential to ensure effective and efficient operations. Typical staff functions funded may include: (1) facilities engineers and maintenance staff responsible for ensuring that building systems are operated properly, facilities and grounds are maintained adequately, utilities are managed appropriately, environmental compliance requirements are met, and buildings are safe; (2) specialized clinical engineers and technicians that maintain and service medical equipment; (3) realty staff that manages the real property requirements and quarters; and (4) facilities planning and construction-monitoring components that assist in the planning and construction projects.

In addition, this sub-activity provides funding for related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities-related personal property, and biomedical equipment repair and maintenance. IHS reduced the energy related utility consumption for IHS managed facilities from 2,149,000 British Thermal Units per Square Meter (BTU/SM) in 2003 to 1,920,000 BTU/SM in 2012, which is a 10.6 percent reduction. These efforts help stem the growth in utility costs. During the period FY 2003 through FY 2012, total utility costs have increased 46 percent from $15.5 million to $22.6 million and total utility costs per Gross Square Meters (GSM) increased 61 percent from $25/GSM to $40/GSM. The IHS continues to aggressively investigate options to reduce energy costs. However, adequate funds are not available to fully achieve the goals of the Energy Policy Act of 2005; Executive Order 13423, "Strengthening Federal Environmental, Energy, and Transportation Management"; the Energy Independence and Security Act of 2007; and Executive Order 13514, "Federal Leadership in Environmental, Energy and Economic Performance."

2) ENVIRONMENTAL HEALTH SUPPORT

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Environmental Health Support Account provides funding for IHS Area, District, and Service Unit management activities and environmental health staff which include engineers, environmental health officers, environmental health technicians, engineering aides, injury prevention specialists, and institutional environmental health officers. American Indians and Alaska Natives (AI/AN) face hazards in their environment that affect their health status, including: communities in remote and isolated locations; severe climatic conditions; limited availability of safe housing; lack of safe water supply; and lack of public health and safety legislation.

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

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

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

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

OUTPUTS AND OUTCOMES

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
Injury Intervention: Occupant Protection Use (Output)	FY 2012: The Tribal Injury Prevention Cooperative Agreement Programs (TIPCAP) that identified raising seatbelt use as an objective all implemented proven or promising strategies to increase the national TIPCAP seatbelt use percent. . (Target Met)	Implement proven or promising strategies to increase the national seatbelt use rate.	Increase the national Tribal Injury Prevention Cooperative Agreement Programs (TIPCAP) seatbelt use percent by 5 percent, as compared to the 2011 national TIPCAP seatbelt use percent.	N/A
Environmental Surveillance: Identification and control of environmental health risk factors (Output)	FY 2012: All 12 Areas implemented comprehensive interventions targeted at improving the national food risk factor deficiency measure. (Target Met)	Areas will implement comprehensive interventions targeted at improving the national food risk factor deficiency measure	Reduce the national risk factor deficiency percentage by 2% , as compared to the 2011 baseline measure	N/A

GRANT AWARDS

In 2012, the Injury Prevention Program awarded $2.4 Million in cooperative agreements to 33 Tribal programs to create Tribal Injury Prevention Programs where there were none or to continue those that were previously funded. Seven Tribal programs were awarded $70,000 to implement proven or promising motor vehicle or elder fall injury interventions.

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 Request
Number of Awards	Part Ia 16 Part Ib 17 Part II 7	Part Ia 16 (est.) Part Ib 17 (est.) Part II 0	Part Ia 16 (est.) Part Ib 17 (est.) Part II 0
Average Award	Part Ia $65,000 Part Ib $70,219 Part II $10,000	Part Ia $65,000 (est.) Part Ib $80,000 (est.)	Part Ia $65,000 (est.) Part Ib $80,000 (est.)
Range of Awards	Part Ia $65,000 Part Ib $19,241-$80,000 Part II $10,000-$10,554.56	Part Ia $65,000 (est.) Part Ib $80,000 (est.)	Part Ia $65,000 (est.) Part Ib $80,000 (est.)

3) OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Office of Environmental Health and Engineering Support activity provides funds for management activities, personnel, contracts, contractors, and operating costs for the OEHE Headquarters. Personnel have management responsibility for IHS facilities and environmental health programs, provide direct technical services and support to Area personnel, and perform critical management functions. Management activities includes national policy development and implementation, budget formulation, project review and approval, congressional report preparation, quality assurance (internal control reviews, Federal Managers Financial Integrity Act activities and other oversight), technical assistance (consultation and training), long range planning, meetings (with HHS, Tribes, and other Federal agencies), and recruitment and retention. Typical direct support functions performed by OEHE personnel who serve as project officers for health care facilities construction projects are: reviewing and/or writing technical justification documents, participating in design reviews and site surveys, conducting onsite inspections, and monitoring project funding status, etc. In addition, these positions support new real property asset management requirements as required by Executive Order 13327, Real Property Asset Management, and HHS Program Management objectives. These actions are to ensure management accountability and the efficient and economic use of Federal real property.

OEHE Support funds personnel and activities to develop, maintain, and utilize 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 review and approval of Program Justification Documents and Program of Requirements; announcement, review and approval of Joint Venture and Small Ambulatory projects; and awarding and monitoring contracts for health care facilities construction. OEHE coordinates construction, environmental health, and real property activities among 12 Area Offices to ensure program consistency, to ensure the most effective use of resources across IHS and to support field programs through budget preparation and required reporting, thus ensuring the most effective use of resources to improve access to quality health care services.

OUTPUTS AND OUTCOMES – This program has no outputs and outcomes.

GRANT AWARDS – This program has no additional grant awards.

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

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$22,582	$22,720	$22,582	$0
FTE	0	0	0	0

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

FY 2014 Authorization...Permanent

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

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

Accurate clinical diagnosis and effective therapeutic procedures depend in large part on healthcare providers using modern and effective medical equipment to assure the best possible health outcomes. The IHS and Tribal health programs manage laboratory, x-ray, patient monitoring, pharmacy, and biomedical equipment valued at approximately $500 million and an estimated 90,000 devices. With today's medical devices having an average life expectancy of approximately six years, medical equipment replacement is a continual process necessary to replace worn out equipment or provide equipment with newer technology to enhance the speed and accuracy of diagnosis and treatment.

Equipment Funds Allocation Method

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

- Tribally-Constructed Healthcare Facilities – The IHS provides medical equipment funds to support the initial purchase of equipment for Tribally-constructed healthcare facilities. $5 million is set aside annually for competitive awards to Tribes and Tribal organizations that construct new or expand healthcare facilities space using non-IHS funding sources. As a result, approximately 500,000 patients will be treated with updated medical equipment.

- TRANSAM and Ambulance Programs – Equipment funds are also used to acquire new and like-new excess medical equipment from the Department of Defense (DoD) or other sources

through the TRANSAM (i.e., Transfer of DoD Excess Medical and Other Supplies to Native Americans) program and to procure ambulances for IHS and Tribal emergency medical services programs. Currently IHS sets aside $500,000 for Ambulances and $500,000 for TRANSAM annually. Under the TRANSAM program, excess equipment and supplies, annual estimated value of $4 million, are acquired for distribution to the Tribes.

- New and Replacement Equipment – The balance, $16.6 million, of equipment funds are allocated to IHS and Tribal healthcare facilities to purchase new medical equipment, including replacement of existing equipment used in diagnosing and treatment of illnesses. The funding allocation is formula based.

FUNDING HISTORY

Fiscal Year	Amount
2009 Recovery Act	$20,000,000
2009 Omnibus	$22,067,000
2010 Enacted	$22,664,000
2011 Enacted	$22,618,000
2012 Enacted	$22,582,000
2013 Continuing Resolution	$22,720,000

BUDGET REQUEST

The FY 2014 budget request for Equipment of $22,582,000 is the same as FY 2012 Enacted level.

FY 2014 Base Funding $22,582,000 – The budget request will provide:
- Approximately $16.6 million for new and routine replacement medical equipment to over 1,500 federally and Tribally-operated healthcare facilities.
- Approximately $5 million for new medical equipment in Tribally-constructed healthcare facilities.
- Approximately $500,000 for the TRANSAM and $500,000 for ambulance programs.

IHS and Tribal healthcare facilities take into account the medical equipment life cycle, acquisition costs, maintenance requirements, intensity of use, and new technologies to prioritize the procurement of new and replacement medical equipment. Emerging medical equipment technologies, telemedicine, and electronic health records have a profound impact on the quality of healthcare. Equipment funds are used to address the most pressing medical equipment needs while incorporating new medical equipment advances.

In FY 2014, the program anticipates the challenge of using available funds to procure new and replacement medical equipment. The Budget does not include adjustments for current services or address the need to replace old equipment with upgraded technologies. In addition, the program anticipates increases in space of which allocated Equipment funds (i.e., newly added Federal and Tribal healthcare space that is eligible for these funds) may be used to address this need. As a result, the program expects delays in the procurement of new and replacement medical equipment and postponement of new technology implementation which are necessary to provide quality health care.

OUTPUTS AND OUTCOMES - This program has no Output or Outcomes.

GRANT AWARDS – This program has no grant awards.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Facilities: 75-0391-0-1-551
PERSONNEL QUARTERS/QUARTERS RETURN FUNDS

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$7,500	$7,500	$7,500	$0
FTE**	32	32	32	0

Quarters funds are not BA but are rents collected for quarters which are returned to the service unit for maintenance and operation costs. They fall under the Program Level Authority.
**FTE numbers reflect only Federal staff and do not include increases in Tribal staff.

Authorizing Legislation ....Public Law 98-473, Sec. 320 as amended
FY 2014 Authorization...Permanent
Allocation Method ....Federal Direct

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

Staff quarters operation, maintenance, and improvement costs are funded with Quarters Return (QR) funds. QR funds are collected from tenants of quarters associated with IHS owned quarters. These funds will be used for the operation, management, and general maintenance of quarters, including maintenance personnel services, security guard services, repairs to housing units and associated grounds, purchase of materials, supplies, and household appliances/equipment (stoves, water heaters, furnaces, etc.). In certain situations, Maintenance and Improvement 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
2009 Enacted	$6,288,000
2010 Enacted	$6,288,000
2011 Enacted	$6,288,000
2012 Enacted	$7,500,000
2013 Continuing Resolution	$7,500,000

BUDGET REQUEST

The FY 2014 budget request of collections for Quarters of $7,500,000 is the same as the FY 2012 Enacted level.

Rental rates are established in accordance with OMB Circular A-45.

OUTPUTS AND OUTCOMES - This program has no Output or Outcomes.

GRANT AWARDS – This program has no grant awards.

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

SPECIAL DIABETES PROGRAM FOR INDIANS

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget	FY 2014 +/- FY 2012
BA	$150,000	$150,000	$150,000	$0
FTE**	0	0	0	0

* To be determined.
** The Special Diabetes Program for Indians funds are not used to support FTEs.

Authorizing Legislation .... 111 Stat. 574, 1997 Balanced Budget Act (P.L. 105-33), Consolidated Appropriation Act 2001 and amendment to Section 330C (c)(2)(c) Public Health Service Act through Senate Bill 2499 (passed the Senate 12/18/07) to extend funding through FY 2009, the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) Title III Special Diabetes Program for Indians (SDPI) to extend funding through FY 2011, the H.R. 4994 Medicare and Medicaid Extenders Act of 2010 to extend SDPI funding through FY 2013 and the American Taxpayer Relief Act of 2012 (P.L. 112-240) to extend funding through FY 2014. The program authorization is set to expire in FY 2014.

FY 2014 Authorization.. Expires FY 2014

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

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Special Diabetes Program for Indians (SDPI) grant program provides funding for diabetes treatment and prevention through 404 Indian Health Service, Tribal and Urban (I/T/U) Indian health grant programs. Now in its 16th year, the SDPI operates with a budget of $150 million per year that is currently authorized through FY 2014. The IHS Office of Clinical and Preventive Services (OCPS), Division of Diabetes Treatment and Prevention (DDTP) provides leadership, programmatic, administrative, and technical oversight to the SDPI grant program.

The mission of the 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 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 336 local SDPI Community-directed grants and sub-grants, and 68 Diabetes Prevention (DP) and Healthy Heart (HH) Initiatives in I/T/U sites.

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 and training. The IHS combines both clinical and public health approaches to address the problem of diabetes and its complications.

Target Population: American Indians and Alaska Natives

Diabetes and its complications are major contributors to death and disability in every Tribal community. AI/ANs have the highest age-adjusted rate of diagnosed diabetes (16.1%) among all racial and ethnic groups in the United States - roughly twice the rate of the general population (8.3%). In some AI/AN communities more than half of adults aged 18 and older have diagnosed diabetes, with prevalence rates reaching as high as 60 percent. Once found mainly in older adults, the disease increasingly affects AI/AN youth, threatening the health, well-being, and quality of life of future generations.

Diabetes is the fourth leading cause of death among AI/ANs, and the diabetes mortality rate among AI/ANs is 3 to 4 times that of non-AI/ANs. AI/ANs are two and a half times more likely than those in the white population to suffer from heart disease, frequently as a complication of diabetes. The complications of diabetes also lead to much higher incidence rates of blindness, vascular insufficiency leading to amputation, and kidney failure leading to dialysis than in the general U.S. population. However, since 1999, the incidence of kidney failure leading to dialysis has declined 18 percent among the AI/AN population with diabetes over age 45 years, a 29 percent 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 was attributed to the reduction in risk factors and improvements in diabetes care practices in Indian communities as shown by the yearly IHS Diabetes Care and Outcomes Audit.

Allocation Method

In the Balanced Budget Act of 1997, Congress instructed the IHS to use SDPI funds to "establish grants for the prevention and treatment of diabetes" to address the growing problem of diabetes in AI/ANs. The entities eligible to receive these grants included IHS programs, Tribes and Tribal organizations, and urban Indian organizations.

In accordance with legislative intent, the IHS distributed this funding to over 400 entities through a process that included Tribal consultation, development of a formula for distribution of funds, and a formal grant application and administrative process.

Strategy

The SDPI brought Tribes together to work toward a common purpose and share information and lessons learned. The Tribal Leaders Diabetes Committee (TLDC) established in 1998, reviews information on the SDPI progress and provides recommendations on diabetes-related issues to the IHS Director. Through collaborations and partnerships with federal agencies, private organizations and an extensive I/T/U network, DDTP undertook one of the most strategic diabetes treatment and prevention efforts and demonstrated the ability to design, manage, and measure a complex, long-term project to address this chronic condition.

Because of the significant costs associated with treating diabetes, the Tribes and urban Indian organizations have had to make choices about how to best use their local SDPI funding to address the primary, secondary and tertiary prevention of diabetes in AI/AN communities. A study published by the American Diabetes Association in 2007 on the economic burden of diabetes in the U.S. estimated that it costs $11,744 per year to care for one person with diabetes compared with $5,095 per year for persons without diabetes. A recent IHS analysis, supported by the SDPI, demonstrated that in the Indian health system it costs $7,003 per year to care for an AI/AN person with diabetes compared with $2,205 for an AI/AN person without diabetes, a three-fold

difference. Among AI/ANs with diabetes, care for patients who also have cardiovascular disease (CVD) costs $12,693 per year, a two-fold increase.

SDPI: Three Major Components

As directed by Congress and Tribal consultation, the SDPI consists of three major components: 1) Community-directed programs, 2) Diabetes and Cardiovascular Disease Prevention Demonstration Projects that have now transitioned to the Diabetes Prevention and Healthy Heart (DP/HH) Initiatives, and 3) Diabetes Data and program delivery infrastructure.

1) <u>Community-directed Programs</u>

The Community-directed component provides over $116 million per year in grants and sub-grants for local diabetes treatment and prevention services at 363 I/T/U health programs in 34 states. Each of the communities served by the Community-directed programs is unique in that its diabetes treatment and prevention needs and priorities are defined locally. They use these priorities to design and implement interventions that best address the problem of diabetes in local communities across the lifespan.

The Consolidated Appropriations Act of 2001 established statutory authority for SDPI to implement a best practices approach to diabetes treatment and prevention. The SDPI has incorporated these Indian Health Diabetes Best Practices into the Community-directed grant application process used throughout AI/AN communities. Grant programs are required to document the use of at least one Diabetes Best Practice (available at: http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=toolsBestPractices), corresponding evaluation measures, and progress in achieving program objectives in order to enhance accountability.

Each of the current 20 Indian Health Diabetes Best Practices provides: 1) guidelines, 2) key recommendations, 3) direction for how to monitor progress and outcomes, including key measures, 4) specific recommendations for clinical settings, communities, and organizations, 5) instructions on how to evaluate and sustain a program, 6) additional tools, including web-based resources, exemplary programs, and program experts to contact for assistance, and 7) specific suggestions for improving programs and overall accountability in the Indian health system.

In September 2010 IHS implemented a new competitive grant application process for the Community-directed grants. A total of 363 grant and sub-grants were awarded. The Community-directed programs continue capacity building efforts to provide quality diabetes prevention and care services guided by the Diabetes Best Practices.

<u>Impact of the Community-directed Programs</u>

These programs have employed successful, proven strategies to address key areas of diabetes treatment and prevention, based on IHS Standards of Care and the Indian Health Diabetes Best Practices, including activities and services in the following areas:

- *Providing quality care for people with diabetes*
    - 64% more grant programs have diabetes teams (94% in 2010 compared with only 30% in 1997);
- *Reducing the risk for diabetes in youth and adults*
    - 68% more grant programs have type 2 diabetes prevention programs for youth (74% in 2010 compared with only 6% in 1997);

- *Nutrition*
    - 50% more grant programs offer nutrition services for adults (89% in 2010 compared with only 39% in 1997);
- *Physical activity*
    - 71% more grant programs offer community walking and running programs (91% in 2010 compared with only 20% in 1997);
- *Weight management*
    - 57% more grant programs offer adult weight management programs (76% in 2010 compared with only 19% in 1997);
- *Behavior change*
    - 70% more grant programs offer organized diabetes education activities (95% in 2010 compared with only 25% in 1997).

Key clinical outcome measures have improved among AI/AN people 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 realize cost savings. Highlighted below are important improvements in clinical outcomes (based on the IHS Diabetes Audit) since the inception of the SDPI Community-directed programs.

- *Improving Blood Sugar Control*
  Blood sugar control among AI/ANs with diabetes served by the IHS has improved over time. The average blood sugar level (as measured by the A1C test) decreased 11% from 9.00% in 1996 to 8.03% in 2012, nearing the A1C goal for most patients of less than 7%.

- *Improving Blood Lipid Levels*
  Average total cholesterol in IHS patients with diabetes decreased 16% from 204 mg/dL in 1997 to 171.41 mg/dL in 2012. Average LDL cholesterol (i.e., "bad" cholesterol) declined 20% from 118 mg/dL in 1998 to 94.57 mg/dL in 2012, surpassing the goal of less than 100 mg/dL.

- *Improving Kidney Function*
  The prevalence of proteinuria (the presence of protein in the urine, which is a sign of kidney dysfunction) decreased 10%, from 25% in 1997 to about 15% in 2007. At the same time, use of ACE inhibitors to slow the progression of diabetes-related kidney disease increased 31% from 42% in 1997 to 73% in 2008 in patients served by IHS.

2) <u>Diabetes Prevention and Healthy Heart Demonstration Projects</u>
In the 2002 reauthorization of the SDPI, Congress directed the IHS to use additional funding to plan a new competitive grant program to address diabetes prevention and cardiovascular risk reduction. A significant increase in Congressional funding for SDPI beginning in 2004 enabled the IHS to translate research-based diabetes prevention and cardiovascular risk reduction strategies into AI/AN communities. Sixty-six Demonstration Projects were funded to focus on primary prevention of type 2 diabetes in those adults at risk for developing diabetes (36 programs) and reduction of cardiovascular risk in adults diagnosed with type 2 diabetes (30 programs) to I/T/U health programs for six years.

<u>Diabetes Prevention (DP) Demonstration Program</u>
The goal of the Diabetes Prevention Program was to translate the NIH Diabetes Prevention Program (DPP) study's 16-session lifestyle intervention curriculum in a diverse set of AI/AN communities. Specific objectives included: 1) prevent onset of diabetes through modest weight loss in people with pre-diabetes, and 2) achieve changes in clinical and behavioral characteristics

of participants that support diabetes risk reduction. Programs developed culturally appropriate adaptations and strategies to promote recruitment, retention and successful patient outcomes.

The DP Demonstration Program successfully achieved its objective of translating the NIH DPP in AI/AN community settings. The DP participants who completed the follow-up assessment had a significantly reduced 8-year risk of developing diabetes. These results were similar to the results that were achieved by the NIH DPP lifestyle intervention group study participants, which is a much higher rate of success compared to other translational projects. In addition, the DP participants achieved significant weight loss, lower blood sugar levels, improved consumption of healthy foods, increased physical activity, improved blood pressure and blood lipid levels, and improved health-related quality of life following participation in the program.

Healthy Heart (HH) Demonstration Project

The HH Demonstration Project was created to demonstrate reduction of cardiovascular disease factors in adults with diabetes by implementing intensive, clinic-based case management interventions in AI/AN health programs using current standards of care. Specific objectives included: 1) controlling the key cardiovascular risk factors – blood sugar, blood pressure, and blood lipids, and 2) achieving changes in weight, body mass index (BMI), waist circumferences, and heart health-related behaviors such as aspirin use, smoking cessation, healthy eating, and physical activity.

The HH Project achieved its objective of applying intensive case management and patient education to reduce cardiovascular disease risk factors among AI/ANs with diabetes. Participants who completed the follow-up assessment had significantly reduced their 10-year risk of developing coronary heart disease. They achieved significant improvements in meeting goals for control of blood pressure, blood glucose, improved lipid profiles, weight, BMI, and waist circumference. The HH Project has led to significant reductions in diabetes-related complications, reductions in the costs of care, and improved quality of life for people with diabetes.

Transition to DP/HH Initiatives

In September 2010, as a result of a new competitive grant application process, the IHS awarded 68 cooperative agreements to previous and new sites to continue to implement and disseminate the Diabetes Prevention and Healthy Heart Initiative activities. These Initiative programs have begun the work of implementing successful activities from the Demonstration Projects and of evaluating and identifying best practices, lessons learned, and shared resources developed from the experience of the Demonstration Projects during their 6-year project period. The DP/HH Initiative recipients continue to evaluate their progress as they implement the DP and HH program activities within their communities. They will continue to develop the dissemination toolkits, beta test their usefulness and revise as necessary as well as design an effective plan for sharing these resources with other AI/AN communities.

3) Diabetes Data and Program Delivery Infrastructure

The IHS has used administrative funding from the SDPI to strengthen the diabetes data infrastructure of the Indian health system by improving diabetes surveillance and evaluation capabilities. SDPI supports the IHS Diabetes Data infrastructure in the development and implementation of the IHS Electronic Health Record, and the IHS Diabetes Management System (a software program that is part of the RPMS system) in all 12 IHS Areas. As a result, the Indian health system is better able to identify and track AI/ANs with diabetes and improve clinical care and services. The improvements 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. These improvements facilitate program management and accountability. Technical

assistance, provider networks, clinical monitoring, and grant evaluation activities at the Headquarters and Area office levels have also been strengthened.
Facilities associated with SDPI programs participate in the annual IHS Diabetes Care and Outcomes Audit. The Diabetes Audit is the cornerstone of the IHS DDTP diabetes care surveillance system, tracking annual performance on 59 diabetes care and health outcome measures that are based on the IHS Standards of Care for People with Diabetes. Data collection for the Diabetes Audit follows a standardized protocol to ensure statistical integrity and comparability of measures over time. In 2008, submission of data by participating facilities was substantially improved by the creation of the Web Audit, a set of internet-based tools for data entry, review and analysis of the data. This process utilizes modern technology and enhances both DDTP as well as SDPI grant program's ability to monitor trends and gather important data on diabetes care outcomes. The 2012 Diabetes Audit included a review of 99,334 patient charts, a representative sample of diabetes care to 140,251 patients with diabetes, at 320 I/T/U health facilities. More data were collected in the 2012 audit year than ever before. This Diabetes Audit enables IHS and the SDPI programs to monitor and evaluate yearly performance at the local, regional, and national levels.

Diabetes clinical practice has become more complex including an increasing number of guidelines issued by national organizations. The IHS DDTP has developed a variety of clinical tools and resources to assist Indian health clinicians in caring for an increasing number of medically complex patients. The DDTP has sought to review and compile this information and provide it in easily accessed web-based formats. The DDTP "Diabetes LEARN" (Linked Education and Resource Network) is a virtual repository of diabetes information addressing training and resource needs of a multigenerational workforce in diverse settings that often work in geographically isolated settings and/or have limited time and budgets. Diabetes LEARN is a cost-efficient model to provide training and evidence-based, peer reviewed information that is frequently updated and tailored to meet the audiences' needs.

Key Performance/Accomplishments
Annual SDPI assessments have shown significant improvements in diabetes clinical care and community services provided over time when compared to the baseline SDPI assessment in 1997. The evaluation of SDPI and diabetes clinical measures suggests that population-level diabetes-related health is better among AI/AN patients since the implementation of SDPI. SDPI outcome measures have demonstrated improvement in FY 2012. Modifications to program activities, including increased accountability and evaluation, will be implemented in FY 2012-2014 and will contribute to improved performance outcome measures in subsequent years. Continual efforts to improve blood glucose, blood pressure and cholesterol values will further reduce microvascular as well as macrovascular complications.

FY 2012 Outcomes: Diabetes

1.	Poor Glycemic Control:	Proportion of patients with diagnosed diabetes that have poor glycemic control (A1C>9.5).	Target exceeded for 2011; will be discontinued for 2013
2.	Ideal Glycemic Control:	Proportion of patients with diagnosed diabetes with ideal glycemic control (A1C<7.0).	Target exceeded
3.	Blood Pressure Control:	Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<130/80).	Target exceeded.
4.	Dyslipidemia Assessment	Proportion of patients with diagnosed diabetes assessed for Dyslipidemia (LDL cholesterol).	Target exceeded

The implementation of the SDPI program has been a complex process that has demonstrated success in improving quality diabetes care. Serious challenges remain, such as: significant numbers of vacancies for professional health care positions in rural areas, inadequate space to set-up programs and conduct program activities, decreased access to clinical services in rural areas, and additional needs for training and technical assistance. In addition, secular trends in diabetes and obesity prevalence, as well as risk factors and known behaviors that are difficult to change in families and communities, continue to pose challenges.

Reporting
In addition to internal monitoring of the Community-directed Programs and the DP and HH Initiatives, the DDTP has completed four SDPI Reports to Congress to document the progress made since 1998. These SDPI Reports to Congress are as follows:

- January 2000 Interim Report to Congress on SDPI
- December 2004 Interim Report to Congress on SDPI
- 2007 SDPI Report to Congress: On the Path To A Healthier Future
- 2011 SDPI Report to Congress: Making Progress Toward A Healthier Future

FUNDING HISTORY

Fiscal Year	Amount
2009 Enacted	$150,000,000
2010 Omnibus	$150,000,000
2011 Enacted	$150,000,000
2012 Enacted	$150,000,000
2013 Enacted	$150,000,000

BUDGET

The Special Diabetes Program for Indians budget for FY 2004 through FY 2014 is $150,000,000 annually. The distribution of funding remained the same since 2004 after Tribal consultation and is illustrated below:

Special Diabetes Program for Indians – Total Yearly Costs 2004-2013

CATEGORY	Percentage of the total	(Dollars in Millions)
Original Diabetes Grants – now called Community-directed Diabetes Programs (364 Tribal and IHS grants and sub-grants in FY 2010)	69.9%	$104.8
Administration of Community-directed SDPI grants (Includes administrative funds to IHS Areas, Tribal Leaders Diabetes Committee, Div of Diabetes, Grants Operations, evaluation support contracts, etc.)	2.7%	4.1
Urban Indian Health Program community-directed diabetes programs (34 grants) ($7.4M allocated to 34 grants; remaining amount redistributed within existing grants)	5 %	7.5
Diabetes Prevention & Healthy Heart Initiatives (68 grants)	15.5%	23.2
Administration of Demonstration Project Diabetes Grants (Includes administrative funds 1) to support the DP/HH Initiatives coordinating center; 2) to support the limited dissemination activities; 3) to HQ; 4) to support contracts, etc.)	2.8%	4.1
Funds to strengthen the Data Infrastructure of IHS	3.4%	5.2
Native Diabetes Wellness Center (CDC)	0.7%	1.0
TOTAL:	**100%**	**$150.0**

The FY 2014 authorization for the Special Diabetes Program for Indians is $150,000,000. The final distribution of funding is dependent on tribal consultation. The FY 2014 budget is illustrated below:

Special Diabetes Program for Indians – Total Yearly Costs FY 2014*

CATEGORY	Percentage of the total	(Dollars in Millions)
Original Diabetes Grants – now called Community-directed Diabetes Programs (includes 364 Tribal and IHS grants and sub-grants and 34 Urban Indian Health Program grants and administrative support)	77.6%	$116.5
Diabetes Prevention & Healthy Heart Initiatives (68 grants) and administrative support	18.2%	27.3
Funds to strength the Data Infrastructure of IHS	3.4%	5.2
Funds to support the CDC Native Diabetes Wellness Program	0.8	1.0
TOTAL:	**100%**	**$150.0**

*Tribal consultation will be conducted on the FY 2014 funding and, based on the final decisions of the IHS Director and Agency priorities; the activities will be continued or modified appropriately.

The following tables show the accomplishments in terms of outputs and outcomes as well as the estimated change in performance. Most measures showed improvement in FY 2012. Modifications to program activities, including increased accountability and evaluation, are being implemented in FY 2011-2014 which will contribute to improved performance on outcome measures in subsequent years.

Outputs and Outcomes

Measure	Most Recent	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
1: **Diabetes: Poor Glycemic Control**: Proportion of patients with diagnosed diabetes that have poor glycemic control (A1C > 9.5). IHS-All[1,2]	FY 2012: 20%/19.8% (Target Not Met)	19%/18.6%	N/A Discontinued in FY 2013	N/A
1: Tribally Operated Health Programs	FY 2012: 16.1% (Target Not Met)	14.8%	N/A Discontinued in FY 2013	N/A
2: American Indian and Alaska Native patients with diagnosed diabetes achieve **Good Glycemic Control** (A1c less than 8.0) IHS-All[2]	FY 2012: 37%/33.2% (Target Exceeded)	37%/32.7%	TBD	N/A (Baseline in FY 2013)
2: Tribally Operated Health Programs	FY 2012: 36.8% (Target Exceeded)	35.8%	TBD	N/A (Baseline in FY 2013)
3: **Diabetes: Blood Pressure Control**: Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<140/90). IHS-All[2]	FY 2012: 39%/38.9% (Target Exceeded)	39%/38.7%	TBD	N/A (Baseline in FY 2013)
3: Tribally Operated Health Programs	FY 2012: 37.2% (Target Exceeded)	36.6%	TBD	N/A (Baseline in FY 2013)
4: **Diabetes: Dyslipidemia Assessment:** Proportion of patients with diagnosed	FY 2012: 76%/71.0% (Target Exceeded)	77%/70.3%	69.2%	-1.1%

Measure	Most Recent	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
diabetes assessed for Dyslipidemia (LDL cholesterol). IHS-All[2]				
4: Tribally Operated Health Programs	FY 2012: 69.9% (Target Not Met)	70.0%	68.2%	-1.8%

[1]*For Poor Glycemic Control, a reduction in the rate represents improvement.*
[2]*First figure in results column is Diabetes audit data for which data is not currently available; second is from the Clinical Reporting System.*

GRANTS AWARDS

The SDPI provides grants for diabetes treatment and prevention services to IHS, Tribal and Urban Indian health programs in 35 states. The Community-directed grant programs provide local diabetes treatment and prevention services based on community needs. The Diabetes Prevention and Healthy Heart Initiative grant programs have begun the implementation and dissemination of what was learned during the DP and HH Demonstration Projects.

Size of Awards

CFDA No. 93.443 / SDPI Community-directed Grant Programs			
(whole dollars)	FY 2012 Enacted	FY 2013 Request	FY2014 Request
Number of Awards	364 (includes sub-grants)	364 (includes sub-grants)	364 (includes sub-grants)
Average Award	$306,614	$306,614	$306,614
Range of Awards	$12,549 - $6,483,988	$12,549 - $6,483,988	$12,549 - $6,483,988
Total Awards	**$111,607,619**	**$111,607,619**	**$111,607,619**

CFDA No. 93.443 / SDPI Diabetes Prevention / Healthy Heart Initiative Grants			
(whole dollars)	FY 2012 Enacted	FY 2013 Request	FY2014 Request
Number of Awards	68	68	68
Average Award	$324,300	$324,300	$324,300
Range of Awards	$137,500 – $397,000	$137,500 – $397,000	$137,500 – $397,000
Total Awards	**$23,182,200**	**$23,182,200**	**$23,182,200**

FY 2013 Mandatory State/Formula Grants

CFDA No. 93.442 / Special Diabetes Program for Indians Community-Directed Grant Programs by State and FY 2012 Annual Financial Assistance Awards						
State	State Name	Total # Grant Programs	FY 2012 Enacted	FY 2013 Enacted	FY 2014 Request	Difference +/- 2013
AK	Alaska	25	$8,927,252	$8,927,252	$8,927,252	$0
AL	Alabama	1	201,191	201,191	201,191	$0
AZ	Arizona	32	25,964,591	25,964,591	25,964,591	$0
CA	California	41	8,698,479	8,698,479	8,698,479	$0
CO	Colorado	3	728,212	728,212	728,212	$0
CT	Connecticut	2	197,399	197,399	197,399	$0
FL	Florida	2	515,077	515,077	515,077	$0
IA	Iowa	1	254,197	254,197	254,197	$0
ID	Idaho	4	760,150	760,150	760,150	$0
IL	Illinois	1	226,282	226,282	226,282	$0
KS	Kansas	7	660,186	660,186	660,186	$0
LA	Louisiana	4	307,288	307,288	307,288	$0
MA	Massachusetts	2	68,142	68,142	68,142	$0
ME	Maine	5	445,865	445,865	445,865	$0
MI	Michigan	13	2,128,707	2,128,707	2,128,707	$0
MN	Minnesota	13	3,287,642	3,287,642	3,287,642	$0
MS	Mississippi	1	1,022,920	1,022,920	1,022,920	$0
MT	Montana	17	5,512,348	5,512,348	5,512,348	$0
NE	Nebraska	5	1,590,573	1,590,573	1,590,573	$0
NV	Nevada	15	3,260,719	3,260,719	3,260,719	$0
NM	New Mexico	31	6,938,491	6,938,491	6,938,491	$0
NY	New York	4	1,185,398	1,185,398	1,185,398	$0
NC	North Carolina	1	1,198,729	1,198,729	1,198,729	$0
ND	North Dakota	7	2,643,997	2,643,997	2,643,997	$0
OK	Oklahoma	33	17,592,178	17,592,178	17,592,178	$0
OR	Oregon	14	1,799,861	1,799,861	1,799,861	$0
RI	Rhode Island	1	98,109	98,109	98,109	$0
SC	South Carolina	1	137,023	137,023	137,023	$0
SD	South Dakota	14	5,439,117	5,439,117	5,439,117	$0
TN	Tennessee	2	79,915	79,915	79,915	$0
TX	Texas	4	584,689	584,689	589,689	$0
UT	Utah	7	1,449,293	1,449,293	1,449,293	$0
WA	Washington	34	3,892,836	3,892,836	3,892,836	$0
WI	Wisconsin	13	3,062,885	3,062,885	3,062,885	$0
WY	Wyoming	3	747,878	747,878	747,878	$0
Funds Pending Distribution*			**483,210**	**297,383**	**297,383**	**$0**

CFDA No. 93.442 / Special Diabetes Program for Indians Community-Directed Grant Programs by State and FY 2012 Annual Financial Assistance Awards							
State	State Name		Total # Grant Programs	FY 2012 Enacted	FY 2013 Enacted	FY 2014 Request	Difference +/- 2013
	TOTAL	**364***** (IHS, Tribal & Urban grants and sub-grantees)		**$111,607,619**	**$111,793,446**	**$111,793,446**	**$0**
	Indian Tribes	**286 primary grants and sub-grants**		**$91,713,631**			
	Total States	**#35 states**		**$111,607,619**			

*Funds pending distribution in FY 2011 due to disapproved applications or no application submitted for 10 sites.
**For FY 2011, 364 grants and sub-grants received financial assistance awards compared to 384 original SDPI grants in 1998.

CFDA No. 93.442 / Special Diabetes Program for Indians Diabetes Prevention (DP) and Healthy Heart (HH) Initiative Grants by State and FY 2012 Annual Financial Assistance Awards						
	State	Total # DP and HH Initiatives	Total FY 2012 Enacted	FY 2013 Enacted	FY 2014 Request	Difference +/- 2013
AK	Alaska	5	$1,694,200	$1,694,200	$1,694,200	$0
AZ	Arizona	6	2,163,900	2,163,900	2,163,900	$0
CA	California	11	3,388,500	3,388,500	3,388,500	$0
ID	Idaho	1	324,300	324,300	324,300	$0
KS	Kansas	1	397,000	397,000	397,000	$0
MI	Michigan	2	648,600	648,600	648,600	$0
MN	Minnesota	4	1,297,200	1,297,200	1,297,200	$0
MS	Mississippi	1	397,000	397,000	397,000	$0
MT	Montana	2	648,600	648,600	648,600	$0
NC	North Carolina	1	324,300	324,300	324,300	$0
NE	Nebraska	2	648,600	648,600	648,600	$0
NM	New Mexico	5	1,766,900	1,766,900	1,766,900	$0
NY	New York	2	648,600	648,600	648,600	$0
OK	Oklahoma	8	2,957,900	2,957,900	2,957,900	$0
OR	Oregon	2	794,000	794,000	794,000	$0
SD	South Dakota	8	2,667,100	2,667,100	2,667,100	$0
UT	Utah	1	397,000	397,000	397,000	$0
WA	Washington	5	1,694,200	1,694,200	1,694,200	$0
WI	Wisconsin	1	324,300	324,300	324,300	$0

CFDA No. 93.442 / Special Diabetes Program for Indians Diabetes Prevention (DP) and Healthy Heart (HH) Initiative Grants by State and FY 2012 Annual Financial Assistance Awards						
	State	Total # DP and HH Initiatives	Total FY 2012 Enacted	FY 2013 Enacted	FY 2014 Request	Difference +/- 2013
	Total	**68**	**$23,182,200**	**$23,182,200**	**$23,182,200**	**$0**
	Indian Tribes	**61 primary and sub-grant sites**				
	Total States	**#9 States**	**$23,182,200**			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Drug Control Budget
FY 2014

RESOURCE SUMMARY

	Budget Authority (in Millions)		
	FY 2012 Enacted	FY 2013 Continuing Resolution	FY 2014 President's Budget
Drug Resources by Function			
Prevention	18.736	18.807	18.862
Treatment	77.233	77.665	77.998
Construction	1.997	0.000	15.500
Total Drug Resources by Function	**$97.966**	**$96.472**	**$112.360**
Drug Resources by Decision Unit			
Alcohol and Substance Abuse	91.566	92.069	92.457
Urban Indian Health Program	4.403	4.403	4.403
Facilities Construction	1.997	0.000	15.500
Total Drug Resources by Decision Unit	**$97.966**	**$96.472**	**$112.360**
Drug Resources Personnel Summary			
Total FTEs (direct only)	171	171	171
Drug Resources as a Percent of Budget			
Agency Budget	$ 5,418.079	$ 5,463.922	$5,661.675
Drug Resources Percentage	1.81%	1.77%	1.98%

MISSION
The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing Federal health services to American Indians and Alaska Natives (AI/AN). IHS supports substance abuse treatment and prevention services as part of this mission.

METHODOLOGY
The IHS includes the appropriation for Alcohol and Substance Abuse (excluding the amount designated as Adult Alcohol Treatment) and the portion of Urban Indian Health Program (UIHP) funds from the National Institute on Alcohol Abuse and Alcoholism programs transferred to the IHS under the UIHP budget.

BUDGET
In FY 2014, IHS requests $112.4 million for its drug control activities, an increase of $14.4 million above the FY 2012 Enacted level. The request includes construction costs for the Southern California Youth Regional Treatment Center.

Alcohol and Substance Abuse
Total FY 2014 Request: $196.4 million
The FY 2014 budget request includes an increase in current services to support the Alcohol and Substance Abuse Program projected pay costs and staffing needs in FY 2014. The FY 2014 budget request is necessary to maintain the program's progress in addressing the alcohol and substance abuse needs by improving access to behavioral health services through telebehavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

Urban Indian Health Program – Alcohol and Substance Abuse Title V Grants
Total FY 2014 Request: $43.0 million
The FY 2014 request includes funding for the Urban Indian Health Program which will be used to continue serving urban American Indians and Alaska Natives impacted by alcohol and substance abuse through the Title V grant program, Alcohol and Substance Abuse Prevention and Treatment. Substance abuse prevention, treatment, and education programs address alcohol/drugs, suicide, self-esteem, injury control, domestic violence, and sexual abuse. All Urban Indian Health Programs have active partnerships with their local Veterans Health Administration (VHA) programs and several have identified joint alcohol and substance abuse initiatives.

ONDCP FUNDING PRIORITIES

In FY 2014, the IHS budget request for its drug control activities supports the Office of National Drug Control Policy's (ONDCP) funding priorities as well as the 2012 National Drug Control Strategy. The Strategy emphasizes the partnership between Federal agencies, state, local, Tribal, and international counterparts and addresses public health and public safety challenges. IHS is also working with Federal partners to implement the ONDCP's Prescription Drug Abuse Prevention Plan, "Epidemic: Responding to America's Prescription Drug Abuse Crisis." The Prescription Drug Abuse Prevention Plan expands upon the Administration's National Drug Control Strategy which offers a valuable opportunity for IHS to advance its mission by strengthening existing programs to control and reduce substance abuse and eliminate its deleterious effects on the health and safety of AI/AN patients and communities.

In FY 2014, IHS will continue to serve American Indians and Alaska Natives impacted by substance abuse and dependence through its Youth Regional Treatment Centers (YRTCs) and other IHS, Tribal, and Urban Indian operated substance abuse treatment and prevention programs. In addition to those direct services, the IHS Methamphetamine and Suicide Prevention Initiative (MSPI) is a nationally-coordinated demonstration pilot program, focusing on providing targeted methamphetamine and suicide prevention and intervention resources to communities in Indian Country with the greatest need for these programs. There is mutual development and implementation of the MSPI project with Tribes, Tribal programs, and other Federal agencies which now provides support to 125 IHS, Tribal, and Urban Indian health programs nationally. The strategic goal is to support Tribal programs in their continued substance abuse prevention, treatment, and infrastructure development. These efforts represent an innovative partnership with IHS to deliver services by and for the communities themselves, with a national support network for ongoing program development and evaluation.

Substance abuse and dependence in all of its forms continue to rank high on the concern list of the Tribal partners. IHS believes that a shift in emphasis to earlier intervention is required to be successful in reducing the consequences of substance abuse and dependence. IHS proposes focusing on intervention earlier with younger high risk and hazardous users and preventing further progression by recognizing and responding to the sequelae of the abuse. IHS promotes

expanded health care services such as mental and behavioral health treatment and prevention by providing training on substance use disorders to IHS, Tribal, and Urban Indian health programs at annual conferences, meetings, and webinars. Continuing Medical Education (CMEs) and Continuing Education Credits (CEUs) are offered in these training opportunities provided to primary care providers with a special focus on emergency clinics and on women and families.

Data from the 2009 National Survey on Drug Use and Health show that the AI/AN population leads all other ethnic groups in past 30-day misuse of prescription-type drugs. In response, IHS has developed and established a number of initiatives to curb substance abuse and dependence. For example, ONDCP has been working with IHS in selected states to share prescription drug information with state prescription drug monitoring programs (PDMPs). IHS has partnered with the North Dakota PDMP and secured $100,000 for the programming required to transmit data to states utilizing the American Society for Automation in Pharmacy versions 4.0 and 4.1 export formats. The resulting agreement included the initialization, testing, troubleshooting, and institution of routine reporting to state PDMPs for all Federal sites within the states of North Dakota, South Dakota, and Minnesota. Because South Dakota does not have a functioning PDMP, IHS facilities in South Dakota are reporting to the North Dakota PDMP. IHS has partnered with the Bureau of Justice Assistance and secured an additional $35,000 to program the three remaining programming solutions: ASAP 1995; ASAP 2005; and version 3.0. These partnerships will bring all IHS facilities operating in states with functioning PDMPs into reporting compliance along with those Tribal and Urban Indian health programs likely to utilize IHS reporting systems by June 1, 2013.

PERFORMANCE

Introduction

This section on the FY 2012 performance of the drug control portion of the IHS Alcohol and Substance Abuse Program is based on Agency Government Performance and Results Act (GPRA) documents. IHS has added two program measures to report on the effectiveness of IHS programs that focus on drug abuse. IHS is also in the process of developing a measure for prescription drug abuse. The IHS Alcohol and Substance Abuse Program provides anti-drug abuse activities to raise community awareness and target high-risk groups in addition to educating staff on issues and skills related to substance abuse.

The measures reported in the table provide targets and results from both Tribally-Operated Health Programs and Federally-Administered Health Programs. Currently, Tribally-Operated Health Programs have 17 measures, including alcohol- and health- related performance indicators.

IHS Alcohol and Substance Abuse Program		
Selected Measures of Performance	FY 2012 Target	FY 2012 Achieved
Alcohol-use screening among appropriate female patients	58.7%	63.8%
Accreditation rate for Youth Regional Treatment Centers*	100%	91%
Report on number of Emergency Department patients who receive Substance Use Disorder (SUD) intervention	39,496	41,319
Report on # SUD services in primary care clinics	100,266	113,567

* In operation 18 months or more.

Discussion

Heavy drinking during pregnancy can cause significant birth defects, including Fetal Alcohol Syndrome (FAS). Known as the leading and most preventable cause of mental retardation, the rates of FAS are higher among American Indians and Alaska Natives than the general population. Screening with intervention has been shown to be effective in reducing alcohol misuse in pregnancy and to reduce the incidence of FAS.

In FY 2012, the 58.7 percent target for FAS Prevention was exceeded. In FY 2014, the target is 61.9% for the proportion of women screened for alcohol to prevent FAS. There have been significant increases in results since FY 2005, due to increased provider awareness, and an Agency emphasis on behavioral health screening.

The accreditation measure for Youth Regional Treatment Centers reflects an evaluation of the quality of care associated with accreditation status by either the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities (CARF), state certification, or regional Tribal health authority certification. The actual performance measure was not met in FY 2012 as a result of internal infrastructure challenges with one YRTC program. IHS is committed to providing the necessary technical assistance needed in order to assist this facility in obtaining CARF accreditation. The FY 2014 performance target for the YRTCs is 100 percent accreditation and certification status.

The IHS provides several training opportunities annually on alcohol and substance abuse issues for its providers. The 2012 IHS National Behavioral Health Conference was held June 25-28 in Bloomington, Minnesota. The theme of the 2012 conference, Mobilizing Partnerships to Promote Wellness, emphasized the importance of collaboration in working to improve the behavioral health status of American Indians and Alaska Natives. The conference also integrated the Methamphetamine and Suicide Prevention Initiative (MSPI) and the Domestic Violence Prevention Initiative (DVPI) annual meetings. A total of 657 participants attended the conference, which included 225 MSPI participants and 106 DVPI participants, representing 186 Tribes and 36 states. The conference included 11 half- to full-day preconference training sessions and 14 workshop tracks that provided intensive skill-building and continuing education on a wide range of behavioral health topics, including prescription drug abuse and pain management, veterans' health, post traumatic stress disorder, and best practice approaches to addressing co-occurring disorders. The IHS Telebehavioral Health Center of Excellence (TBHCE) conducted webinar training for over 100 participants on the following topics: Introduction to Addiction; Opiate Dependence; Introduction to Medication Assisted Treatments for Opiate Dependence: Screening for Addiction and Monitoring for Aberrant Behavior in Patients with Chronic Pain; and a three part series on Traditional and Biomedical Approaches to Screening, Assessment, Diagnosis, and Treatment for Co-occurring Disorders.

IHS has historically had a problem with obtaining treatment for adult patients in rural and remote areas. Office Based Opioid Therapy (OBOT) has dramatically changed this treatment obstacle. Now many of IHS facilities can provide treatment to patients on-site. From 2002 through 2012, the IHS has provided 29 trainings for OBOT. To date, IHS has trained 200 physicians and 200 midlevel practitioners in the use of buprenorphine to help deal with this increasing trend. The coursework in these training sessions can be applied to the educational requirements needed to apply for a Substance Abuse and Mental Health Services Administration (SAMHSA) Drug Abuse Treatment Act (DATA) 2000 waiver. This has fundamentally changed the way IHS practitioners view the problem and interact with AI/AN patients.

To address prescription drug abuse, IHS convened a multidisciplinary pain management taskforce charged with studying the use and abuse of IHS prescribed opioids. The taskforce has developed guidance for IHS facilities, a draft national IHS pain management policy, and is developing web based tools for local facility use. The policy has been completed and is now going through the IHS approval process. The policy describes system controls that must be in place at the IHS Area and facility levels, requires the signing of a pain agreement between the prescriber and the patient, defines what should be done if the agreement is broken, requires urine drug testing and medication counts, mandates a local Chronic Pain Management Review Committee, and empowers the prescriber to enforce the agreements. The policy requires IHS facilities to join state-operated PDMPs to monitor patients visiting multiple providers. IHS has created an exception to the Health Insurance Portability and Accountability Act rules to allow IHS to report to PDMPs.

IHS is collaborating with other agencies working in the field of substance disorders such as SAMHSA, the Veterans Health Administration, National Institutes of Health, Health Resources and Services Administration, and Centers for Medicare and Medicaid Services to ensure that the best available information, training, protocols, evaluations, performance measures, and data needs and management skills are incorporated and shared with all agencies and organizations working on substance disorders.

IHS has devoted considerable effort to develop and share effective programs throughout the Indian health system. IHS believes developing programs that are collaborative, community driven, and nationally supported offer the most promising potential for long term success and sustainment. IHS is working in partnership and consultation with Tribes to improve the health of AI/AN communities.

FY 2014 BUDGET SUBMISSION
INDIAN HEALTH SERVICE
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2012 Enacted	FY 2014 Estimate	FY 14 +/- FY 2012
DIRECT OBLIGATIONS			
Personnel Compensation:			
Full-Time Permanent(11.0)………………………	447,417	455,166	7,749
Other than Full-Time Permanent(11.3)…………	21,905	22,299	394
Other Personnel Comp.(11.5)……………………	58,905	59,738	833
Military Personnel Comp (11.7)…………………	96,179	98,401	2,222
Special Personal Services Payments (11.8)………	251	253	2
Subtotal, Personnel Compensation....……………	624,657	635,857	11,200
Civilian Personnel Benefits(12.1)………………….	158,670	161,372	2,702
Military Personnel Benefits (12.2)	41,598	42,498	900
Benefits to Former Personnel(13.0)………………	9,191	9,331	140
Subtotal, Pay Costs………………….	**834,116**	**849,058**	**14,942**
Travel(21.0)………………………………………	45,454	47,274	1,820
Transportation of Things(22.0)……………………	10,816	11,141	325
Rental Payments to GSA(23.1)…………………….	9,705	10,146	441
Rental Payments to Others(23.2)…………………..	1,219	1,314	95
Communications, Utilities and Miscellaneous Charges(23.3……………………	26,759	27,603	844
Printing and Reproduction(24.0)…………………..	265	273	8
Other Contractual Services:			
Advisory and Assistance Services(25.1)………….	6,171	6,453	282
Other Services(25.2)……………………………	186,618	192,523	5,905
Purchases from Govt. Accts.(25.3)………………	49,576	51,606	2,030
Operation and Maintenance of Facilities(25.4)…..	14,561	14,860	299
Research and Development Contracts(25.5)…….	41	41	0
Medical Care(25.6)………………………………	322,651	342,290	19,639
Operation and Maintenance of Equipment(25.7)…	22,309	22,975	666
Subsistence and Support of Persons(25.8)……….	4,833	4,864	31
Subtotal, Other Contractual Current.......………	**606,760**	**635,612**	**28,852**
Supplies and Materials(26.0)………………………	113,984	120,492	6,508
Equipment (31.0)…………………………………	23,699	24,248	549
Land & Structures (32.0)…………………………	41,322	40,973	(349)
Investments & Loans (33.0)………………………	0	0	0
Grants, Subsidies, & Contributions (41.0)………..	2,591,977	2,662,019	70,042
Insurance Claims & Indemnities (42.0)……………	413	445	32
Interest & Dividends (43.0)………………………	38	39	1
Subtotal Non-Pay Costs.....………	**3,472,411**	**3,581,579**	**109,168**
Total, Direct Obligations………………	**4,306,527**	**4,430,637**	**124,110**

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

Object Class	FY 2012 Enacted	FY 2014 Estimate	Increase or Decrease
Personnel Compensation:			
Full-Time Permanent (11.0)	447,417	455,166	7,749
Other than Full-Time Permanent (11.3)	21,905	22,299	394
Other Personnel Comp. (11.5)	58,905	59,738	833
Military Personnel Comp. (11.7)	96,179	98,401	2,222
Special Personnel Services Payments (11.8)	251	253	2
Subtotal, Personnel Compensation	624,657	635,857	11,200
Civilian Personnel Benefits (12.1)	158,670	161,372	2,702
Millitary Personnel Benefits (12.2)	41,598	42,498	900
Benefits to Former Personnel (13.0)	9,191	9,331	140
Total, Pay Costs	**834,116**	**849,058**	**14,942**
Travel (21.0)	10,632	11,006	374
Transportation of Things (22.0)	10,816	11,141	325
Rental Payments to Others (23.2)	1,219	1,314	95
Communications, Utilities & Misc. Charges (23.3)	26,759	27,603	844
Printing and Reproduction (24.0)	265	273	8
Other Contractual Services:			
Advisory and Assistance Services (25.1)	6,171	6,453	282
Other Services (25.2)	186,618	192,523	5,905
Purchases from Govt. Accts. (25.3)	49,576	51,606	2,030
Operation and Maintenance of Facilities (25.4)	14,561	14,860	299
Operation and Maintenance of Equipment (25.7)	22,309	22,975	666
Subsistance and Support of Persons (25.8)	4,833	4,864	31
Subtotal, Other Contractual	284,068	293,281	9,213
Supplies and Materials (26.0)	113,984	120,492	6,508
Total, Non-Pay Costs	**447,743**	**465,110**	**17,367**
Total Salaries & Expenses	1,281,859	1,314,168	32,309
Direct FTE	9,289	9,422	133

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

	FY 2012 Enacted	FY 2013 Estimate	FY 2014 Request
Headquarters			
Sub-Total, Headquarters	445	463	463
Area Offices			
Aberdeen Area Office	2,132	2,152	2,152
Alaska Area Office	496	501	501
Albuquerque Area Office	1,017	1,026	1,026
Bemidji Area Office	537	542	542
Billings Area Office	943	952	952
California Area Office	95	96	96
Nashville Area Office	180	182	182
Navajo Area Office	4,206	4,243	4,243
Oklahoma City Area Office	1,715	1,731	1,731
Phoenix Area Office	2,642	2,666	2,666
Portland Area Office	540	545	545
Tucson Area Office	461	465	465
Sub-Total, Area Offices	14,964	15,101	15,101
Trust Funds (Gift)	23	23	23
TOTAL FTES	15,432	15,587	15,587

Average GS Grade

2010............................	8.1
2011............................	8.1
2012............................	8.1

INDIAN HEALTH SERVICE
DETAIL OF PERMANENT POSITIONS

(Dollars in Thousands)

	FY 2012 Estimate	FY 2014 Estimate
Total - ES's......................	18	18
Total - ES Salaries......................	$3,065	$3,081
GS/GM-15..	432	437
GS/GM-14..	412	416
GS/GM-13..	423	428
GS-12..	943	954
GS-11..	1,328	1,343
GS-10..	577	583
GS-9..	1,357	1,372
GS-8..	337	341
GS-7..	1,066	1,078
GS-6...	1,370	1,385
GS-5..	2,283	2,308
GS-4..	1,209	1,222
GS-3..	210	212
GS-2..	47	48
GS-1..	1	1
Subtotal..	11,996	12,130
Total - GS Salaries................................	$644,744	$655,723
Assistant Surgeon General CO-08......	1	1
Assistant Surgeon General CO-07......	7	7
Director Grade CO-06..........................	475	479
Senior Grade CO-05.............................	581	587
Full Grade CO-04..................................	571	577
Senior Assistant Grade CO-03............	359	363
Assistant Grade CO-02.......................	64	65
Junior Grade CO-01..............................	13	13
Subtotal..	2,071	2,092
Total - CO Salaries	$137,777	$140,899
Ungraded..	1,324	1,324
Total - Ungraded Salaries	$48,529	$49,355
Trust Funds (Gift)	23	23
Average ES level................................	ES-02	
Average ES salary..............................	$170	
Average GS grade..............................	8.1	
Average GS salary.............................	$54	

INDIAN HEALTH SERVICE

Programs Proposed for Elimination

The Indian Health Service FY 2014 budget request does not include any programs for proposed elimination.

INDIAN HEALTH SERVICE
Summary of Reimbursements, Assessments, and Purchases
FY 2011

OMBJ 2014

		Object Class								FY 2011	FY 2012	FY 2013	FY 2014
		11.1 & 12.1	21.0	22.0	23.2 & 23.3	24.0	25.3	26.0	31.0	Actual	Actual	Estimate	Estimate
Type of Funding	**Reimbursement for Services Purchased within HHS**												
SSF	Service & Supply Fund				98,330		81,324,900			17,055,000	15,936,000	24,166,950	24,166,950
SSF	HHS Consolidated Acquisition System (HCAS) Operations and Maintenance						11,392,818			3,318,000	2,651,922	2,711,448	2,711,448
SSF	Unified Financial Management System (UFMS) Operations and Maintenance						22,652,814			5,896,000	4,728,868	6,013,973	6,013,973
SSF	UFMS Assessment and Upgrade (Under JFA as of FY 10)						0						
	Subtotal SSF	0	0	0	98,330	0	115,370,532	0	0	26,269,000	23,316,790	32,892,371	32,892,371
OS TAP	Audit Resolution						175,558			20,045	27,513	64,000	64,000
OS TAP	Web Communications						6,846,119			2,272,119		2,287,000	2,287,000
OS TAP	HHS Consolidated Acquisition System (HCAS) O & M											0	0
OS TAP	Unified Financial Management System (UFMS) O & M											0	0
OS TAP	Strategic Sourcing Program (SSP)						290,738			64,738	64,000	81,000	81,000
OS TAP	Vendor Management Office (VMO) new in FY 2013						0			0	0	0	0
OS TAP	Web Crawler						24,000			6,000	6,000	6,000	6,000
OS TAP	Telecommunications Management/WITS						216,459				216,459	0	0
OS TAP	Telecommunications Services						42,240				42,240	0	0
OS TAP	Portfolio Management						0				0	0	0
OS TAP	HHS University						32,448				32,448	0	0
OS TAP	Small Business Center						703,282			169,282	176,000	179,000	179,000
OS TAP	Tracking Accountability Government Grants System (TAGGS)						671,810			121,810	194,000	178,000	178,000
OS TAP	Enterprise Architecture Program (EAP) new in FY 2013						0				0	0	0
OS TAP	Office of Enterprise Application Development (OEAD) new in FY 2013						0				0	0	0
OS TAP	Networx						321,000				321,000	0	0
OS TAP	Division of Security & Emergency Services (DSES) new in FY 2013						0				0	0	0
OS TAP	Departmental Contract Information System (DCIS)						1,645,523			290,523	439,000	458,000	458,000
OS TAP	Acquisition Integration Modernization (AIM)						972,000			259,000	259,000	227,000	227,000
OS TAP	High Performing Organizations and Competitive Sourcing Reporting (HPO & CSM)						101,042			52,042	49,000	0	0
OS TAP	Commissioned Corps Force Management (CCFM)						16,748,900			427,929	327,972	8,082,000	7,911,000
OS TAP	Human Resource Services						3,947,934			2,619,350	1,328,584	0	0
OS TAP	HHS NET						1,039,883			641,199	398,684	0	0
OS TAP	HSPD-12						4,485,572			2,243,690	2,241,882	0	0
OS TAP	OGC Claims						1,345,242			286,650	353,591	350,000	355,000
OS TAP	EEO Investigations (new for non-psc in FY11)						792,343			359,458	432,885	0	0
OS TAP	EEO Services (new for non-psc in FY11)						6,000			0	6,000	0	0
	Subtotal Non-PSC	0	0	0	0	0	40,408,093	0	0	9,833,835	6,916,258	11,912,000	11,746,000
JFA	UFMS Assessment and Upgrade (under JFA as of FY 10)						1,543,043			1,543,043	1,105,000	1,105,000	1,105,000
JFA	Office of General Counsel	535,860	43,144	16		697	384,309	1,196	18,633	996,393	1,248,000	1,355,000	1,355,000
JFA	OGC Ethics Program						333,000			102,355	320,000	320,000	320,000
JFA	OGC Ethics Program - 2-OMS-13-0007										0	201,560	201,560
JFA	HCAS						0			0	0	0	0
JFA	HHS Enterprise						0			0	0	0	0
JFA *	Legislatively Mandated Initiatives and Emerging Technologies (formerly part of HHS Enterprise) LMIE						1,438,025			1,438,025	1,217,736	1,204,309	707,069
JFA	IT Access for the Disabled						0			0	0	0	0
JFA	Regional Health Administrators						308,010			308,010	308,010	308,010	308,010
JFA	Motor Vehicle Management Information System						8,000			8,000	8,400	0	0
JFA	Secretarial Protective Operations Staff						0			0	0	0	0
JFA	(Environmental) Compliance and Process Tracking System						0			0	0	0	0
JFA	Health Services Research Library						868,216			868,216	860,424	940,921	940,921
JFA	Office of Global Health Affairs						13,404			13,404	13,404	13,404	13,404
JFA *	CFO Financial Statement Audit						535,000			535,000	555,000	566,000	577,000
JFA *	Regions Together Initiative									0	0	0	0
JFA	Media Monitoring and Analysis						59,322			45,960	61,695	65,125	65,125
	Subtotal JFA Assessments	535,860	43,144	16	0	697	5,490,329	1,196	18,633	5,858,406	5,697,669	6,079,329	5,593,089
	Government-wide Administrative Functions												
JFA	Tri-Council (CFOC, CIOC, PEC)						120,795			59,898	60,897	0	0
JFA *	Government-wide E-Gov Initiatives (formerly part of HHS Enterprise)						2,545,131			342,023	351,886	881,534	969,688
JFA *	340B Drug Discount Program (HRSA/Office of Pharmacy Affairs-OPA)						236,312			0	0	116,410	119,902
JFA	Federal Employment Services						296,500			71,205	76,269	74,513	74,513
JFA	President's Council on Bioethics						91,200			22,800	22,800	22,800	22,800
	Subtotal, GAF	0	0	0	0	0	3,289,938	0	0	495,926	511,852	1,095,257	1,186,903
	Grand Total	535,860	43,144	16	98,330	697	164,558,892	1,196	18,633	42,457,167	36,442,569	51,978,957	51,418,363

* New

Object Class Description:
11.1 & 12.1 -- Salaries & Benefits
21.0 -- Travel
22.0 -- Transportation of Things
23.2. & 23.3-- Rental Payments, Communications, Utilities
24.0 -- Printing & Reproduction
25.3 -- Purchases of goods and servics from Gov't Accounts
26.0 -- Supplies & Materials
31.0 -- Equipment

Physicians' Comparability Allowance (PCA)
Indian Health Service
Table 1

		PY 2012 (Actual)	CY 2013 (Estimates)	BY 2014* (Estimates)
1) Number of Physicians Receiving PCAs		45	45	45
2) Number of Physicians with One-Year PCA Agreements		5	5	5
3) Number of Physicians with Multi-Year PCA Agreements		40	40	40
4) Average Annual PCA Physician Pay (without PCA payment)		$147,857	$147,857	$147,857
5) Average Annual PCA Payment		$25,000	$25,000	$25,000
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	40	40	40
	Category II Research Position			
	Category III Occupational Health			
	Category IV-A Disability Evaluation			
	Category IV-B Health and Medical Admin.	4	4	4

*FY 2014 data will be approved during the FY 2015 Budget cycle.

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

Not applicable.

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

Maximum annual PCA for Category I (Clinical Position) - $25,000. Factors used were category allowance, duties and location (remote), allowance for mission-specific factors, board certification and retention incentives.

Most of our physicians have moved over to Title 38 Physician and Dentist Pay. However, the Areas that do not use Title 38 are utilizing PCA and have tenure.

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

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

Physician vacancy rates continue in the 20% range due to a shortage of physicians, particularly in primary care specialties.

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

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

10% of IHS civil service physicians are currently taking advantage of this recruitment and retention tool.

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

FY 2014 HHS
Government-Wide E-Gov Initiatives Funds

IHS Allocation Statement:

The **IHS** will use **$363,820** of its **FY 2014** budget to support the following government-wide E-Government initiatives.

FY 2014 E-Gov Initiatives and Lines of Business*	Total	IHS
Budget Formulation and Execution LoB	$105,000	$13,263
Disaster Assist Improvement Plan	$121,154	$0
E-Rulemaking (moved from FFS)	$975,000	$0
Federal Health Architecture LoB	$3,522,000	$100,019
Financial Management LoB /1	$230,616	$26,610
Geospatial LoB	$50,000	$0
GovBenefits.gov	$390,982	$38,669
Grants.gov	$7,844,642	$56,368
Human Resources Management LoB	$130,435	$29,783
IAE - Loans and Grants	$5,006,640	$39,565
Integrated Acquisition Environment	$2,359,151	$59,543
FY 2014 E-Gov Initiatives Total	**$20,735,620**	**$363,820**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from the continued operation and development and enhancement of these initiatives and lines of business include:

Benefits.Gov: GovBenefits.gov is the official benefits website of the Federal Government, providing all citizens with information and eligibility prescreening services for more than 1,000 federally funded benefit and assistance programs. Helping to eliminate redundant solutions and promote efficiency in government, Benefits.gov also creates and hosts multiple other websites on behalf of its 17 Federal partner agencies – including GovLoans.gov, DisasterAssistance.gov and BEST.SSA.gov – each of which leverages Benefits.gov's existing architecture, infrastructure and management team. More than 90 HHS programs use Benefit.gov as a portal for providing services to citizens.

Budget Formulation and Execution: The focus of the Budget Formulation and Execution Line of Business (BFE LoB) is to build a "budget office of the future" by promoting information sharing across government agency budget offices and building a "community of practice." Through this government-wide effort, the budget community is developing common tools and identifying best practices for all aspects of budget formulation and execution.

Goals of the BFE LoB include improvement and enhancements of:

- Efficiency and effectiveness of agency and central processes for formulating and executing the Federal Budget;
- Integration and standardized exchange of budget formulation, execution, planning, performance measurement, and financial management information and activities across the government;
- Capabilities for analyzing budget formulation, execution, planning, performance, and financial information in support of decision-making;
- Capabilities for aligning programs and their outputs and outcomes with budget levels and actual costs to institutionalize budget and performance integration; and
- Efficiency and effectiveness of the Federal budgeting workforce.

Disaster Assistance Improvement Plan (DAIP): The objective of the Disaster Assistance Improvement Program (DAIP) is to simplify the process of identifying and applying for disaster assistance as required by Executive Order 13411. To that end, the program created DisasterAssistance.gov, a user-friendly Web portal that consolidates disaster assistance information and application interfaces to multiple Federal forms of assistance (FOAs) in one place. Individuals in need of assistance following a presidentially declared disaster designated for individual assistance can now go to DisasterAssistance.gov to register online.

Currently, 17 Federal agencies, including HHS, contribute to the portal, which offers applications for or information about almost 70 FOAs as well as news, information and resources to help individuals, families and businesses prepare for, respond to and recover from disasters.".

E-Rulemaking: E-Rulemaking provides citizens one access point to view and comment on rules and notices. This program and its supporting application allow agencies to fulfill the E-Government Act of 2002 requirement to ensure a publicly accessible website containing electronic dockets for regulations.

The E-Rulemaking program includes two important components:

- Regulations.gov: the public website that provides citizens, small businesses, educators, multinational corporations, civic organizations, and all levels of government one-stop Internet access to view, download, and submit comments on all Federal regulations. Agencies are required to ensure their public regulatory dockets are electronically accessible and searchable using Regulations.gov and accept electronic submissions via the website.

- Federal Docket Management System (FDMS): an advanced "back-end" docket management system that provides Department and Agency staff with improved internal docket management functionality and the ability to publicly post all relevant documents on Regulations.gov (e.g., Federal Register documents, proposed rules, notices, supporting analyses, and public comments).

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.

Financial and Grants Management: 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.

Grants Management supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. The Administration for Children and Families (ACF) is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users.

Additionally, NIH is an internally HHS-designated Center of Excellence. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Geospatial: Promotes coordination and alignment of geospatial data collection and maintenance among all levels of government: provides one-stop web access to geospatial information through development of a portal; encourages collaborative planning for future investments in geospatial data; expands partnerships that help leverage investments and reduce duplication; and, facilitates partnerships and collaborative approaches in the sharing and stewardship of data. Up-to-date accessible information helps leverage resources and support programs: economic development, environmental quality and homeland security. HHS registers its geospatial data, making it available from the single access point.

Grants.Gov: Grants.gov is the Federal Government's single website providing information on over 1000 grant programs – representing approximately $500 billion awarded by the 26 grant-making agencies and other Federal grant-making organizations. The initiative enables Federal agencies to publish grant funding opportunities and application packages online while allowing over 1 million organizations that comprise the grant community (state, local, and tribal governments, education and research organizations, non-profit organizations, public housing agencies, and individuals) to search for opportunities and download, complete, and electronically submit applications.

All 26 major Federal grant making agencies posted 100% of their synopses for discretionary funding opportunity announcements on Grants.gov.

Human Resources Management: The HR LoB vision is to create government-wide, modern, cost-effective, standardized, and interoperable HR solutions to provide common core functionality to support the strategic management of Human Resources through the establishment of Shared Service Centers (SSCs). Driven from a business perspective rather than a technology focus, the solutions will address distinct business improvements enhancing the government's performance of HR and payroll services in support of agency missions delivering services to citizens. The HR LoB concept of operations calls for agencies to receive core services from an HR LoB provider. These core HR services are defined as personnel action processing, compensation management (payroll) and benefits management. Leveraging shared services solutions will allow the HR LoB to significantly improve HR and payroll service delivery, save taxpayer dollars, and reduce administrative burdens. HHS will begin using the National Business Center, which operates the HR LoB solution, in FY 2014 to support its core HR services.

Integrated Acquisitions Environment: Since 2002, the Integrated Acquisition Environment (IAE) has offered a portfolio of nine acquisition services which facilitates all phases of the Federal acquisition lifecycle for buyers, sellers, and the public – bringing transparency and visibility to the process of Federal acquisition. These services evolved from the "Adopt, Adapt, Acquire" strategy.

Integrated Acquisitions Environment – Loans & Grants: All agencies participating in the posting and/or making Federal awards are required by the Federal Funding Accountability and Transparency Act (Transparency Act) of 2006 and the American Recovery and Reinvestment Act of 2009 (ARRA) to disclose award and sub-award information on a publicly accessible website. FFATA requires OMB to lead the development of a single, searchable website through which the public can readily access Federal award information.

Department of Health & Human Services
Indian Health Service

Number of Service Units and Facilities
Operated by IHS and Tribes, October 1, 2012

Type of Facility	TOTAL	IHS Total	TRIBAL Total	Title I [a]	Title V [b]	Other [c]
Service Units	**168**	61	107			
Hospitals	**44**	28	16	1	15	0
Ambulatory	**577**	**97**	480	146	327	7
Health Centers	296	61	235	95	140	0
School Health Centers	9	3	6	3	3	0
Health Stations	108	33	75	40	34	1
Alaska Village Clinics	164	0	164	8	150	6

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

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

[c] Operated by a local government, not a tribe, for some Alaska Native villages through a standard procurement contract

Indian Health Service
Summary of Inpatient Admissions and Outpatient Visits
Federal and Tribal
FY 2010 Data

Direct Care Admissions

	IHS	Tribal	TOTAL
TOTAL	**27,733**	**23,364**	**51,097**
Aberdeen	4,051		4,051
Alaska		12,555	12,555
Albuquerque	1,510		1,510
Bemidji	451		451
Billings	1,866		1,866
California			*
Nashville		1,225	1,225
Navajo	12,931	3,337	16,268
Oklahoma	1,397	6,132	7,529
Phoenix	5,035	115	5,150
Portland			*
Tucson	492		492

* No direct inpatient facilities in FY 2010

Direct Care Outpatient Visits

	IHS	Tribal	TOTAL
TOTAL	**5,103,970**	**7,327,047**	**12,431,017**
Aberdeen	814,590	89,603	904,193
Alaska	**	1,604,560	1,604,560
Albuquerque	487,283	87,885	575,168
Bemidji	275,822	666,693	942,515
Billings	498,587	123,163	621,750
California	**	532,873	532,873
Nashville	13,316	483,592	496,908
Navajo	1,178,958	367,849	1,546,807
Oklahoma	576,412	2,277,266	2,853,678
Phoenix	825,068	459,489	1,284,557
Portland	289,615	561,903	851,518
Tucson	144,319	72,171	216,490

** No IHS facilities in FY 2010

INDIAN HEALTH SERVICE
Immunization Expenditures

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Estimate	FY 2014 Estimate	Increase or Decrease
Infants, <2 yrs	$12,903,354	$12,903,354	$13,329,165	$21,922,093	+$8,592,928; additional administration costs for new infant vaccines
Adolescents, 13-17 years				$12,412,350	New Item for 2014 – Administration costs for adolescent vaccines not previously included
HPV vaccine, Female 19-26 years	$9,088,511	$9,088,511	$9,388,432	$6,001,292	-$3,387,140
HPV Vaccine, Males 19-21 yrs				$5,889,641	New for 2014 – Provision of Affordable Care Act
Tdap, 19+ yrs				$6,508,229	New for 2014 - Provision of Affordable Care Act
Hepatitis B for diabetics, 19-64 yrs				$5,752,971	New for 2014 - Provision of Affordable Care Act
Influenza, 19+ yrs			$3,210,800	$25,969,076	+$22,758,276; Administration costs not previously included; HP 2020 goal of 80%
Zoster vaccine, 60+ yrs				$494,463	New for 2014 - Provision of Affordable Care Act
Pneumococcal, 65+ yrs	$1,786,625	$1,786,625		$392,934	Not included in FY 2013 Estimate
Monitoring	$106,914	$106,914	$110,442	$114,528	+$4,086
TOTAL	$23,885,404	$23,885,404	$26,038,839	$85,457,577	

1/ The immunization estimates do not include the Hepatitis B and Haemophilus Immunization program (Alaska) budget line item

The Indian Health Service (IHS) patient care data system does not calculate itemized costs for the treatment of various conditions. Because the cost of vaccines for infants and adolescents < 18 years of age is covered by the Vaccines for Children program, only the costs for vaccine administration, which are not covered by the VFC program, are included for this age group. Vaccine administration fees were based on an average of the CMS Maximum Regional Charges for vaccine administration, multiplied by the number of doses of vaccine routinely recommended for each age group (25 doses for children < 2 yrs; 5 doses of vaccine for adolescents). For 2014, estimates for the administration of new infant vaccines (e.g., rotavirus) and administration costs for adolescents vaccines were added.

In order to incorporate the vaccine provisions included under the Affordable Care Act and Healthcare Reform, all routinely recommended adult vaccines were added to the IHS Core Formulary in September of 2011. Costs for the purchase and administration of these vaccines are included in the 2014 estimated costs. In prior years, costs were only included for adults 65+ yrs and for influenza vaccine. The assumptions for these calculations are included in the table below.

Costs for monitoring of immunization coverage were also included, and represent 3.7% increase over the FY 2013 estimate.

FY 2011 Estimated Costs = FY 2010 CR

FY 2012 Estimated Costs = FY 2011 cost times 3.3 percent
FY 2013 Estimated Costs = FY 2012 cost times 3.1 percent

For 2014, $85, 343,049 is estimated for vaccine costs, and $114,528 for immunization monitoring costs, for a total of $85,457,577 estimated for all immunization expenditures. This represents an increase over previous years for the following reasons:

1. Administration costs for new infant vaccines and adolescent vaccines were not previously included.
2. Under the Affordable Care Act, all routinely recommended vaccines should be provided at no cost. This budget estimate includes adult vaccinations not included in previous budget estimates.
3. Healthy People 2020 goals were used as the coverage targets.

Calculations for the costs included as part of the 2014 estimated immunization costs were based on the assumptions outlined in the table below:

	Estimated User Pop (FY 2010)	Coverage Goal†	Current Coverage	No. to be vaccinated	Vaccine costs (per dose)	Admin fee (per dose)**	No. of doses per patient	Total Immun expenditures per patient	Total
Infants, <2 yrs	50,442	80%	NA	40,354	$0.00	$21.73	25	$543.25	$21,922,093
Adolescents, 13-17 years	142,802	80%	NA	114,242	$0.00	$21.73	5	$108.65	$12,412,350
HPV Females, 19-26	99,095	60%	42%	17,837	$90.42	$21.73	3	$336.45	$6,001,292
HPV Males, 19-21 yrs	35,725	60%	11%	17,505	$90.42	$21.73	3	$336.45	$5,889,641
Tdap, 19+ yrs	1,023,049	80%	66%	143,227	$23.71	$21.73	1	$45.44	$6,508,229
Hepatitis B for diabetics, 19-64 yrs	99,344	60%	16%	41,724	$24.23	$21.73	3	$137.88	$5,752,971
Influenza, 19+ yrs	1,023,049	80%	NA	818,439	$10.00	$21.73	1	$31.73	$25,969,076
Zoster, 60 yrs	181,828	30%	28%	3,637	$114.24	$21.73	1	$135.97	$494,463
Pneumococcal, 65+ yrs	113,016	90%	74%	18,083	$22.85	$21.73	1	$44.58	$392,934
Total Vaccine Costs									$85,343,049

*Coverage estimates based on most current coverage levels reported by IHS
HPV estimate is 1 dose coverage. http://www.ihs.gov/epi/index.cfm?module=epi_vaccine_reports
** Based on an average of the 2013 state CMS Maximum Regional Charges for Vaccine administration. http://www.cdc.gov/vaccines/programs/vfc/index.html
† Based on Healthy People 2020 where applicable

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

1. Individuals outside these target groups are regular recipients of immunizations (e.g., immunization for health care workers and those at specific risk for other vaccine-preventable diseases), however, there is not a methodology to estimate the size of these groups.
2. There is not a methodology to estimate indirect costs or administrative overhead associated with the administration of immunizations, or operation of the immunization program. Therefore, the CMS vaccine administration fee was used to estimate these indirect costs.

FISCAL YEAR 2014 LEGISLATIVE PROPOSAL
Indian Health Service

Provide Indian Health Service Health Professions Scholarship Program and Health Professions Loan Repayment Program with a Tax Exemption

Proposal: IHS is seeking tax treatment, similar to the treatment provided to recipients of National Health Service Corps (NHSC) and Armed Forces Health Professions scholarships, to allow scholarship funds for qualified tuition and related expenses received under the Indian Health Services Health Professions Scholarships to be excluded from gross income under Section 117(c)(2) of the Internal Revenue Code (IRC) and to allow participants in the IHS Loan Repayment Program to exclude from gross income student loan amounts that are forgiven by the IHS Loan Repayment program under Section 108(f)(4) of the IRC.[1]

Current Law: Generally, benefits awarded in the form of scholarship awards and loan repayments are regarded as Federal taxable income by the IRS under Title 25 of the Internal Revenue Code. However, three federal laws currently provide for the non-taxability of federal scholarship awards and loan repayment programs:

- Section 413 of P.L. 107-16 (the Economic Growth and Tax Relief Reconciliation Act of 2001) provides that National Health Service Corps and F. Edward Hebert Armed Forces Health Professions Scholarships and Financial Assistance Program scholarships are not taxable.

- Section 320 of P.L. 108-357 (the American Jobs Creation Act of 2004) provides that funds received through the National Health Service Corps Loan Repayment Program authorized under 338B(g) of the Public Health Service Act or state loan repayment programs authorized by section 338I of Public Health Service Act are not taxable.

- Section 10908 of P.L. 111-148 (the Patient Protection and Affordable Care Act of 2010) provides that in the case of an individual, gross income shall not include any amount received under section 338B(g) of the Public Health Service Act, under a State program described in section 338I of such Act, or under any other State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas (as determined by such State).

As IHS programs are not included in the three exceptions, IHS scholarship awards and loan repayments are taxed under Title 25 of the IRC.

Rationale**:** The IHS, as a rural healthcare provider, has difficulty recruiting healthcare professionals. There are over 1,550 vacancies for healthcare professionals including: physicians,

[1] This proposal applies exclusively to two IHS programs described in the Indian Health Care Improvement Act (Public Law 94-437): the Indian Health Service Health Professions Scholarship Program (Section 104), and IHS Health Professions Loan Repayment Program (Section 108). The tax treatment of all other IHS programs would be unchanged.

dentists, nurses, pharmacists, physician assistants, and nurse practitioners. The IHS Health Professions Scholarship Program and the Loan Repayment Program play a significant role in the recruitment and retention of the healthcare professionals needed to fill these vacancies.

The IHS Health Professions Scholarship and IHS Loan Forgiveness Program are very similar to other programs that receive preferred tax treatment, and should therefore receive similar tax treatment. Currently, benefits awarded through IHS in the form of loan repayment and scholarships are regarded as Federal taxable income to the recipient; however, the same benefits offered under the NHSC are not taxable. This disparate tax treatment of IHS-funded scholarship and loan repayment awards increases the overall tax bracket for the participants and creates a financial disincentive for those otherwise willing to serve American Indian and Alaska Native patients by working in Indian health facilities.

The ability to exempt scholarship and loan repayment funds from gross income would make this recruitment and retention tool more attractive to potential participants. Thus, the IHS would be better able to increase the number of healthcare providers entering and remaining within the IHS to provide primary healthcare and specialty services.

Effective Date: Upon enactment.

Indian Health Service

Indian Self Determination

Indian Health Service Philosophy -- The Indian Health Service (IHS) implements the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law Number (Pub. L. No.) 93-638, as amended, which recognizes the unique legal and political relationship between the United States and American Indian and Alaska Native peoples. Accordingly, the IHS supports Tribal sovereignty (1) by assisting Tribes in exercising their right to administer IHS health programs, or portions thereof, and (2) by continuing to directly provide services to Tribes that choose the IHS as their health care provider. A Tribal decision to enter or not enter into ISDEAA agreements are equal expressions of self-determination.

Title I Contracts and Title V Self-Governance Compacts – Titles I and V of the ISDEAA provide Tribes the option to exercise the right to self-determination by assuming control and management of programs previously administered by the federal government. Since 1992, the IHS has entered into agreements with Tribes and Tribal organizations to plan, conduct, and administer programs authorized under Section 102 of the Act. Today, approximately $2.5 billion of the Agency's appropriation is under Tribal health administration through Title I contracts and Title V compacts. The IHS and Tribes have entered 222 Title I contracts and Annual Funding Agreements. Under Title V, the IHS is a party to 82 compacts and 107 funding agreements; the Title V program constitutes $1.50 million or 34.8 percent of the IHS budget, and 59.7 percent of federally-recognized Tribes.

IHS and Tribally-Operated Service Unit and Medical Facilities – In recent years, the amount of funding administered under ISDEAA contracts and compacts has nearly doubled with a corresponding increase in services provided and managed by Tribal programs. Tribes have traditionally assumed control of community services, later expanding into providing medical care. For example, Tribes operate nearly all of the Community Health Representative Program and community-based alcohol programs. In addition, the number of Tribally-operated hospitals has increased to over 36 percent of the hospitals funded by IHS. With the increase of ambulatory medical facilities, Tribes continue to expand their provision of health care.

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

The demand for CSC funding has increased because of the new and expanded programs, services, functions, or activities assumed by Tribes and Tribal organizations under both Titles I and V of the ISDEAA. Tribes and Tribal organizations use this funding to increase their Tribal capacity to professionally manage ISDEAA agreements and the corresponding services in their communities.

In its June 18, 2012 ruling in Salazar v. Ramah Navajo Chapter, the United States Supreme Court held that "not to exceed" language in past appropriations was not sufficient to limit contract

support costs. The Court identified legislative remedies, ranging from amending the authorizing statute, to changing payments for contract support costs, to enacting line-item appropriations for each contract, to appropriating full funding for CSC. To balance the priorities of all tribes with the available appropriations, and in accordance with the Supreme Court's decision, the Administration proposes new appropriations language for both IHS and the Bureau of Indian Affairs to provide a specific amount for contract support costs funding for each Indian Self-Determination and Education Assistance Act contract. Due to fiscal constraints, funding for CSC must be balanced with funding for direct health care services for tribes. The Administration looks forward to working with Tribes and Congress to develop a balanced, long-term solution.

Indian Health Service

Self Governance Funded Compacts FY 2012

Feb 25.2013

Compacts by State	**IHS Services**	**IHS Facilities**	**Contract Support Costs Direct**	**Contract Support Costs Indirect**	**Total**
Alabama	**$3,937,000**	**$228,000**	**$130,000**	**$648,000**	**$4,943,000**
Poarch Band of Creek Indians	$3,937,000	$228,000	$130,000	$648,000	$4,943,000
Alaska	**$425,749,000**	**$30,425,000**	**$35,947,000**	**$107,071,000**	**$599,192,000**
Alaska Native Tribal Health Consortium	$110,712,000	$19,676,000	$ 10,052,000	$ 12,471,000	$ 152,911,000
Aleutian Pribilof Islands Association, In	$3,393,000	$776,000	$ 349,000	$ 1,278,000	$ 5,796,000
Arctic Slope Native Association	$8,291,000	$65,000	$ 1,208,000	$ 2,912,000	$ 12,476,000
Bristol Bay Area Health Corporation	$22,487,000	$954,000	$ 2,043,000	$ 7,841,000	$ 33,325,000
Chickaloon Native Village	$56,000	$1,000	$ 10,000	$ 7,000	$ 74,000
Chugachmiut	$3,696,000	$80,000	$ 188,000	$ 1,576,000	$ 5,540,000
Copper River Native Association	$2,250,000	$31,000	$ 213,000	$ 569,000	$ 3,063,000
Council of Athabascan Tribal Governm	$2,018,000	$107,000	$ 70,000	$ 1,012,000	$ 3,207,000
Eastern Aleutian Tribes, Inc.	$3,164,000	$23,000	$ 154,000	$ 1,304,000	$ 4,645,000
Kenalitze Indian Tribe	$2,255,000	$10,000	$ 203,000	$ 376,000	$ 2,844,000
Ketchikan Indian Community	$5,609,000	$138,000	$ 892,000	$ 2,818,000	$ 9,457,000
Knik Traditional Council	$71,000	$1,000	$ 9,000	$ 11,000	$ 92,000
Kodiak Area Native Association	$7,353,000	$90,000	$ 394,000	$ 1,665,000	$ 9,502,000
Maniilaq Association	$27,886,000	$930,000	$ 2,442,000	$ 11,920,000	$ 43,178,000
Metlakatla Indian Community	$6,284,000	$951,000	$ 411,000	$ 895,000	$ 8,541,000
Mount Sanford Tribal Consortium	$798,000	$1,000	$ 71,000	$ 199,000	$ 1,069,000
Native Village of Eklutna	$182,000	$2,000	$ 5,000	$ 20,000	$ 209,000
Native Village of Eyak	$776,000	$19,000	$ 76,000	$ 161,000	$ 1,032,000
Norton Sound Health Corporation	$25,449,000	$727,000	$ 1,803,000	$ 4,867,000	$ 32,846,000
Seldovia Village Tribe	$1,822,000	$35,000	$ 66,000	$ 491,000	$ 2,414,000
Southcentral Foundation	$68,875,000	$1,583,000	$ 5,235,000	$ 20,636,000	$ 96,329,000
SouthEast Alaska Regional Health Corp	$39,692,000	$1,398,000	$ 3,088,000	$ 8,584,000	$ 52,762,000
Tanana Chiefs Conference	$35,264,000	$692,000	$ 1,952,000	$ 7,357,000	$ 45,265,000
Yakutat Tlingit Tribe	$320,000	$2,000	$ 27,000	$ 81,000	$ 430,000
Yukon-Kuskokwim Health Corporation	$47,046,000	$2,133,000	$ 4,986,000	$ 18,020,000	$ 72,185,000
Arizona	**$97,329,000**	**$9,599,000**	**$ 4,076,000**	**$ 17,984,000**	**$ 128,988,000**
Gila River Indian Community	$36,042,000	$4,606,000	$ 1,508,000	$ 4,442,000	$ 46,598,000
Tuba City Health Regional Care Corpor	$40,204,000	$3,810,000	$ 1,863,000	$ 8,495,000	$ 54,372,000
Winslow Indian Health Care Center, Inc	$21,083,000	$1,183,000	$ 705,000	$ 5,047,000	$ 28,018,000
California	**$55,772,000**	**$2,722,000**	**$ 2,178,000**	**$ 16,128,000**	**$ 76,800,000**
Consolidated Tribal Health Project, Inc.	$3,708,000	$175,000	$ 84,000	$ 1,344,000	$ 5,311,000
Feather River Tribal Health, Inc.	$5,350,000	$328,000	$ 140,000	$ 818,000	$ 6,636,000
Hoopa Valley Tribe	$5,017,000	$186,000	$ 221,000	$ 954,000	$ 6,378,000
Indian Health Council, Inc.	$8,174,000	$423,000	$ 233,000	$ 2,481,000	$ 11,311,000
Karuk Tribe of California	$2,904,000	$149,000	$ 80,000	$ 1,163,000	$ 4,296,000
Northern Valley Indian Health, Inc.	$2,245,000	$716,000	$ 55,000	$ 532,000	$ 3,548,000
Redding Rancheria	$6,444,000	$119,000	$ 490,000	$ 2,411,000	$ 9,464,000
Riverside-San Bernardino County India	$20,332,000	$504,000	$ 742,000	$ 5,863,000	$ 27,441,000
Susanville Indian Rancheria	$1,598,000	$122,000	$ 133,000	$ 562,000	$ 2,415,000
Connecticut	**$2,432,000**	**$33,000**	**$ -**	**$ 31,000**	**$ 2,496,000**
Mohegan Tribe of Indians of Connectic	$2,432,000	$33,000	$ -	$ 31,000	$ 2,496,000
Florida	**$6,709,000**	**$461,000**	**$ 218,000**	**$ 1,069,000**	**$ 8,457,000**
Seminole Tribe of Florida	$6,709,000	$461,000	$ 218,000	$ 1,069,000	$ 8,457,000
Kansas	**$2,598,000**	**$105,000**	**$ 5,000**	**$ 233,000**	**$ 2,941,000**
Prairie Band of Potawatomi Nation	$2,598,000	$105,000	$ 5,000	$ 233,000	$ 2,941,000
Idaho	**$14,864,000**	**$1,323,000**	**$ 1,043,000**	**$ 1,871,000**	**$ 19,101,000**
Coeur D'Alene Tribe	$5,721,000	$608,000	$ 621,000	$ 1,017,000	$ 7,967,000
Kootenai Tribe of Idaho	$622,000	$32,000	$ 58,000	$ 58,000	$ 770,000
Nez Perce Tribe	$8,521,000	$683,000	$ 364,000	$ 796,000	$ 10,364,000
Louisana	**$1,165,000**	**$91,000**	**$ 97,000**	**$ 118,000**	**$ 1,471,000**
Chitimacha Tribe of Louisana	$1,165,000	$91,000	$ 97,000	$ 118,000	$ 1,471,000
Maine	**$3,222,000**	**$158,000**	**$ 143,000**	**$ 701,000**	**$ 4,224,000**
Penobscot Indian Nation	$3,222,000	$158,000	$ 143,000	$ 701,000	$ 4,224,000
Massachusetts	**$712,000**	**$73,000**	**$ 178,000**	**$ 217,000**	**$ 1,180,000**
Wampanoag Tribe of Gay Head	$712,000	$73,000	$ 178,000	$ 217,000	$ 1,180,000
Michigan	**$26,019,000**	**$1,175,000**	**$ 1,548,000**	**$ 2,716,000**	**$ 31,458,000**
Grand Traverse Band of Ottawa and Ch	$2,935,000	$223,000	$ 195,000	$ 451,000	$ 3,804,000
Keweenaw Bay Indian Community	$3,424,000	$316,000	$ 473,000	$ 618,000	$ 4,831,000
Little River Band of Ottawa Indians	$2,073,000	$63,000	$ 214,000	$ 350,000	$ 2,700,000
Sault Ste. Marie Tribe of Chippewa Ind	$17,587,000	$573,000	$ 666,000	$ 1,297,000	$ 20,123,000
Minnesota	**$20,794,000**	**$1,258,000**	**$ 2,166,000**	**$ 1,831,000**	**$ 26,049,000**
Bois Forte Band of Chippewa Indians	$2,674,000	$288,000	$ 67,000	$ 619,000	$ 3,648,000
Fond du Lac Band of Lake Superior Ch	$11,948,000	$625,000	$ 1,061,000	$ 650,000	$ 14,284,000
Mille Lacs Band of Ojibwe	$4,402,000	$292,000	$ 1,023,000	$ 282,000	$ 5,999,000
Shakopee Mdewakanton Sioux Commu	$1,770,000	$53,000	$ 15,000	$ 280,000	$ 2,118,000

Compacts by State	IHS Services	IHS Facilities	Contract Support Costs Direct	Contract Support Costs Indirect	Total
Mississippi	**$16,683,000**	**$1,008,000**	**$ 1,059,000**	**$ 1,776,000**	**$ 20,526,000**
Mississippi Band of Choctaw Indians	$16,683,000	$1,008,000	$ 1,059,000	$ 1,776,000	$ 20,526,000
Montana	**$20,352,000**	**$1,372,000**	**$ 1,646,000**	**$ 3,293,000**	**$ 26,663,000**
Chippewa Cree Tribe of the Rocky Boy	$ 9,822,000	$712,000	$ 943,000	$ 2,090,000	$ 13,567,000
Confederated Salish and Kootenai Tribe	$10,530,000	$660,000	$ 703,000	$ 1,203,000	$ 13,096,000
Nevada	**$19,989,000**	**$930,000**	**$ 1,273,000**	**$ 3,484,000**	**$ 25,676,000**
Duck Valley Shoshone-Paiute Tribe	$6,766,000	$456,000	$ 661,000	$ 1,583,000	$ 9,466,000
Duckwater Shoshone Tribe	$1,053,000	$29,000	$ 166,000	$ 757,000	$ 2,005,000
Ely Shoshone Tribe	$1,269,000	$19,000	$ 49,000	$ 260,000	$ 1,597,000
Las Vegas Paiute Tribe	$4,050,000	$80,000	$ 109,000	$ 250,000	$ 4,489,000
Washoe Tribe of Nevada and California	$4,914,000	$198,000	$ 202,000	$ 303,000	$ 5,617,000
Yerington Paiute Tribe of Nevada	$1,937,000	$148,000	$ 86,000	$ 331,000	$ 2,502,000
New Mexico	**$16,158,000**	**$763,000**	**$ 1,045,000**	**$ 1,690,000**	**$ 19,656,000**
Pueblo of Jemez	$9,794,000	$274,000	$ 839,000	$ 1,192,000	$ 12,099,000
Pueblo of Sandia	$2,038,000	$158,000	$ 32,000	$ 273,000	$ 2,501,000
Taos Pueblo	$4,326,000	$331,000	$ 174,000	$ 225,000	$ 5,056,000
New York	**$7,802,000**	**$397,000**	**$ 205,000**	**$ 726,000**	**$ 9,130,000**
St. Regis Mohawk Tribe	$7,802,000	$397,000	$ 205,000	$ 726,000	$ 9,130,000
North Carolina	**$20,843,000**	**$1,504,000**	**$ 855,000**	**$ 3,349,000**	**$ 26,551,000**
Eastern Band of Cherokee Indians	$20,843,000	$1,504,000	$ 855,000	$ 3,349,000	$ 26,551,000
Oklahoma	**$322,844,000**	**$35,858,000**	**$ 20,589,000**	**$ 39,658,000**	**$ 418,949,000**
Absentee Shawnee Tribe of Oklahoma	$9,520,000	$1,040,000	$ 751,000	$ 994,000	$ 12,305,000
Cherokee Nation	$109,120,000	$11,747,000	$ 4,592,000	$ 12,356,000	$ 137,815,000
Chickasaw Nation	$65,234,000	$11,319,000	$ 7,364,000	$ 10,097,000	$ 94,014,000
Choctaw Nation of Oklahoma	$56,671,000	$8,118,000	$ 5,385,000	$ 6,884,000	$ 77,058,000
Citizen Potawatomi Nation	$13,134,000	$1,063,000	$ 699,000	$ 2,766,000	$ 17,662,000
Kaw Nation	$1,327,000	$99,000	$ 181,000	$ 231,000	$ 1,838,000
Kickapoo Tribe of Oklahoma	$7,544,000	$206,000	$ 139,000	$ 870,000	$ 8,759,000
Modoc Tribe of Oklahoma	$8,000	$131,000	$ 4,000	$ 16,000	$ 159,000
Muscogee (Creek) Nation	$40,605,000	$1,717,000	$ 1,051,000	$ 3,507,000	$ 46,880,000
Northeastern Tribal Health System	$6,860,000	$244,000	$ 134,000	$ 814,000	$ 8,052,000
Ponca Tribe of Oklahoma	$3,708,000	$55,000	$ 142,000	$ 392,000	$ 4,297,000
Sac and Fox Nation	$7,306,000	$69,000	$ 113,000	$ 441,000	$ 7,929,000
Wyandotte Nation	$1,807,000	$50,000	$ 34,000	$ 290,000	$ 2,181,000
Oregon	**$23,297,000**	**$1,136,000**	**$ 2,235,000**	**$ 7,119,000**	**$ 33,787,000**
Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians of Oregon	$1,585,000	$77,000	$ 258,000	$ 522,000	$ 2,442,000
Confederated Tribes of Grand Ronde	$6,083,000	$279,000	$ 478,000	$ 2,371,000	$ 9,211,000
Confederated Tribes of Siletz Indians o	$7,283,000	$214,000	$ 655,000	$ 1,804,000	$ 9,956,000
Confederated Tribes of the Umatilla Re	$6,424,000	$470,000	$ 639,000	$ 1,595,000	$ 9,128,000
Coquille Indian Tribe	$1,922,000	$96,000	$ 205,000	$ 827,000	$ 3,050,000
Utah	**$7,042,000**	**$150,000**	**$ 1,606,000**	**$ 1,508,000**	**$ 10,306,000**
Utah Navajo Health System, Inc.	$7,042,000	$150,000	$ 1,606,000	$ 1,508,000	$ 10,306,000
Washington	**$52,381,000**	**$3,428,000**	**$ 2,391,000**	**$ 11,098,000**	**$ 69,298,000**
Cowlitz Indian Tribe	$3,105,000	$117,000	$ 20,000	$ 413,000	$ 3,655,000
Jamestown S'Klallam Indian Tribe	$926,000	$59,000	$ 80,000	$ 284,000	$ 1,349,000
Kalispel Tribe of Indians	$996,000	$77,000	$ 19,000	$ 60,000	$ 1,152,000
Lower Elwha Klallam Tribe	$1,780,000	$99,000	$ 95,000	$ 312,000	$ 2,286,000
Lummi Indian Nation	$7,571,000	$583,000	$ 225,000	$ 1,697,000	$ 10,076,000
Makah Indian Tribe	$3,688,000	$361,000	$ 265,000	$ 921,000	$ 5,235,000
Muckleshoot Indian Tribe	$6,861,000	$276,000	$ 168,000	$ -	$ 7,305,000
Nisqually Indian Tribe	$2,275,000	$141,000	$ 102,000	$ 566,000	$ 3,084,000
Port Gamble S'Klallam Tribe	$2,459,000	$133,000	$ 126,000	$ 659,000	$ 3,377,000
Quinault Indian Nation	$5,344,000	$429,000	$ 171,000	$ 1,696,000	$ 7,640,000
Shoalwater Bay Indian Tribe	$1,832,000	$36,000	$ 255,000	$ 694,000	$ 2,817,000
Skokomish Indian Tribe	$2,001,000	$145,000	$ 102,000	$ 476,000	$ 2,724,000
Squaxin Island Indian Tribe	$2,693,000	$180,000	$ 180,000	$ 907,000	$ 3,960,000
Suquamish Tribe	$1,588,000	$57,000	$ 137,000	$ 521,000	$ 2,303,000
Swinomish Indian Tribal Community	$2,156,000	$148,000	$ 153,000	$ 704,000	$ 3,161,000
Tulalip Tribes of Washington	$7,106,000	$587,000	$ 293,000	$ 1,188,000	$ 9,174,000
Wisconsin	**$25,574,000**	**$1,167,000**	**$ 1,319,000**	**$ 1,476,000**	**$ 29,536,000**
Forest County Potawatomi Community	$2,714,000	$187,000	$ 615,000	$ 337,000	$ 3,853,000
Oneida Tribe of Indians of Wisconsin	$19,372,000	$745,000	$ 279,000	$ 700,000	$ 21,096,000
Stockbridge-Munsee Community	$3,488,000	$235,000	$ 425,000	$ 439,000	$ 4,587,000
Grand Total	**$1,187,225,000**	**$95,214,000**	**$ 80,346,000**	**$ 224,287,000**	**$ 1,597,378,000**

Indian Health Service
FY 2012 Self-Governance Funding Agreements
By Area

Area	Program Tribal Shares	Area Tribal Shares	Headqtrs Tribal Shares	Contract Support Costs (Direct)	Contract Support Costs (Indirect)	Total
Alaska	431,506,000	13,895,000	10,774,000	35,946,000	107,071,000	599,192,000
Aberdeen	152,000	128,000				280,000
Albuquerque	13,775,000	2,397,000	749,000	1,045,000	1,690,000	19,656,000
Bemidji	70,745,000	3,125,000	2,117,000	5,033,000	6,023,000	87,043,000
Billings	17,721,000	2,009,000	970,000	1,693,000	4,270,000	26,663,000
California	49,183,000	3,509,000	2,445,000	2,252,000	19,411,000	76,800,000
Nashville	57,516,000	6,104,000	2,247,000	2,945,000	10,166,000	78,978,000
Navajo	65,616,000	3,344,000	3,003,000	4,174,000	16,559,000	92,696,000
Oklahoma	327,197,000	11,030,000	12,538,000	23,301,000	47,824,000	421,890,000
Phoenix	55,020,425	1,705,000	1,633,000	2,824,575	11,091,000	72,274,000
Portland	81,861,000	6,268,000	3,524,000	6,373,000	24,160,000	122,186,000
Total, IHS	1,170,292,425	53,514,000	40,000,000	85,586,575	248,265,000	1,597,658,000