# DEPARTMENT OF HEALTH AND HUMAN SERVICES

## Fiscal Year 2024

## Indian Health Service

***Justification of Estimates for Appropriations Committees***

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

MAR 10 2023

I present the Indian Health Service (IHS) Fiscal Year (FY) 2024 Congressional Justification. The FY 2024 President's Budget builds on the historic enactment of advance appropriations for the IHS, which is a step towards securing stable and predictable funding to improve the overall health status of American Indians and Alaska Natives, and ensuring that the disproportionate impacts experienced by tribal communities during the government shutdowns and continuing resolutions are never repeated.

The FY 2024 budget proposes a two-pronged approach. First, in FY 2024, the budget includes $9.7 billion in discretionary and mandatory funding for IHS, an increase of $2.5 billion or 36 percent above FY 2023 enacted. This includes $8.1 billion in discretionary funding, and $1.6 billion in proposed mandatory funding for Contract Support Costs, Section 105(*l*) Leases, and the Special Diabetes Program for Indians. Second, the budget makes all funding for IHS mandatory beginning in FY 2025. Under the proposed mandatory structure, IHS funding would grow automatically to address inflationary factors, key operational needs, and existing backlogs in both healthcare services and facilities infrastructure.

The Indian health system faces challenges related to access, quality, management, and operations. This budget aims to address these challenges and builds on the progress that we have already made.

The bold action in the FY 2024 President's Budget demonstrates the Administration's continued commitment to work to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level and strengthen the Nation-to-Nation relationship. I am excited about what we will achieve together to improve the health and well-being of American Indians and Alaska Natives.

Roselyn Tso -S
Digitally signed by Roselyn Tso -S
Date: 2023.03.10 14:31:37 -05'00'

Roselyn Tso
Director

# INDIAN HEALTH SERVICE

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES
## INDIAN HEALTH SERVICE
## FY 2024 Performance Budget Submission to Congress

## TABLE OF CONTENTS


Letter from OPDIV Head
Organizational Chart
Table of Contents

Page

**Executive Summary**

Introduction and Mission ....1
Overview of Budget Submission ....2
Overview of Performance ....8
All Purpose Table ....10
Detail of Changes FY 2023....11
Staffing / Operating Costs for Newly-Constructed Facilities FY 2024 ....12

**Appropriation Accounts**

*Budget Exhibits*
Appropriations Language....13
Amounts Available for Obligation....22
Summary of Change....26
Budget Authority by Activity....27
Authorizing Legislation ....28
Appropriations History Table ....29

**Current Services/Staffing of Newly Constructed Facilities**

Current Services....33
Staffing of Newly Constructed Facilities....35

**Services**

Clinical Services
Clinical Services Summary ....37
Hospitals & Health Clinics ....40
Epidemiology Centers....84
Information Technology ....89
Electronic Health Record ....98
Dental Health....103
Mental Health....112

Alcohol & Substance Abuse ....................120
Purchased/Referred Care....................134
Preventive Health
Preventive Health Summary....................140
Public Health Nursing....................142
Health Education....................149
Community Health Representatives....................154
Immunization AK ....................161

Other Services
Urban Health....................168
Indian Health Professions ....................175
Tribal Management Grants ....................182
Direct Operations....................185
Self-Governance....................189
Public and Private Collections....................193

**Facilities**

Facilities Summary ....................200
Maintenance & Improvement ....................202
Sanitation Facilities Construction....................207
Health Care Facilities Construction....................212
Facilities & Environmental Health Support Summary ....................217
Facilities Support ....................217
Environmental Health Support ....................219
Office of Environmental Health & Engineering Support ....................221
Equipment....................227
Quarters....................231

**Mandatory**

Contract Support Costs ....................234
ISDEAA 105 (l) Leases ....................237
Special Diabetes Program for Indians....................240
Mandatory Narrative ....................248

**Drug Budget**

Drug Control Programs....................253

**Supplemental Tables**

*Exhibits*

Budget Authority by Object Class ....................267
Salaries and Expenses....................268

Detail of Full-Time Equivalent Employment (FTE)....................................................269
Detail of Positions.............................................................................................270
Cyber Activity Funding.........................................................................................271

## Operating Division-Specific Requirements

*IHS-Specific Requirements*
Federal & Tribal Operated Service Units & Medical Facilities......................................272
Summary of Inpatient Admissions and Outpatient Visits...............................................273
Immunization Expenditures.....................................................................................274
Annual Facilities Plan...........................................................................................277
Federal/Tribal Crosswalk Tables..............................................................................278
Legislative Proposals............................................................................................281

## Self Determination

*Self-Determination*
Self-Determination Program.....................................................................................300
Self-Determination Tables.......................................................................................301

## Non-Recurring Expense Fund

Non-Recurring Expense Fund.....................................................................................305

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**INDIAN HEALTH SERVICE**
**FY 2024 Performance Budget Submission to Congress**

## TABLE OF CONTENTS

### Executive Summary

Page

Introduction and Mission ....................1
Overview of Budget Submission ....................2
Overview of Performance ....................10
All Purpose Table ....................12
Detail of Changes ....................13
Staffing / Operating Costs for Newly-Constructed Facilities FY 2024 ....................16

## 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 2.8 million American Indians and Alaska Natives through a network of over 600 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.

United States Government and Indian Nations

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

Indian Health Service and Its Partnership with Tribes

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

The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), as amended, and the Indian Health Care Improvement Act of 1976 (IHCIA), as amended, provided new opportunities for the IHS and Tribes to deliver quality and accessible health care.

The IHCIA includes specific authorizations such as improvements for urban Indian health programs, Indian health professions programs, and the authority to collect from Medicare and Medicaid and other third-party insurers for services rendered at IHS or Tribal facilities. Under the ISDEAA, many Tribes have assumed the administrative and programmatic roles previously carried out by the Federal Government. Tribes currently administer over half of IHS resources through ISDEAA contracts and compacts. The IHS directly administers the remaining resources and manages programs where Tribes have chosen not to contract or compact health programs.

INDIAN HEALTH SERVICE
FY 2024 Budget Submission to Congress

## Overview of Budget

The fiscal year (FY) 2024 Indian Health Service (IHS) budget encompasses the overall goals of: 1) ensuring comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian/Alaska Native (AI/AN) people; 2) promoting excellence and quality through innovation of the Indian health system into an optimally performing organization; and 3) strengthening IHS program management and operations in carrying out the agency mission to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. The budget conveys the President's commitment to provide high-quality health care services for AI/ANs. The budget reflects the importance of providing health care, consistent with statutory authorities, to AI/ANs. In addition, the budget supports the HHS Secretary's priorities to advance health equity and address pressing public health issues such as HIV/Hepatitis C, the opioid epidemic, cancer, and maternal mortality.

The IHS provides a wide range of clinical, public health, community, and facilities infrastructure services to approximately 2.8 million AI/ANs who are members of 574 federally recognized tribes in 37 states. Comprehensive primary health care and disease prevention services are provided through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations. These facilities are predominately primary care settings and are managed by IHS, tribal, and urban (I/T/U) Indian health programs.

The IHS meets the annual statutory requirement to consult with and solicit the participation of Tribes and tribal organizations in the development of the budget for IHS. Likewise, IHS confers with urban Indian organizations. The consultation and confer input informs the IHS budget formulation process. The core of the agency's formulation process consists of the priorities and recommendations developed in consultation with Tribes through this independent annual budget process led by the National Tribal Budget Formulation Workgroup[1]. IHS is strongly committed to this process and it ensures that the IHS budget is relevant to the health needs and priorities of AI/ANs. The tribal priorities identified in the consultation process are also instrumental to inform senior officials of other U.S. Department of Health and Human Services (HHS) agencies of the health needs of the AI/AN population, so that they have the opportunity to reflect those priorities in the Department's budget requests.

## Summary of Budget Submission

The FY 2024 President's Budget proposes to take bold action to remediate the chronic underinvestment in IHS by taking a two-pronged approach. First, in FY 2024, the budget includes $9.7 billion for IHS, an increase of $2.5 billion or 36 percent above FY 2023 enacted. This includes $8.1 billion in discretionary funding (including $5.1 billion in advance appropriations enacted in the FY 2023 Omnibus) and $1.6 billion in proposed mandatory funding for Contract Support Costs, Section 105(l) Leases, and the Special Diabetes Program for Indians.

The FY 2024 President's Budget builds on the historic enactment of advance appropriations for the IHS by maintaining discretionary funding for the Services and Facilities accounts in FY 2024. Advance appropriations represent an important step towards securing stable and predictable funding to improve the

[1] https://www.ihs.gov/budgetformulation/tribalbudgetconsultation/

overall health status of AI/ANs, and ensuring that the disproportionate impacts experienced by tribal communities during government shutdowns and continuing resolutions are never repeated.

While the progress achieved through the enactment of advance appropriations will have a lasting impact on Indian Country, funding growth beyond what can be accomplished through discretionary spending is needed to fulfill the federal government's commitments to Indian Country. Funding for IHS has grown substantially in the last decade – 68 percent from FY 2013 to FY 2023 – however, this growth is not sufficient to address the historic under investment and persistent health disparities in AI/AN communities.

The Administration continues to support mandatory funding for IHS as the most appropriate long-term funding solution for the agency and will continue to work collaboratively with tribes and Congress to move toward sustainable, mandatory funding. Until this solution is enacted, it is critical that Congress continue to prioritize advance appropriations for IHS through the discretionary appropriations process to ensure funding for healthcare services and critical facilities activities are not disrupted.

To this end, the budget begins to shift contract support costs and section 105(l) Leases to mandatory in FY 2024 and makes all funding for IHS mandatory beginning in FY 2025. Under the proposed mandatory structure, IHS funding would grow automatically to address inflationary factors, key operational needs, and existing backlogs in both healthcare services and facilities infrastructure.

These major steps demonstrate the Administration's continued commitment to honor the United States' treaty responsibility to tribal nations and strengthen the nation-to-nation relationship.

Historical trauma and chronic underinvestment significantly contributed to the perpetuation of health disparities in Indian Country. AI/ANs born today have an average life expectancy that is 10.9 years fewer than the U.S. all-races population. AI/AN life expectancy dropped from an estimated 71.8 years in 2019 to 65.2 years in 2021 – the same life expectancy as the general United States population in 1944. AI/ANs also experience disproportionate rates of mortality from most major health issues, including chronic liver disease and cirrhosis, diabetes, unintentional injuries, assault and homicide, and suicide.

The COVID-19 pandemic compounded the impact of these disparities in tribal communities, with AI/ANs experiencing disproportionate rates of COVID-19 infection, hospitalization, and death. Underfunding of direct health care services in tribal communities, aging infrastructure, high vacancy rates, and other systemic issues significantly contributed to these stark inequities. The COVID-19 experience in Indian Country illustrates the urgent need for large-scale investments to improve the overall health status of AI/ANs, and ensure that the disproportionate impacts experienced during the pandemic are never repeated.

Mandatory funding provides a long-term solution for adequate, stable, and predictable funding for the Indian health system. The challenges of an annual discretionary budget are well documented by the Government Accountability Office in their report GAO-18-652, Indian Health Service: Considerations Related to Providing Advance Appropriation Authority. While advance appropriations resolve some of the challenges presented by annual discretionary funding like the instability caused by continuing resolutions and lapses in appropriations, they do not address issues of adequacy or predictability in funding. Adequacy and predictability in funding would support enhanced recruitment and retention of health professionals and would enable health programs to more effectively complete longer-term planning activities over multiple years. These changes will have a direct positive impact on the availability and delivery of quality health care.

Mandatory funding for the IHS provides the opportunity for significant funding increases that could not be achieved under discretionary funding caps. Further, this mandatory and legislative funding proposal would authorize and appropriate funding through FY 2033, ensuring predictability that would allow IHS, Tribal, and urban Indian health programs the opportunity for long-term and strategic planning.

The budget also exempts IHS from proposed law sequestration, which is the legislatively mandated process of budget control consisting of automatic, across-the-board spending reductions to enforce budget targets to limit federal spending. Exempting the IHS budget from sequestration ensures funding for direct health care services to AI/ANs is not reduced, consistent with the treatment of other critical programs such as veterans' benefits and nutrition assistance programs. The budget also includes inflation factors to address the growing cost of providing direct health care services, including pay costs, medical and non-medical inflation, and population growth.

While this is a historic first step, the IHS recognizes that we must continue to work in consultation with Tribes and confer with urban Indian organizations, and with our partners in Congress, to ensure the budget is structured and implemented correctly with the resources identified over the next 10 years.

## FY 2024 President's Budget

For the first year of the proposal, the budget includes $9.7 billion in total funding for the IHS, which includes $8.1 billion in discretionary funding, and $1.6 billion in proposed mandatory funding for Contract Support Costs, Section 105(l) Leases, and the Special Diabetes Program for Indians. This is an increase of $2.5 billion above the FY 2023 Enacted level.

**Crosscutting changes from the FY 2023 Enacted level include:**

- Current Services: +$346 million to offset the rising cost of providing direct health care services, including tribal and federal pay costs ($100 million), medical and non-medical inflation ($119 million), and population growth ($127 million). These resources will help the IHS to maintain services at the FY 2023 levels by shoring up base operating budgets of IHS, Tribal, and urban Indian health programs in the face of increasing costs.

- Staffing and Operating Costs for Newly-Constructed Health Care Facilities: +$82 million for staffing of eight newly-constructed health care facilities. These funds support the staffing packages for new or expanded facilities, which will expand the availability of direct health care services in areas where existing health care capacity is overextended.

**Indian Health Services account changes from the FY 2023 Enacted level include:**

- Direct Health Care Services General Increase: +$742 million to expand access to direct health care services by increasing funding across IHS' direct health care service program lines. These resources will support efforts to reduce health disparities and improve the overall health status for AI/ANs by increasing the availability of health care services in Indian Country.

- Electronic Health Record: +$691 million to improve the quality of health care in Indian Country and health status of AI/ANs by modernizing the IHS Electronic Health Record (EHR) system.

- Cancer Moonshot Initiative: +$108 million to develop a coordinated public health and clinical cancer prevention initiative to implement best practices and prevention strategies to address incidence of cancer and mortality among AI/ANs.

- Addressing Targeted Public Health Challenges: +$59 million to make targeted investments in IHS as part of Administration initiatives to address our Nation's most pressing public health challenges, which disproportionately impact American Indian and Alaska Native communities. This includes HIV and Hepatitis C (+$47 million), improving maternal health (+$3 million), and addressing opioid use (+$9 million).

- Assessments: +$27 million to offset the increasing costs of central assessments charged to the IHS by HHS since FY 2014. To address the growing costs of shared services at HHS, the IHS has delayed hiring and investments in critical systems, working to shield direct health care services to the maximum extent possible. However, the IHS is at a point where it can no longer sacrifice oversight and management of national health programs to absorb these rising costs.

- National Community Health Aide Program (CHAP): +$20 million to support the expansion of CHAP to the lower 48 states. These additional resources would support the training, certifying, and hiring of health aides, as well as national program management activities.

- Indian Health Professions: +$13 million to offer additional IHS Scholarship and Loan Repayment awards, bolstering recruitment and retention efforts through these two high demand programs, and through other strategies.

- Direct Operations: +$12 million to support the efficient and effective administration and oversight of national and Area-level functions like financial management, human resources, grants management, acquisitions, Indian Self-Determination and Education Assistance Act contracting and compacting administration, contract support costs and tribal lease payments administration, performance management, compliance, and other administrative supports and systems.

- Division of Telehealth: +$10 million to appropriately manage and oversee a comprehensive telehealth program at the IHS that would expand telehealth services, develop governance structures, provide training to users, and integrate with clinical services.

- Office of Quality: +$10 million to support activities that ensure high quality service provision and that CMS accreditation standards are met including a mock survey program, gap analyses for at-risk facilities, quality measures and reporting enhancements, training on medical quality issues, and expanded risk management activities.

- New Tribes: +$5 million to support new federally recognized Tribes.

- Division of Graduate Medical Education: +$4 million to expand and support Graduate Medical Education programs to create a pipeline for future physicians to address longstanding vacancy issues at IHS.

- Tribal Management Grants: +$2 million for an additional 15-20 awards to Tribes to access their capacity to directly operate health care services currently provided by the IHS.

- Nurse Preceptorship: +$1 million to create a new program to provide training, development, mentoring, and other on-the-job supports to improve placement rates of first year nurses in IHS and Tribal Health Programs.

**Indian Health Facilities account changes from the FY 2023 Enacted level include:**

- Facilities and Environmental Health Support: +$51 million for Facilities and Environment Health Support for additional Infrastructure Investment and Jobs Act program support activities and other administrative items.

- Maintenance and Improvement: +$10 million for major projects to reduce the Backlog of Essential Maintenance. Alteration, and Repair (BEMAR), as well as routine maintenance and repair to sustain the condition of federal and Tribal healthcare facilities, and environmental compliance projects to meet changing healthcare delivery needs.

- Equipment: +$10 million for maintenance and upgrades to existing medical equipment, and procurement of new medical equipment to replace units that are at the end of their useable lifecycle at IHS and Tribal healthcare facilities.

**Contract Support Costs and Section 105*(l)* Lease Agreements:** The budget includes a mandatory indefinite appropriation for Contract Support Costs and Section 105*(l)* lease agreements with estimated funding levels of $1.2 billion for Contract Support Costs (+$199 million above the FY 2023 Enacted level) and $153 million for Section 105*(l)* Lease Agreements (+$42 million above the FY 2023 Enacted level).

**Special Diabetes Program for Indians:** The budget includes $250 million in mandatory funding for the Special Diabetes Program for Indians (SDPI), and proposes to exempt the program from mandatory sequester. This is a +$103 million increase above FY 2023 Enacted post-sequestration for this evidence-based successful program. The budget includes a legislative proposal to reauthorize the SDPI for three-years, and increase funding to $250 million in FY 2024, $260 million in FY 2025, and $270 million in FY 2026.

## FY 2025 - FY 2033 President's Budget

The budget proposes full mandatory funding for IHS from FY 2025 to FY 2033, and exempts IHS funding from sequestration. Funding would grow automatically to address a number of factors, described below. This mandatory formula culminates in a total funding level of approximately $44.0 billion in FY 2033. When compared with the FY 2023 Enacted level of $7.1 billion, the FY 2033 proposed funding level represents an increase of +$36.9 billion, or 519 percent.

In total, the mandatory budget would provide nearly $288 billion for the IHS over ten-years. When accounting for the discretionary baseline, the net-total for the proposal is $192 billion over ten-years. Funding would automatically grow to account for the following factors:

- Inflationary factors including Consumer Price Index for All Consumers medical and non-medical inflation, and pay cost growth.

- Staffing increases for newly constructed or expanded health care facilities.

- Funding for new federally recognized tribes.

- Increased funding to address the Level of Need Gap documented by the 2018 Indian Health Care Improvement Fund workgroup. The budget would continue growth for direct services once the 2018 gap is addressed.

- Recurring funding for long-COVID treatment and to sustain investments made in the American Rescue Plan Act for behavioral health and public health workforce activities.

- Increases funding from FY 2025 to FY 2029 to address the remaining projects on the 1993 Health Care Facilities Construction Priority List. Funding will continue to increase each year beginning in FY 2030 to begin addressing the full scope of Facilities needs as identified in the most recent IHS Facilities Needs Assessment Report to Congress.[2]

- Increases funding for Sanitation Facilities Construction starting in FY 2027 due to the significant resources appropriated for this program in the Infrastructure Investment and Jobs Act. FY 2027 is the first year IHS will not receive Infrastructure Investment and Jobs Act (IIJA) resources for this purpose.

- Provides funding increases in FY 2025 and FY 2026 for Maintenance and Improvement and Medical Equipment to address current backlogs. Once the backlogs are addressed, the budget ensures sufficient funding is maintained for ongoing maintenance and equipment needs.

- Increases funding for Facilities and Environmental Health Support proportional to growth in the other IHS facilities programs to ensure adequate staffing and operational capacity to carry out proposed facilities funding increases.

- Establishes a new dedicated funding stream to address public health capacity and infrastructure needs in Indian Country. This funding will support an innovative hub-and-spoke model to address local public health needs in partnership with tribes and urban Indian organizations. Establishing a new program to build public health capacity is a key lesson learned from the COVID-19 pandemic, and a top recommendation shared by tribal leaders in consultation with HHS.

- Grows funding for Direct Operations to ensure IHS has adequate administrative capacity to implement and oversee significant proposed funding increases.

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[2] *2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*

## Overview of Agency Performance

This FY 2024 performance budget represents IHS's progress in providing health care services to approximately 2.8 million American Indian and Alaska Natives in 37 states. The budget provides critical support in assuring the availability and expansion of health care services, assuring the quality of services, and in providing operational support for the Indian health care system. This performance overview provides a summary of Agency performance reporting and performance management.

The IHS operates a health services delivery system providing a range of clinical, public health, community, and environmental services. This system integrates health services delivery through IHS facilities, including services purchased by IHS through contractual arrangements with providers in the private sector, and delivered through tribally operated programs and urban Indian health programs. During FY 2022, IHS and Tribal facilities provided 38,704 inpatient admissions and 14,386,694 outpatient visits. IHS performance improvement is a concerted effort by all members of the Indian health system working together to improve a comprehensive set of existing performance measures. This includes all clinic-based, hospital-based, and community-based programs administered by federal, tribal, and urban programs. This budget request reflects Government Performance and Results Act (GPRA) and GPRA Modernization Act (GPRAMA) measures that support the IHS mission and improvement of AI/AN health outcomes.

*Performance Reporting*

The IHS budget measures support the agency's strategic goals and objectives and are focused on monitoring population health (clinical measures) and strategies to assess program trends and management (non-clinical measures). Tribes administer over 62.1 percent of IHS resources through ISDEAA contracts and compacts and may choose to participate in IHS GPRA/GPRAMA performance reporting. The FY 2024 budget includes several budget related measures as reported in the outcomes and outputs tables. Starting in FY 2020 and in response to the Evidence Act, the IHS implemented an Evaluation Policy to ensure review and evaluation input in all Notice of Funding Opportunity which allows data to be aggregated across grant recipients for program improvement and evaluation. Evaluation results may be highlighted in the narrative section of the budget.

Annually, IHS reports valid and reliable aggregated clinical measures using a centralized reporting system to meet the GPRA/GPRAMA requirements. Beginning in FY 2018, the IHS clinical results were reported from a new system, the Integrated Data Collection System Data Mart (IDCS DM). [1] The IDCS DM provides those Tribes using non-RPMS EHRs the option to report data for GPRA/GPRAMA purposes and aggregated national results include participating Tribal programs. The IDCS DM calculates measure results using any data (RPMS, non-RPMS or Fiscal Intermediary) submitted to the IHS National Data Warehouse (NDW) and assures reporting of valid and reliable clinical measure results. The IHS clinical GPRA/GPRAMA measure results are reported from the IDCS DM and reflect aggregated Federal, Tribal, and urban (I/T/U) results.

The IHS budget supports maintaining or exceeding targets for clinical measures including, childhood and adult immunizations; breastfeeding rates; critical health screenings; access to dental services and preventive procedures such as, dental sealants and topical fluorides; and several diabetes care measures. Other non-clinical measures include reporting on the

number of: public health nursing activities; trainings and technical assistance provided by Tribal Epidemiology Centers; scholarship awards; new or like-new and existing AI/AN homes provided with sanitations facilities; and health care facilities construction projects completed. The FY 2024 budget request reflects the most recent year results available and projects flat targets for clinical GPRA/GPRAMA measures.

*COVID-19*

During FY 2022, the Indian health care system continued to address the coronavirus (COVID-19) pandemic response and recovery. As IHS modified its delivery system to address COVID-19, impacts may be represented in FY 2022 results for clinical and non-clinical measures, and the FY 2024 budget may highlight COVID-19 response activities.

*Performance Management*

IHS cascades performance goals and objectives and performance-related metrics agency-wide, and aligns them with the agency's strategic plan. Specific measures cascade from senior executive performance plans to those of subordinate managers and supervisors. From there, they cascade into employee performance plans, which ensures that performance of all employees relates to key agency performance objectives. Agency leadership periodically reviews progress in meeting these agency performance objectives, holding regular discussions with senior executives to identify challenges to success and determine feasible solutions. Agency leadership then implements those solutions, making specific adjustments or taking corrective actions that eliminate or minimize obstacles preventing the achievement of desired results. The connection between performance objectives, performance measures, and employee accountability enables agency leadership to direct the efforts of the workforce more accurately, and to make more informed and effective decisions. The impact is greater success in meeting the full array of agency mission requirements.

In 2023, IHS implemented the Office of Personnel Management's USA Performance (USAP) system agency-wide for all civil service employees. USAP is an electronic performance management system. This system will greatly enhance performance management at the IHS, making the process 100% electronic, as well as streamlining the process for rating officials and employees. This system will enable agency-wide tracking of performance plan establishment, mid-year reviews, and final ratings.

[1] The IHS clinical GPRA/GPRAMA measures reported before FY 2018 are incomparable with IDCS DM results.

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

| Program | FY 2022 | FY 2023 | FY 2023 | | |
|---|---|---|---|---|---|
| | Final /1 | Enacted /2 | President's Budget | FY 2022 +/- FY 2021 President's Budget | FTE |
| **SERVICES** | | | | | |
| **Clinical Services** | **4,190,727** | **4,433,191** | **6,436,747** | **2,003,556** | **7,420** |
| Hospitals & Health Clinics | 2,374,984 | 2,503,025 | 3,553,742 | 1,050,717 | 6,153 |
| Electronic Health Record System | 145,019 | 217,564 | 913,186 | 695,622 | 206 |
| Dental Services | 232,566 | 248,098 | 319,029 | 70,931 | 539 |
| Mental Health | 121,109 | 127,171 | 163,992 | 36,821 | 200 |
| Alcohol & Substance Abuse | 258,024 | 266,440 | 308,701 | 42,261 | 235 |
| Purchased/Referred Care | 984,887 | 996,755 | 1,178,097 | 181,342 | 87 |
| Indian Health Care Improvement Fund /3 | 74,138 | 74,138 | 0 | -74,138 | 0 |
| **Preventive Health** | **190,718** | **202,527** | **237,530** | **35,003** | **252** |
| Public Health Nursing | 101,641 | 110,782 | 132,359 | 21,577 | 227 |
| Health Education | 23,250 | 24,350 | 28,106 | 3,756 | 16 |
| Community Health Representatives | 63,679 | 65,212 | 74,556 | 9,344 | 9 |
| Immunization AK | 2,148 | 2,183 | 2,509 | 326 | 0 |
| **Other Services** | **249,825** | **283,952** | **338,668** | **54,716** | **294** |
| Urban Health | 73,424 | 90,419 | 115,156 | 24,737 | 9 |
| Indian Health Professions | 73,039 | 80,568 | 94,324 | 13,756 | 13 |
| Tribal Management Grants | 2,466 | 2,986 | 4,487 | 1,501 | 0 |
| Direct Operations | 95,046 | 103,805 | 118,475 | 14,670 | 261 |
| Self-Governance | 5,850 | 6,174 | 6,226 | 52 | 11 |
| **TOTAL, SERVICES** | **4,631,270** | **4,919,670** | **7,012,945** | **2,093,275** | **7,966** |
| **FACILITIES** | **940,328** | **958,553** | **1,066,055** | **107,502** | **1,268** |
| Maintenance & Improvement | 169,664 | 170,595 | 187,528 | 16,933 | 0 |
| Sanitation Facilities Construction | 197,783 | 196,167 | 201,021 | 4,854 | 108 |
| Health Care Facilities Construction | 259,293 | 260,896 | 260,899 | 3 | 0 |
| Facilities & Environ Health Support | 283,124 | 298,297 | 371,530 | 73,233 | 1,160 |
| Equipment | 30,464 | 32,598 | 45,077 | 12,479 | 0 |
| **TOTAL, SERVICES & FACILITIES** | **5,571,598** | **5,878,223** | **8,079,000** | **2,200,777** | **9,234** |
| **CONTRACT SUPPORT COSTS /4** | | | | | |
| Total, Contract Support Costs | **880,000** | **969,000** | **1,168,000** | **199,000** | **0** |
| **SECTION 105(*l*) LEASES /4** | | | | | |
| Total Section 105(*l*) Leases | **150,000** | **111,000** | **153,000** | **42,000** | **0** |
| **SPECIAL DIABETES PROGRAM FOR INDIANS (SDPI)** | | | | | |
| Total, Special Diabetes Program for Indians | **147,000** | **147,000** | **250,000** | **103,000** | **22** |
| | | | | | |
| **TOTAL, Budget Authority** | **6,601,598** | **6,958,223** | **8,079,000** | **1,120,777** | |
| **TOTAL, Program Level** | **6,748,598** | **7,105,223** | **9,650,000** | **2,544,777** | |
| | | | | | |
| **FTE Total** | | | | | **16,127** |
| Other FTE /5 | | | | | **6,874** |
| | | | | | |
| **Infrastructure Investment and Jobs Act** | **700,000** | **700,000** | **700,000** | **0** | |
| **NEF /6** | **80,210** | **114,788** | **112,373** | | |

1/ The FY 2022 column reflects final regular appropriation levels, including required and permissive transfers. Supplemental resources from the Infrastructure Investment and Jobs Act are reflected separately. The IIJA appropriated a total $3.5 billion over 5 years, from FY 2022-FY 2026.

2/ The FY 2022 column reflects enacted regular appropriation levels, including required transfers, and the rescission of $29 million within Services account total, consistent with the FY 2023 Consolidated Appropriations Act.

3/ The budget proposes to realign funding for the Indian Health Care Improvement fund into the Hospitals and Health Clinics funding line.

4/ Maintains indefinite authority for Contract Support Costs and Section 105(l) Lease Agreements. The FY 2024 budget proposes mandatory indefinite appropriations for these accounts.

5/ Other FTE includes reimbursable FTE and FTE from trust funds (gift).

6/ FY 2023 and FY 2024 NEF amounts are planned estimates and subject to change.

**Indian Health Service**
**Detail of Changes**
*(Dollars in Thousands)*

| Sub IHS Activity | FY 2023 Enacted | FY 2024 Current Services | Staffing of Newly Constructed Facilities | Indian Health Care Improvement Fund /1 | Direct Health Care Services Increase | Electronic Health Record | Hepatitis C & HIV | Opioids Grants | Maternal Health | Assessments | National Community Health Aide Program | Indian Health Professions | Direct Operations | Division of Telehealth | Office of Quality | Cancer Initiative | Division of GME | Tribal Management Grants | Nurse Preceptorship | New Tribes /2 | Maintenance and Improvement | Equipment | Facilities and Environ. Health Support | Contract Support Costs | 105(l) Leases | Subtotal of Changes | FY 2024 President's Budget Total /4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SERVICES** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hospitals & Health Clinics | 2,503,025 | 188,280 | 63,560 | 74,138 | 494,739 | 0 | 47,000 | 0 | 3,000 | 27,000 | 20,000 | 0 | 0 | 10,000 | 10,000 | 108,000 | 4,000 | 0 | 1,000 | 0 | 0 | 0 | 0 | 0 | 0 | 1,050,717 | 3,553,742 |
| Electronic Health Record System | 217,564 | 5,142 | 0 | 0 | 0 | 690,480 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 695,622 | 913,186 |
| Dental Services | 248,098 | 19,288 | 6,631 | 0 | 45,012 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 70,931 | 319,029 |
| Mental Health | 127,171 | 9,145 | 2,984 | 0 | 24,692 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 36,821 | 163,992 |
| Alcohol & Substance Abuse | 266,440 | 16,094 | 403 | 0 | 16,764 | 0 | 0 | 9,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 42,261 | 308,701 |
| Purchased/Referred Care | 996,755 | 55,259 | 0 | 0 | 121,083 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5,000 | 0 | 0 | 0 | 0 | 0 | 181,342 | 1,178,097 |
| Indian Health Care Improvement Fund /1 | 74,138 | 0 | 0 | (74,138) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (74,138) | 0 |
| Total, Clinical Services | 4,433,191 | 293,208 | 73,578 | 0 | 702,290 | 690,480 | 47,000 | 9,000 | 3,000 | 27,000 | 20,000 | 0 | 0 | 10,000 | 10,000 | 108,000 | 4,000 | 0 | 1,000 | 5,000 | 0 | 0 | 0 | 0 | 0 | 2,003,556 | 6,436,747 |
| Public Health Nursing | 110,782 | 7,767 | 844 | 0 | 12,966 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 21,577 | 132,359 |
| Health Education | 24,350 | 3,137 | 396 | 0 | 223 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,756 | 28,106 |
| Community Health Representatives | 65,212 | 3,895 | 0 | 0 | 5,449 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9,344 | 74,556 |
| Immunization AK | 2,183 | 124 | 0 | 0 | 202 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 326 | 2,509 |
| Total, Preventive Health | 202,527 | 14,923 | 1,240 | 0 | 18,840 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 35,003 | 237,530 |
| Urban Health | 90,419 | 3,837 | 0 | 0 | 20,900 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 24,737 | 115,156 |
| Indian Health Professions | 80,568 | 756 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 13,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 13,756 | 94,324 |
| Tribal Management | 2,986 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,500 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,501 | 4,487 |
| Direct Operations | 103,805 | 3,097 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11,573 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14,670 | 118,475 |
| Self-Governance | 6,174 | 52 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 52 | 6,226 |
| Total, Other Services | 283,952 | 7,743 | 0 | 0 | 20,900 | 0 | 0 | 0 | 0 | 0 | 0 | 13,000 | 11,573 | 0 | 0 | 0 | 0 | 1,500 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 54,716 | 338,668 |
| **Total, Services** | **4,919,670** | **315,874** | **74,818** | **0** | **742,030** | **690,480** | **47,000** | **9,000** | **3,000** | **27,000** | **20,000** | **13,000** | **11,573** | **10,000** | **10,000** | **108,000** | **4,000** | **1,500** | **1,000** | **5,000** | **0** | **0** | **0** | **0** | **0** | **2,093,275** | **7,012,945** |
| **FACILITIES** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maintenance & Improvement | 170,595 | 6,933 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10,000 | 0 | 0 | 0 | 0 | 16,933 | 187,528 |
| Sanitation Facilities Construction | 196,167 | 4,854 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4,854 | 201,021 |
| Health Care Facility Construction (HCFC) | 260,896 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 260,899 |
| Facility & Environmental Health Support | 298,297 | 15,891 | 6,836 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 50,506 | 0 | 0 | 73,233 | 371,530 |
| Equipment | 32,598 | 2,479 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10,000 | 0 | 0 | 0 | 12,479 | 45,077 |
| Total, Facilities | 958,553 | 30,160 | 6,836 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10,000 | 10,000 | 50,506 | 0 | 0 | 107,502 | 1,066,055 |
| **Total, Services & Facilities** | **5,878,223** | **346,034** | **81,654** | **0** | **742,030** | **690,480** | **47,000** | **9,000** | **3,000** | **27,000** | **20,000** | **13,000** | **11,573** | **10,000** | **10,000** | **108,000** | **4,000** | **1,500** | **1,000** | **5,000** | **10,000** | **10,000** | **50,506** | **0** | **0** | **2,200,777** | **8,079,000** |
| **CONTRACT SUPPORT COSTS /3** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total, Contract Support Costs | **969,000** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **199,000** | **0** | **199,000** | **1,168,000** |
| **SECTION 105(l) LEASES /3** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total Section 105(l) Leases | **111,000** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **42,000** | **42,000** | **153,000** |
| **TOTAL, IHS /4** | **7,105,223** | **346,034** | **81,654** | **0** | **742,030** | **690,480** | **47,000** | **9,000** | **3,000** | **27,000** | **20,000** | **13,000** | **11,573** | **10,000** | **10,000** | **108,000** | **4,000** | **1,500** | **1,000** | **5,000** | **10,000** | **10,000** | **50,506** | **199,000** | **42,000** | **2,441,777** | **9,400,000** |

1/ The budget proposes to realign funding for the Indian Health Care Improvement fund into the Hospitals and Health Clinics funding line.

2/ Funding for New Tribes is currently reflected in Purchased/Referred Care. However, final funding will need to be reflected in the appropriate Program, Project, or Activity (PPA or budget line) when these numbers are identified.

3/ Maintains indefinite authority for Contract Support Costs and Section 105(l) Lease Agreements. The FY 2024 budget proposes a mandatory indefinite appropriation for these accounts.

4/ Excludes funding for the Special Diabetes Program for Indians.

**STAFFING and OPERATING COSTS FOR NEWLY-CONSTRUCTED HEALTHCARE FACILITIES**

**FY 2024 Budget -- Estimates**

*(Dollars in Thousands)*

| | Seward, AK | | Dilkon, AZ | | Naytahwaush, MN | | New Town, ND | | Omaha, NE | | El Paso, TX | | Rapid City, SD | | **TOTAL** | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Chugachmiut Regional Health Center (JV) | | Alternative Rural Health Center | | Naytahwaush Health Center (JV) | | Elbowoods Memorial Health Center (JV) | | Fred LeRoy Health and Wellness Center (JV) | | Ysleta Del Sur Health Center (JV) | | Rapid City Health Center | | | | |
| Opening Date | February 2024 | | March 2023 | | March 2023 | | April 2024 | | November 2023 | | January 2023 | | January 2023 | | | | |
| **Grand Total** /2 | **26** | **$5,879** | **223** | **$31,094** | **50** | **$7,095** | **16** | **$2,545** | **221** | **$32,265** | **23** | **$2,610** | **15** | **$166** | **238** | **336** | **$81,654** |

1/ Includes Utilities

2/ As a result of JVCPs entering their planning phases and detailed budgets not yet available, preliminary estimates are included for budget planning purposes.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**INDIAN HEALTH SERVICE**
**FY 2024 Performance Budget Submission to Congress**

## TABLE OF CONTENTS

**Appropriation Accounts**

Page

*Budget Exhibits*
Appropriations Language....................................................................................13
Amounts Available for Obligation.........................................................................22
Summary of Changes..........................................................................................26
Budget Authority by Activity ...............................................................................27
Authorizing Legislation .......................................................................................28
Appropriations History Table ..............................................................................29

**INDIAN HEALTH SERVICES**

For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination and Education Assistance Act, the Indian Health Care Improvement Act, and titles II and III of the Public Health Service Act with respect to the Indian Health Service, **[**$4,919,670,000, to**]***$2,384,977,000*, *which shall* remain available until September 30, **[**2024**]***2025,* except as otherwise provided herein**[**; and, in addition, $4,627,968,000, which shall become available on October 1, 2023, and remain available through September 30, 2025, except as otherwise provided herein**]***, and shall be in addition to funds previously appropriated under this heading that became available on October 1, 2023;* together with payments received during **[**each**]** *the* fiscal year pursuant to sections 231(b) and 233 of the Public Health Service Act (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 $2,500,000 shall be available **[**for each of fiscal years 2023 and 2024**]** for grants or contracts with public or private institutions to provide alcohol or drug treatment services to Indians, including alcohol detoxification services: *Provided further,* That **[**of the total amount of funds provided, $1,993,510,000**]** *$1,178,097,000* shall remain available until expended for Purchased/Referred Care, **[**of which $996,755,000 shall be from funds that become available on October 1, 2023: *Provided further,* That of the total amount specified in the preceding proviso for Purchased/Referred Care, $108,000,000 shall be**]***including $54,000,000* for the Indian Catastrophic Health Emergency Fund **[**of which $54,000,000 shall be from funds that become available on October 1, 2023**]**: *Provided further,* That **[**for each of fiscal years 2023 and 2024**]** *of the funds provided*, up to **[**$51,000,000**]** *$54,000,000* shall remain available until expended for implementation of the loan repayment program under section 108 of the Indian Health Care Improvement Act: *Provided further,* That of the **[**total amount of**]** funds provided, **[**$116,000,000 , including $58,000,000 from funds that become available on October 1, 2023,**]***$58,000,000* shall be for costs related to or resulting from accreditation emergencies, including supplementing activities funded under the heading "Indian Health Facilities", of which up to **[**$4,000,000 for each of fiscal years 2023 and 2024**]** *$4,000,000* may be used to supplement amounts otherwise available for Purchased/Referred Care: *Provided further,* That the amounts collected by the Federal Government as authorized by sections 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. 1613a and 1616a) during the preceding fiscal year for breach of contracts shall be deposited in the Fund authorized by section 108A of that Act (25 U.S.C. 1616a–1) and shall remain available until expended and, notwithstanding section 108A(c) of that 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 that Act (25 U.S.C. 1613a and 1616a): *Provided further,* That the amounts made available within this account for the Substance Abuse and Suicide Prevention Program, for Opioid Prevention, Treatment and Recovery Services, for the Domestic Violence Prevention Program, for the Zero Suicide Initiative, for the housing subsidy authority for civilian employees, for Aftercare Pilot Programs at Youth Regional Treatment Centers, for transformation and modernization costs of the Indian Health Service Electronic Health Record system, for national quality and oversight activities, **[**to improve**]** *for improving* collections from public and private insurance at Indian Health Service and tribally operated facilities, for an initiative to treat or reduce the transmission of HIV and HCV, for a maternal health initiative, for the Telebehaviorial Health Center of Excellence, for Alzheimer's **[**grants**]** *activities*, for Village Built Clinics, for a produce prescription pilot, and for accreditation emergencies 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 *that are available for two fiscal years* 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**]***such second year of availability*: *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 (25 U.S.C. 1613) 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, and from 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 none of the funds provided that become available on October 1, 2023, may be used for implementation of the Electronic Health Record System or the Indian Health Care Improvement Fund**]**: *Provided further,* That of the funds provided, $74,138,000 is for the Indian Health Care Improvement Fund and may be used, as needed, to carry out activities typically funded under the Indian Health Facilities account **[**: *Provided further,* That none of the funds appropriated by this Act, or any other Act, to the Indian Health Service for the Electronic Health Record system shall be available for obligation or expenditure for the selection or implementation of a new Information Technology

infrastructure system, unless the Committees on Appropriations of the House of Representatives and the Senate are consulted 90 days in advance of such obligation**]**. **[**Of the unobligated balances under the heading "Indian Health Services" from amounts made available in title III of division G of Public Law 117–103 for the fiscal year 2022 costs of staffing and operating new facilities, $29,388,000 are hereby rescinded**]**. *(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2023.)*

## CONTRACT SUPPORT COSTS

For payments to tribes and tribal organizations for contract support costs associated with Indian Self-Determination and Education Assistance Act agreements with the Indian Health Service for fiscal year **[**2023**]***2024*, such sums as may be necessary: Provided, That notwithstanding any other provision of law, no amounts made available under this heading shall be available for transfer to another budget account: Provided further, That amounts obligated but not expended by a tribe or tribal organization for contract support costs for such agreements for the current fiscal year shall be applied to contract support costs due for such agreements for subsequent fiscal years.

(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2023.)

## PAYMENTS FOR TRIBAL LEASES

For payments to tribes and tribal organizations for leases pursuant to section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5324(l)) for fiscal year **[**2023**]***2024*, such sums as may be necessary, which shall be available for obligation through September 30, **[**2024**]***2025*: Provided, That notwithstanding any other provision of law, no amounts made available under this heading shall be available for transfer to another budget account.

(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2023.)

## INDIAN HEALTH FACILITIES

For construction, repair, maintenance, demolition, 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, **[**$958,553,000, to remain available until expended; and, in addition, $501,490,000, which shall become available on October 1, 2023 and**]** *$564,565,000, which shall* remain available until expended *and shall be in addition to funds previously appropriated under this heading that became available on October 1, 2023*: *Provided*, That notwithstanding any other provision of law, funds appropriated for the planning, design, construction, renovation, or expansion of health facilities for the benefit of an Indian tribe or tribes may be used to purchase land on which such facilities will be located: *Provided further*, That not to exceed $500,000 may be used **[**for each of fiscal years 2023 and 2024**]** 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 provided that become available on October 1, 2023, may be used for Health Care Facilities Construction or for Sanitation Facilities Construction: *Provided further*, That of the amount appropriated under this heading for fiscal year 2023 for Sanitation Facilities Construction, $15,192,000 shall be for projects specified for Sanitation Facilities Construction (CDS) in the table titled "Interior and Environment Incorporation of Community Project Funding Items/Congressionally Directed Spending Items" included for this division in the explanatory statement described in section 4 (in the matter preceding division A of this consolidated Act):**]** *Provided further*, That none of the funds appropriated to the Indian Health Service may be used for sanitation facilities construction for new homes funded with grants by the housing programs of the United States Department of Housing and Urban Development.

(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2023.)

## 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 of Health and Human Services; 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 not- withstanding any other law or regulation, funds transferred from the Department of Housing and Urban Development to the Indian Health Service shall be administered under Public Law 86–121, the Indian Sanitation Facilities Act and Public Law 93–638: *Provided further*, That funds appropriated to the Indian Health Service in this Act, except those used for administrative and program direction purposes, shall not be subject to limitations directed at curtailing Federal travel and transportation: *Provided further*, That none of the funds made available to the Indian Health Service in this Act shall be used for any assessments or charges by the Department of Health and Human Services unless *such assessments or charges are* identified in the budget justification and provided in this Act, or **[**approved by**]** *are notified to* 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 et seq.), 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 sub- sequent 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 costs associated with the provision of goods, services, or technical assistance: *Provided further*, That the Indian Health Service may provide to civilian medical personnel serving in hospitals operated by the Indian Health Service housing allowances equivalent to those that would be provided to members of the Commissioned Corps of the United States Public Health Service serving in similar positions at such hospitals**[**:*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.]

(Department of the Interior, Environment, and Related Agencies Appropriations Act, 2023.)

| Language Provision | Explanation |
| --- | --- |
| INDIAN HEALTH SERVICE PROVISIONS | |
| For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination and Education Assistance Act, the Indian Health Care Improvement Act, and titles II and III of the Public Health Service Act with respect to the Indian Health Service, [$4,919,670,000, to] *$2,384,977,000, which shall* remain available until September 30, [2024]*2025*, except as otherwise provided herein[; and, in addition, $4,627,968,000, which shall become available on October 1, 2023, and remain available through September 30, 2025, except as otherwise provided herein]*, and shall be in addition to funds previously appropriated under this heading that became available on October 1, 2023;* | Maintains the fiscal year 2024 advance appropriation and appropriates additional funding for fiscal year 2024 for the Indian Health Services account. |
| *Provided further,* That $2,500,000 shall be available [for each of fiscal years 2023 and 2024] for grants or contracts with public or private institutions to provide alcohol or drug treatment services to Indians, including alcohol detoxification services: | Provides funding for fiscal year 2024 appropriations and removes reference to prior fiscal year. |
| *Provided further,* That [of the total amount of funds provided, $1,993,510,000] *$1,178,097,000* shall remain available until expended for Purchased/Referred Care, [of which $996,755,000 shall be from funds that become available on October 1, 2023: *Provided further,* That of the total amount specified in the preceding proviso for Purchased/Referred Care, $108,000,000 shall be]*including $54,000,000* for the Indian Catastrophic Health Emergency Fund [of which $54,000,000 shall be from funds that become available on October 1, 2023]: | Provides funding for fiscal year 2024 appropriations for Purchased and Referred Care, including the Indian Catastrophic Health Emergency Fund. |
| *Provided further,* That [for each of fiscal years 2023 and 2024] *of the funds provided*, up to [$51,000,000] *$54,000,000* shall remain available until expended for implementation of the loan repayment program under section 108 of the Indian Health Care Improvement Act: | Provides funding for fiscal year 2024 for the IHS Loan Repayment program. |
| *Provided further,* That of the [total amount of] funds provided, [$116,000,000, including $58,000,000 from funds that become available on | Provides funding for fiscal year 2024 for Accreditation Emergencies. |

| | |
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| October 1, 2023,]*$58,000,000* shall be for costs related to or resulting from accreditation emergencies, including supplementing activities funded under the heading "Indian Health Facilities", of which up to [$4,000,000 for each of fiscal years 2023 and 2024] *$4,000,000* may be used to supplement amounts otherwise available for Purchased/Referred Care: | |
| *Provided further,* That the amounts made available within this account for the Substance Abuse and Suicide Prevention Program, for Opioid Prevention, Treatment and Recovery Services, for the Domestic Violence Prevention Program, for the Zero Suicide Initiative, for the housing subsidy authority for civilian employees, for Aftercare Pilot Programs at Youth Regional Treatment Centers, for transformation and modernization costs of the Indian Health Service Electronic Health Record system, for national quality and oversight activities, [to improve] *for improving* collections from public and private insurance at Indian Health Service and tribally operated facilities, for an initiative to treat or reduce the transmission of HIV and HCV, for a maternal health initiative, for the Telebehaviorial Health Center of Excellence, for Alzheimer's [grants] *activities*, for Village Built Clinics, for a produce prescription pilot, and for accreditation emergencies shall be allocated at the discretion of the Director of the Indian Health Service and shall remain available until expended: | Removes requirement that Alzheimer's funds must be allocated through grants. |
| *Provided further,* That funds provided in this Act *that are available for two fiscal years* may be used *in their second year of availability* for annual contracts and grants that fall within 2 fiscal years, provided the total obligation is recorded in [the year the funds are appropriated]*such second year of availability*: | Provides that funds that are available for two fiscal years may be used in their second year of availability for annual contracts and grants that extend beyond two fiscal years, so long as the total obligation for such a contract is recorded in the second year of availability of the funds. |
| [:*Provided further,* That none of the funds provided that become available on October 1, 2023, may be used for implementation of the Electronic Health Record System or the Indian Health Care Improvement Fund] | Removes funding prohibition for the Electronic Health Record System and Indian Health Care Improvement Fund included in the 2024 advance appropriation. |
| [: *Provided further,* That none of the funds appropriated by this Act, or any other Act, to the Indian Health Service for the Electronic Health Record system shall be available for obligation or expenditure for the selection or implementation of a new Information Technology infrastructure system, unless the Committees on Appropriations of the | Removes notification requirement for the Electronic Health Record System. |

| | |
|---|---|
| House of Representatives and the Senate are consulted 90 days in advance of such obligation]. | |
| [Of the unobligated balances under the heading "Indian Health Services" from amounts made available in title III of division G of Public Law 117–103 for the fiscal year 2022 costs of staffing and operating new facilities, $29,388,000 are hereby rescinded] | Removes fiscal year 2023 funding rescission. |
| CONTRACT SUPPORT COSTS | |
| For payments to tribes and tribal organizations for contract support costs associated with Indian Self-Determination and Education Assistance Act agreements with the Indian Health Service for fiscal year [2023]*2024*, such sums as may be necessary: Provided, That notwithstanding any other provision of law, no amounts made available under this heading shall be available for transfer to another budget account: Provided further, That amounts obligated but not expended by a tribe or tribal organization for contract support costs for such agreements for the current fiscal year shall be applied to contract support costs due for such agreements for subsequent fiscal years. | The FY 2024 budget proposes to reclassify this account to indefinite mandatory funding. However, we have included appropriations language to maintain indefinite discretionary funding should Congress not reclassify this account. The budget maintains the current policy to fully-fund these legally required payments to tribes. |
| PAYMENTS FOR TRIBAL LEASES | |
| For payments to tribes and tribal organizations for leases pursuant to section 105(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5324(l)) for fiscal year [2023]*2024*, such sums as may be necessary, which shall be available for obligation through September 30, [2024]*2025*: Provided, That notwithstanding any other provision of law, no amounts made available under this heading shall be available for transfer to another budget account. | The FY 2024 budget proposes to reclassify this account to indefinite mandatory funding. However, we have included appropriations language to maintain indefinite discretionary funding should Congress not reclassify this account. The budget maintains the current policy to fully-fund these legally required payments to tribes. |
| FACILITIES PROVISIONS | |
| For construction, repair, maintenance, demolition, 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 | Maintains the fiscal year 2024 advance appropriation and appropriates additional funding for fiscal year 2024 for the Indian Health Facilities account. |

| | |
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| Public Health Service Act with respect to environmental health and facilities support activities of the Indian Health Service, **[**$958,553,000, to remain available until expended; and, in addition, $501,490,000, which shall become available on October 1, 2023, and**]** *$564,565,000, which shall* remain available until expended *and shall be in addition to funds previously appropriated under this heading that became available on October 1, 2023*: | |
| *Provided further*, That not to exceed $500,000 may be used **[**for each of fiscal years 2023 and 2024**]** by the Indian Health Service to purchase TRANSAM equipment from the Department of Defense for distribution to the Indian Health Service and tribal facilities: | Provides funding for fiscal year 2024 appropriations and removes reference to prior fiscal year. |
| **[***Provided further*, That none of the funds provided that become available on October 1, 2023, may be used for Health Care Facilities Construction or for Sanitation Facilities Construction: Provided further, That of the amount appropriated under this heading for fiscal year 2023 for Sanitation Facilities Construction, $15,192,000 shall be for projects specified for Sanitation Facilities Construction (CDS) in the table titled "Interior and Environment Incorporation of Community Project Funding Items/Congressionally Directed Spending Items" included for this division in the explanatory statement described in section 4 (in the matter preceding division A of this consolidated Act):**]** | Removes fiscal year 2023 congressionally directed spending, |

**INDIAN HEALTH SERVICE**
**Amounts Available for Obligations**

**SERVICES**

| | FY 2022 | FY 2023 | FY 2024 |
|---|---|---|---|
| General Fund Discretionary Appropriation: | | | |
| Appropriation (Interior) | $4,631,270,000 | $4,919,670,000 | $7,012,945,000 |
| Across-the-board reductions (Interior) | $0 | $0 | $0 |
| Subtotal, Appropriation (Interior) | $4,631,270,000 | $4,919,670,000 | $7,012,945,000 |
| Mandatory Appropriation: | | | |
| Appropriation[1] | $147,000,000 | $147,000,000 | $250,000,000 |
| Offsetting Collections: | | | |
| Federal sources | ($291,000,000) | $436,000,000 | $436,000,000 |
| Non-federal sources | ($2,091,000,000) | ($1,432,000,000) | ($1,432,000,000) |
| Subtotal, Offsetting Collections | ($2,382,000,000) | ($996,000,000) | ($996,000,000) |
| Unobligated Balances: | | | |
| Discretionary, Start of Year | $4,754,000,000 | $4,585,000,000 | $2,804,000,000 |
| Mandatory, Start of Year | ($169,000,000) | ($1,781,000,000) | $1,403,000,000 |
| End of Year | $4,585,000,000 | $2,804,000,000 | $4,207,000,000 |
| Total Obligations, Services | $2,396,270,000 | $4,070,670,000 | $4,863,945,000 |

[1]In FY 2022, this reflects the 2% sequester amount for the Special Diabetes Program for Indians.

**INDIAN HEALTH SERVICE**
**Amounts Available for Obligations**

**FACILITIES**

| | FY 2022 | FY 2023 | FY 2024 |
|---|---|---|---|
| General Fund Discretionary Appropriation: | | | |
| Appropriation (Interior) | $940,328,000 | $958,553,000 | $1,066,055,000 |
| Across-the-board reductions (Interior) | $0 | $0 | $0 |
| Subtotal, Appropriation (Interior) | $940,328,000 | $958,553,000 | $1,066,055,000 |
| Mandatory Appropriation: | | | |
| Appropriation | $0 | $0 | $0 |
| Offsetting Collections: | | | |
| Federal sources | (49,000,000) | ($49,000,000) | (49,000,000) |
| Subtotal, Offsetting Collections | (49,000,000) | ($49,000,000) | (49,000,000) |
| Unobligated Balances: | | | |
| Discretionary, Start of Year | $1,642,000,000 | $2,303,000,000 | $3,190,000,000 |
| End of Year | $2,303,000,000 | $3,190,000,000 | $4,398,000,000 |
| Total Obligations, Facilities | $230,328,000 | $22,553,000 | ($190,945,000) |

**INDIAN HEALTH SERVICE**

**Amounts Available for Obligations**

**CONTRACT SUPPORT COSTS**

| | FY 2022 | FY 2023 | FY 2024 |
|---|---|---|---|
| General Fund Discretionary Appropriation: | | | |
| Appropriation (Interior) | $880,000,000 | $969,000,000 | $1,168,000,000 |
| Across-the-board reductions (Interior) | $0 | $0 | $0 |
| Subtotal, Appropriation (Interior) | $880,000,000 | $969,000,000 | $1,168,000,000 |
| Mandatory Appropriation: | | | |
| Appropriation | $0 | $0 | $1,168,000,000 |
| Total Obligations, CSC | $880,000,000 | $969,000,000 | $2,336,000,000 |

## INDIAN HEALTH SERVICE
## Amounts Available for Obligations

### PAYMENTS FOR TRIBAL LEASES

| | FY 2022 | FY 2023 | FY 2024 |
|---|---|---|---|
| General Fund Discretionary Appropriation: | | | |
| Appropriation (Interior) | $150,000,000 | $111,000,000 | $153,000,000 |
| Across-the-board reductions (Interior) | $0 | $0 | $0 |
| Subtotal, Appropriation (Interior) | $150,000,000 | $111,000,000 | $153,000,000 |
| Mandatory Appropriation: | | | |
| Appropriation | $0 | $0 | $153,000,000 |
| Total Obligations, Payments for Tribal Leases | $150,000,000 | $111,000,000 | $306,000,000 |

## INDIAN HEALTH SERVICE
### Budget Authority by Activity

(Dollars in Thousands)

| | 2022 Final | | 2023 Enacted | | 2024 President's Budget | |
|---|---|---|---|---|---|---|
| | FTE 1/ | Amount | FTE 1/ | Amount | FTE 1/ | Amount |
| **SERVICES** | | | | | | |
| Hospitals & Health Clinics | 5,690 | $2,374,984 | 5,661 | $2,503,025 | 6,153 | $3,553,742 |
| Electronic Health Record System | 6 | $145,019 | 6 | $217,564 | 206 | $913,186 |
| Dental Health | 510 | 232,566 | 508 | 248,098 | 539 | 319,029 |
| Mental Health | 168 | 121,109 | 168 | 127,171 | 200 | 163,992 |
| Alcohol & Substance Abuse | 223 | 258,024 | 222 | 266,440 | 235 | 308,701 |
| Purchased/Referred Care | 86 | 984,887 | 85 | 996,755 | 87 | 1,178,097 |
| Indian Health Care Improvement Fund | 46 | 74,138 | 46 | 74,138 | 0 | 0 |
| Total, Clinical Services | 6,730 | 4,190,727 | 6,696 | 4,433,191 | 7,420 | 6,436,747 |
| Public Health Nursing | 190 | 101,641 | 189 | 110,782 | 227 | 132,359 |
| Health Education | 14 | 23,250 | 14 | 24,350 | 16 | 28,106 |
| Comm. Health Reps. | 5 | 63,679 | 5 | 65,212 | 9 | 74,556 |
| Immunization AK | 0 | 2,148 | 0 | 2,183 | 0 | 2,509 |
| Total, Preventive Health | 209 | 190,718 | 208 | 202,527 | 252 | 237,530 |
| Urban Health | 8 | 73,424 | 8 | 90,419 | 9 | 115,156 |
| Indian Health Professions | 13 | 73,039 | 13 | 80,568 | 13 | 94,324 |
| Tribal Management | 0 | 2,466 | 0 | 2,986 | 0 | 4,487 |
| Direct Operations | 254 | 95,046 | 253 | 103,805 | 261 | 118,475 |
| Self-Governance | 12 | 5,850 | 11 | 6,174 | 11 | 6,226 |
| Total, Other services | 287 | 249,825 | 285 | 283,952 | 294 | 338,668 |
| Total, Services | 7,225 | 4,631,270 | 7,189 | 4,919,670 | 7,965 | 7,012,945 |
| | | | | | | |
| **CONTRACT SUPPORT COSTS** | 0 | 880,000 | 0 | 969,000 | 0 | 1,168,000 |
| | | | | | | |
| **PAYMENTS FOR TRIBAL LEASES** | 0 | 150,000 | 0 | 111,000 | 0 | 153,000 |
| **FACILITIES** | | | | | | |
| Maintenance & Improvement | 0 | 169,664 | 0 | 170,595 | 0 | 187,528 |
| Sanitation Facilities Constr. | 115 | 197,783 | 114 | 196,167 | 108 | 201,021 |
| Health Care Facs. Constr. | 0 | 259,293 | 0 | 260,896 | 0 | 260,899 |
| Facil. & Envir. Health Supp. | 1,005 | 283,124 | 1,000 | 298,297 | 1,160 | 371,530 |
| Equipment | 0 | 30,464 | 0 | 32,598 | 0 | 45,077 |
| Total, Facilities | 1,120 | 940,328 | 1,114 | 958,553 | 1,268 | 1,066,055 |
| **SPECIAL DIABETES PROGRAM FOR INDIANS** | | | | | | |
| SDPI | 111 | 147,000 | 111 | 147,000 | 111 | 250,000 |
| Total, SDPI | 111 | 147,000 | 111 | 147,000 | 111 | 250,000 |
| Total IHS 2/ | 15,220 | $6,748,598 | 15,178 | $7,105,223 | 16,127 | $9,650,000 |

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

2/ FTE displayed reflect updated levels, which may differ from the system of record

## Indian Health Service - Combined

**Summary of Changes**

***(Dollars in millions)***

FY 2023 Enacted
Total estimated budget authority....... $7,105,223.000
(Obligations)....... $7,105,223.000

FY 2024 President's Budget
Total estimated budget authority....... $9,650,000.325
(Obligations)....... $9,650,000.325

Net Change....... $2,544,777.325

| | FY 2023 Enacted | | FY 2024 President's Budget | | FY 2024 +/- FY 2023 | |
|---|---|---|---|---|---|---|
| | FTE | BA | FTE | BA | FTE | BA |
| **Increases:** | | | | | | |
| A. Built-in: | | | | | | |
| 1. Annualization of 2023 CO pay increase (3 months)................ | -- | -- | -- | $905,641.821 | -- | +$905,641.821 |
| 2. FY 2024 Pay Raise CO (9 months)........................................ | -- | -- | -- | $3,673,283.226 | -- | +$3,673,283.226 |
| 3. Annualization of 2023 CS Pay Raise (3 months).................... | -- | -- | -- | $7,092,272.467 | -- | +$7,092,272.467 |
| 4. FY 2024 Pay Raise CS (9 months)......................................... | -- | -- | -- | $28,766,257.127 | -- | +$28,766,257.127 |
| **Subtotal, Built-in Increases................................................** | **--** | **--** | **--** | **$40,437,454.642** | **--** | **+$40,437,454.642** |
| B. Program Adjustments: | | | | | | |
| 1. Tribal Pay............................................................................... | -- | $61,720.000 | -- | $58,467.000 | -- | -$3,253.000 |
| 2. Cost of Medical Inflation......................................................... | | $4,989.301 | -- | $5,089.087 | -- | +$99.786 |
| 3. Cost of Non-Medical Inflation................................................. | | $173,775.990 | -- | $180,900.810 | -- | +$7,124.820 |
| 4. 105(l) Tribal Leases................................................................ | -- | -- | -- | $42,000.000 | -- | +$42,000.000 |
| 5. Contract Support Costs.......................................................... | -- | $89,000.000 | -- | $199,000.000 | -- | +$110,000.000 |
| 6. Special Diabetes Program for Indians - Include...................... | -- | $147,000.000 | -- | $250,000.000 | -- | +$103,000.000 |
| 7. Population Growth.................................................................. | -- | $119,357.750 | -- | $121,506.190 | -- | +$2,148.440 |
| **Subtotal, Program Increases..............................................** | **--** | **$595,843.041** | **--** | **$856,963.087** | **--** | **+$261,120.046** |
| C. Phasing -In of Staff & Operating Cost of New Facilities | 348 | $63,008.000 | 238 | $81,645.000 | -110 | +$18,637.000 |
| D. New Tribes............................................................................ | -- | -- | -- | $5,000.000 | -- | +$5,000.000 |
| E. Assessments.......................................................................... | -- | -- | -- | $27,000.000 | -- | +$27,000.000 |
| F. Program Increases................................................................ | 207 | $123,211.000 | 347 | $1,773,089.330 | +140 | +$1,649,878.330 |
| **Subtotal, Program Increases..............................................** | **555** | **$186,219.000** | **585** | **$1,886,734.330** | **+30** | **+$1,700,515.330** |
| **Total Increases...............................................................** | **903** | **$845,070.041** | **823** | **$43,294,797.059** | **-80** | **+$42,449,727.018** |
| **Decreases:** | | | | | | |
| A. Built-in: | | | | | | |
| 1. Decrease in the number of compensable days 1/................... | -- | -$2,836.909 | -- | $2,972.994 | -- | +$5,809.903 |
| 2. Absorption of FY23 CO Pay Increase (3 months)................... | -- | -- | -- | -- | -- | -$2,148.440 |
| 3. Absorption of FY23 CS Pay Increase (3 months)................... | -- | -- | -- | -- | -- | -- |
| 4. Absorption of FY24 CO Pay Increase (9 months)................... | -- | -- | -- | $672,779.130 | -- | +$672,779.130 |
| 5. Absorption of FY24 CS Pay Increase (9 months)................... | -- | -- | -- | $5,268,675.510 | -- | +$5,268,675.510 |
| 4. Absorption of Unfunded Medical Inflationary Costs…….......... | -- | -- | -- | -- | -- | -- |
| 5. Absorption of Unfunded Non-Medical Inflationary Costs…….. | -- | $167,788.990 | -- | $175,080.810 | -- | +$7,291.820 |
| 6. Absorbtion of Population Growth............................................ | -- | $119,357.750 | -- | -- | -- | -$119,357.750 |
| **Subtotal, Built-in Decreases...............................................** | **--** | **284,310** | **--** | **6,119,508** | **## ###** | **5,833,050** |
| B. Program Decrease | | | | | | |
| 1. Correction to Staffing of New Facilities Estimate, FY 2022 2/.. | -- | $29,388.000 | -- | -- | -- | -$29,388.000 |
| 2. 105L Costs Estimate Decrease.............................................. | -- | $39,000.000 | -- | -- | -- | -$39,000.000 |
| **Subtotal, Program Decreases............................................** | **--** | **$68,388.000** | **--** | **--** | **--** | **-$68,388.000** |
| **Total Decreases.............................................................** | **--** | **$352,697.831** | **--** | **$6,119,508.444** | **--** | **+$5,764,662.173** |

Indian Health Service

**Authorizing Legislation**

(Dollars in Thousands)

| | FY 2023 | | FY 2024 | |
|---|---|---|---|---|
| | Amount Authorized | President's Budget | Amount Authorized | President's Budget |
| **1. Services Appropriation:** | 6,261,680 | 6,261,680 | 7,012,945 | 7,012,945 |
| 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 /4:** | 1,142,000 | 1,142,000 | 1,168,000 | 1,168,000 |
| Indian Self Determination and Education Assistance Act (P.L. 93-638), as amended, 25 U.S.C. 450 *et seq.* | | | | |
| **3. Facilities Appropriation:** | 1,567,343 | 1,567,343 | 1,066,055 | 1,066,055 |
| 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). | - | - | - | - |
| **4. Public and Private Collections:** | - | - | - | - |
| IHCIA sec. 206, 25 U.S.C. 1621e. | | | | |
| Social Security Act, sec. 1880 & 1911, 42 U.S.C. 1395qq & 1396j. | | | | |
| **5. Special Diabetes Program for Indians** | 147,000 | 147,000 | 250,000 | 250,000 |
| 42 U.S.C. 245c-3. | | | | |
| **6. Section 105(*l*) Leases /4:** | 150,000 | 150,000 | 153,000 | 153,000 |
| Sec. 900.69 | | | | |
| Unfunded authorizations: | - | - | - | - |
| Total appropriations: | 9,268,023 | 9,268,023 | 9,650,000 | 9,650,000 |
| Total appropriations against Definite authorizations: | 9,268,023 | 9,268,023 | 9,650,000 | 9,650,000 |

4/ Maintains indefinite authority for Contract Support Costs and Section 105(l) Lease Agreements. The FY 2024 budget proposes mandatory indefinite appropriations for these accounts.

INDIAN HEALTH SERVICE
Appropriation History Table
**Services**

| | Budget Request to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| 2005 | $2,612,824,000 | $2,627,918,000 | $2,633,624,000 | $2,632,667,000 |
| Rescission (PL 108-447, Sec. 501) | | | | ($15,638,000) |
| Rescission (PL 108-447, Sec. 122) | | | | ($20,936,000) |
| 2006 | $2,732,298,000 | $2,732,298,000 | $2,732,323,000 | $2,732,298,000 |
| Rescission (PL 109-54) | | | | ($13,006,000) |
| Rescission (PL 109-148) | | | | ($27,192,000) |
| 2007 | $2,822,449,000 | $2,830,085,000 | $2,835,493,000 | $2,818,871,000 |
| 2008 | $2,931,530,000 | $3,023,532,000 | $2,991,924,000 | $3,018,624,000 |
| Rescission (PL 110-161) | | | | ($47,091,000) |
| 2009 Omnibus | $2,971,533,000 | - | - | $3,190,956,000 |
| 2009 ARRA (PL 111-5) | - | - | - | $85,000,000 |
| 2010 | $3,639,868,000 | $3,657,618,000 | $3,639,868,000 | $3,657,618,000 |
| 2011 | $3,657,618,000 | - | - | $3,672,618,000 |
| Rescission (PL 112-10) | | | | ($7,345,000) |
| 2012 | $4,166,139,000 | $4,034,322,000 | - | $3,872,377,000 |
| Rescission (PL 112-74) | | | | ($6,195,804) |
| 2013 | $3,978,974,000 | - | $ 3,914,599,000 | $3,914,599,000 |
| Sequestration | | | | ($194,492,111) |
| Rescission | | | | ($7,829,198) |
| 2014 Omnibus (PL 113-64) | $3,982,498,000 | - | - | $3,982,842,000 |
| 2015 Omnibus (PL 113-235) | $4,172,182,000 | $4,180,557,000 | - | $4,182,147,000 |
| 2016 Omnibus (PL 114-39) | $3,745,290,000 | $3,603,569,000 | $3,539,523,000 | $3,566,387,000 |
| 2017 Omnibus (PL 115-31) | $3,815,109,000 | $3,720,690,000 | $3,650,171,000 | $3,694,462,000 |
| 2018 Congressional Justification | $3,574,365,000 | $3,867,260,000 | $3,759,258,000 | $3,952,290,000 |
| 2019 Congressional Justification | $3,945,975,000 | $4,202,639,000 | $4,072,385,000 | $3,965,711,000 |
| 2020 Congressional Justification | $4,286,542,000 | $4,556,870,000 | $4,318,884,000 | $4,315,205,000 |
| 2021 Congressional Justification | $4,507,113,000 | $4,534,670,000 | $4,266,085,000 | $4,301,391,000 |
| 2022 Congressional Justification | $5,678,336,000 | $5,799,102,000 | $5,414,143,000 | $5,600,985,000 |
| 2023 Congressional Justification | $6,261,680,000 | $5,734,044,000 | $5,218,127,000 | $4,919,670,000 |
| 2024 Congressional Justification | $7,012,945,000 | | | |

INDIAN HEALTH SERVICE
Appropriation History Table
**Facilities**

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| 2009 Omnibus | $353,329,000 | - | - | $390,168,000 |
| 2009 ARRA (PL 111-5) | - | - | - | $415,000,000 |
| 2010 | $394,757,000 | $394,757,000 | $394,757,000 | $394,757,000 |
| 2011 | $394,757,000 | - | - | $404,757,000 |
| Rescission (PL 112-10) | | | | ($810,000) |
| 2012 | $457,669,000 | $427,259,000 | - | $441,052,000 |
| Rescission (PL 112-74) | | | | ($705,683) |
| 2013 | $443,502,000 | - | $ 441,605,000 | $441,605,000 |
| Sequestration | | | | ($22,152,062) |
| Rescission | | | | ($883,210) |
| 2014 Omnibus (PL 113-64) | $448,139,000 | - | - | $451,673,000 |
| 2015 Omnibus (PL 113-235) | $461,995,000 | $461,995,000 | - | $460,234,000 |
| 2016 Omnibus (PL 114-39) | $639,725,000 | $466,329,000 | $521,818,000 | $523,232,000 |
| 2017 Omnibus (PL 115-31) | $569,906,000 | $557,946,000 | $543,607,000 | $545,424,000 |
| 2018 Congressional Justification | $346,956,000 | $551,643,000 | $563,658,000 | $867,504,000 |
| 2019 Congressional Justification | $505,821,000 | $882,748,000 | $877,504,000 | $868,704,000 |
| 2020 Congressional Justification | $803,026,000 | $964,121,000 | $902,878,000 | $911,889,000 |
| 2021 Congressional Justification | $769,455,000 | $934,863,000 | $927,113,000 | $917,888,000 |
| 2022 Congressional Justification | $1,500,943,000 | $1,285,064,000 | $1,172,107,000 | $940,328,000 |
| 2023 Congressional Justification | $1,567,343,000 | $1,306,979,000 | $1,081,936,000 | $958,553,000 |
| 2024 Congressional Justification | $1,066,055,000 | | | |

INDIAN HEALTH SERVICE
Appropriation History Table
**Contract Support Costs**

| | Budget Request to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| 2016 Omnibus (PL 114-39) | $717,970,000 | $717,970,000 | $717,970,000 | $717,970,000 |
| 2017 Omnibus (PL 115-31) | $800,000,000 | $800,000,000 | $800,000,000 | $800,000,000 |
| 2018 Congressional Justification | $717,970,000 | $717,970,000 | $717,970,000 | $717,970,000 |
| 2019 Congressional Justification | $822,227,000 | $822,227,000 | $822,227,000 | $717,970,000 |
| 2020 Congressional Justification | $855,000,000 | $820,000,000 | $820,000,000 | $855,000,000 |
| 2021 Congressional Justification | $855,000,000 | $916,000,000 | $916,000,000 | $916,000,000 |
| 2022 Congressional Justification | $1,142,000,000 | $880,000,000 | $880,000,000 | $880,000,000 |
| 2023 Congressional Justification 1/ | $1,142,000,000 | $969,000,000 | $969,000,000 | $969,000,000 |
| 2024 Congressional Justification 1/ | $1,168,000,000 | | | |

1/ FY 2024 Congressional Justification proposes to make the FY 2024 Budget mandatory.

INDIAN HEALTH SERVICE
Appropriation History Table
**ISDEAA 105*(l)* Leases**

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| 2019 Congressional Justification | $0 | $0 | $0 | $0 |
| 2020 Congressional Justification | $0 | $0 | $0 | $0 |
| 2021 Congressional Justification | $101,000,000 | $101,000,000 | $101,000,000 | $101,000,000 |
| 2022 Congressional Justification | $150,000,000 | $150,000,000 | $150,000,000 | $150,000,000 |
| 2023 Congressional Justification 1/ | $150,000,000 | $111,000,000 | $111,000,000 | $111,000,000 |
| 2024 Congressional Justification 1/ | $153,000,000 | | | |

1/ FY 2024 Congressional Justification proposes to make the FY 2024 Budget mandatory.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**INDIAN HEALTH SERVICE**
**FY 2024 Performance Budget Submission to Congress**

## TABLE OF CONTENTS

### Current Services/Staffing of Newly Constructed Facilities

Page

Current Services....................................................33
Staffing of Newly Constructed Facilities....................................................35

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
**CURRENT SERVICES**

(Dollars in Thousands)

| Program | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget |
|---|---|---|---|
| Pay Costs | $84,379 | $96,216 | $100,574 |
| Non-Medical Inflation | $6,057 | $5,987 | $5,820 |
| Medical Inflation | $29,374 | $18,203 | $112,825 |
| Population Growth | $86,434 | $86,665 | $126,815 |
| Current Services, Total | $206,244 | $207,071 | $346,034 |

**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 2024 Authorization**.........................................................................................Permanent

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

**PROGRAM DESCRIPTION**

Current Services, also known as annual fixed costs, are funds to offset the rising cost of providing direct health care services, including tribal and federal pay costs, medical and non-medical inflation, and population growth. These funds ensure the IHS can maintain services at previous year levels by shoring up base operating budgets of IHS, Tribal, and urban Indian health programs. Without these funds, the level of health care services, access to care, and purchasing power are eroded. This can result in decreases in patient service levels from the prior year.

**BUDGET JUSTIFICATION**

The IHS requests an increase of $346 million for Current Services in FY 2024 to offset pay costs, medical and non-medical inflation, and population growth.

# FY 2024 Current Services Estimates

| | FY 2024 Current Services | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Pay | | | Inflation | | | Population | |
| | Federal | Tribal | Pay | non-med | medical | Inflation | Growth | Curr Svcs |
| Sub Sub Activity | Pay | Pay | Total | 1.02% | 4.10% | Total | 1.80% | Total |
| **SERVICES** | | | | | | | | |
| Hospitals & Health Clinics | 28,646 | 40,985 | 69,631 | 1,441 | 56,624 | 58,065 | 60,584 | 188,280 |
| Electronic Health Record | 5 | 0 | 5 | 16 | 0 | 16 | 5,121 | 5,142 |
| Dental Services | 3,238 | 4,918 | 8,156 | 158 | 5,409 | 5,567 | 5,565 | 19,288 |
| Mental Health | 999 | 1,602 | 2,601 | 5 | 2,955 | 2,960 | 3,584 | 9,145 |
| Alcohol & Substance Abuse | 1,131 | 2,030 | 3,161 | 130 | 6,600 | 6,730 | 6,203 | 16,094 |
| Purchased/Referred Care | 419 | 616 | 1,035 | 2 | 32,297 | 32,299 | 21,925 | 55,259 |
| Indian Health Care Improvement Fund | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total, Clinical Services | 34,438 | 50,151 | 84,589 | 1,752 | 103,885 | 105,637 | 102,982 | 293,208 |
| Public Health Nursing | 991 | 2,002 | 2,993 | 11 | 2,737 | 2,748 | 2,026 | 7,767 |
| Health Education | 94 | 2,230 | 2,324 | 1 | 697 | 698 | 115 | 3,137 |
| Comm. Health Reps | 30 | 128 | 158 | 10 | 2,488 | 2,498 | 1,239 | 3,895 |
| Immunization AK | 0 | 0 | 0 | 0 | 84 | 84 | 40 | 124 |
| Total, Preventive Health | 1,115 | 4,360 | 5,475 | 22 | 6,006 | 6,028 | 3,420 | 14,923 |
| Urban Health | 66 | 99 | 165 | 240 | 1,407 | 1,647 | 2,025 | 3,837 |
| Indian Health Professions | 179 | 0 | 179 | 577 | 0 | 577 | 0 | 756 |
| Tribal Management | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 1 |
| Direct Operations | 2,125 | 736 | 2,861 | 236 | 0 | 236 | 0 | 3,097 |
| Self-Governance | 40 | 4 | 44 | 8 | 0 | 8 | 0 | 52 |
| Total, Other Services | 2,410 | 839 | 3,249 | 1,062 | 1,407 | 2,469 | 2,025 | 7,743 |
| Total, Services | 37,963 | 55,350 | 93,313 | 2,836 | 111,298 | 114,134 | 108,427 | 315,874 |
| **FACILITIES** | | | | | | | | |
| Maintenance & Improvement | 0 | 0 | 0 | 712 | 1 | 713 | 6,220 | 6,933 |
| Sanitation Facilities Constr. | 0 | 0 | 0 | 1,206 | 0 | 1,206 | 3,648 | 4,854 |
| Health Care Fac. Constr. | 0 | 0 | 0 | 3 | 0 | 3 | 0 | 3 |
| Facil. & Envir. Hlth Supp. | 4,144 | 3,117 | 7,261 | 1,060 | 886 | 1,946 | 6,684 | 15,891 |
| Equipment | 0 | 0 | 0 | 3 | 640 | 643 | 1,836 | 2,479 |
| Total, Facilities | 4,144 | 3,117 | 7,261 | 2,984 | 1,527 | 4,511 | 18,388 | 30,160 |
| **TOTAL, IHS** | **42,107** | **58,467** | **100,574** | **5,820** | **112,825** | **118,645** | **126,815** | **346,034** |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
**Staffing of Newly Constructed Facilities**

(Dollars in Thousands)

| Facility | FY 2024 President's Budget | | |
|---|---|---|---|
| | Total | FTE/POS | |
| Chugachmiut Regional Health Center (JV)<br>Seward, AK | $5,879 | 26 | |
| Alternative Rural Health Center<br>Dilkon, AZ | $31,094 | 223 | |
| Naytahwaush Health Center (JV)<br>Naytahwaush, MN | $7,095 | 50 | |
| Elbowoods Memorial Health Center (JV)<br>New Town, ND | $2,545 | 16 | |
| Fred LeRoy Health and Wellness Center (JV)<br>Omaha, NE | $32,265 | 221 | |
| Ysleta Del Sur Health Center (JV)<br>El Paso, TX | $2,610 | 23 | |
| Rapid City Health Center<br>Rapid City, SD | $166 | 15 | |
| **Grand Total** | **$81,654** | **N/A** | |
| **FTE/ POS** | **N/A** | **238** | **336** |

**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 2024 Authorization**..........................................................................................Permanent

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

## PROGRAM DESCRIPTION

The IHS is authorized by the Snyder Act of 1921, the Transfer Act and the Indian Health Care Improvement Act to use government funds to plan, construct and staff facilities for the provision of health care services. Each year the budget includes a staffing request for newly constructed facilities that provides funding for the personnel sufficient to operate a new facility in the first year of operation. This funding becomes part of the recurring funds that the facility receives each year. The staffing tables in the budget request result from collaboration between the Headquarters Office of Finance and Accounting (Budget Formulation), Public Health Support (Division of Planning, Evaluation and Research), Clinical and Preventive Services, Environmental Health and Engineering (Division of Facilities Planning Construction) and the Area Office for the new facility. Each office provides important input as part of the planning process for designing, constructing and opening new facilities that use standard agency planning tools and federal financial accounting practices. Most projects require a two-step process: the first is to develop the overall facility plan for services and space, and the second is to request funds to staff the new facility based on the opening year. For the Joint Venture projects, the IHS and a Tribe enters into a joint venture agreement whereby the Tribe finances and builds their own

health facility and IHS requests funds for the staffing and operating costs for issuance upon completion and opening of the project.

**Allocation Methodology**

The Indian Health Service determines the allocation of staffing for its newly constructed facilities utilizing the Resource Requirements Methodology (RRM). The RRM methodology criteria are used in concert with empirical data and other driving variables, such as Inpatient and Outpatient workload, service population, facility information and budget formulation data to determine the estimates for staffing requirements and operating costs in full-time equivalents. Once the facility opening date determined, a revised staffing plan is developed by the Area Planning Officer as part of the planning phase for the IHS budget. The Budget RRM is reviewed and approved by headquarters offices. IHS provides the approved staffing proposal in a combination of new and existing funds, which includes salaries and overhead, facility operating costs and other support. The new staffing request is for funds needed in addition to the existing staff already funded to reach the desired staffing for the new facility.

## BUDGET JUSTIFICATION

The IHS requests an increase of $82 million for Staffing of New Facilities in FY 2024 to provide staffing packages for seven newly constructed facilities. This includes:

- Chugachmiut Regional Health Center (JV), Seward, AK;
- Alternative Rural Health Center, Dilkon, AZ;
- Naytahwaush Health Center (JV), Naytahwaush, MN;
- Elbowoods Memorial Health Center (JV), New Town, ND;
- Fred LeRoy Health and Wellness Center (JV), Omaha, NE;
- Ysleta Del Sur Health Center (JV), El Paso, TX;
- Rapid City Health Center, Rapid City, SD.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**INDIAN HEALTH SERVICE**
**FY 2024 Performance Budget Submission to Congress**

**TABLE OF CONTENTS**

**Services**

Page

**Services**

Clinical Services
- Clinical Services Summary ....................37
- Hospitals & Health Clinics ....................40
  - Epidemiology Centers ....................84
  - Information Technology ....................89
- Electronic Health Record ....................98
- Dental Health ....................103
- Mental Health ....................112
- Alcohol & Substance Abuse ....................120
- Purchased/Referred Care ....................134

Preventive Health
- Preventive Health Summary ....................140
- Public Health Nursing ....................142
- Health Education ....................149
- Community Health Representatives ....................154
- Immunization AK ....................161

Other Services
- Urban Health ....................168
- Indian Health Professions ....................175
- Tribal Management Grants ....................182
- Direct Operations ....................185
- Self-Governance ....................189
- Public and Private Collections ....................193

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

(Dollars in thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Enacted | Enacted | President's Budget /1 | +/- FY 2023 Budget |
| PL | $4,190,727 | $4,433,191 | $6,436,747 | +$2,003,556 |
| FTE* | 6,730 | 6,696 | 7,420 | +724 |

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

## SUMMARY OF THE BUDGET REQUEST

The FY 2024 Indian Health Service (IHS) Budget submission for Clinical Services is $6.4 billion, which is +$2 billion above the FY 2023 Enacted level. This funding level includes additional resources for:

- Current Services (+$293 million),
- Staffing of Newly Constructed Facilities (+$74 million),
- Direct Health Care General Increase (+$702 million),
- Electronic Health Record (+$690 million),
- Hepatitis C/HIV (+$47 million),
- Opioids Grants (+$9 million),
- Maternal Health (+$3 million),
- Assessments (+$27 million),
- National Community Health Aide Program (+$20 million),
- Division of Telehealth (+$10 million),
- Office of Quality (+$10 million)
- Cancer Moonshot Initiative (+$108 million),
- Division of Graduate Medical Education (+$4 million),
- Nurse Preceptorship (+$1 million), and
- New Tribes (+$5 million)

The budget narratives that follow this summary include detailed explanations of the request.

- **Hospitals and Health Clinics**, supports essential personal health services and community based disease prevention and health promotion services. Health services include: inpatient care, routine and emergency ambulatory care; and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy, and other services. Specialized programs are conducted to address: diabetes; maternal and child health; youth services; communicable diseases including human immunodeficiency virus (HIV)/acquired immune deficiency syndrome, tuberculosis, and hepatitis; women's and men's health; geriatric health; disease surveillance; and healthcare quality improvement.

- **Electronic Health Record (EHR)**, holds an extremely high degree of mission criticality given the ability to provide much-anticipated clinical and administrative capabilities used in modern systems for the delivery of timely and impactful healthcare. Expected benefits from adopting and implementing a modernized or new system include but are not limited to improved patient safety, improved patient outcomes, better disease management, enhanced

population health, improved clinical quality measures, opioid tracking, patient data exchange, third party revenue generation, agency performance reporting, etc. By identifying and properly selecting the best match for proposed system capabilities, the system will support the IHS mission. Additionally, the IHS will obtain interoperability with the Department of Veterans Affairs, Department of Defense, tribal and urban Indian health programs, academic affiliates, and community partners, many of whom are on different Health Information Technology platforms. The IHS must consider an integrated EHR system solution that will allow for a meaningful integration to create a system that serves IHS/Tribal/Urban beneficiaries in the best possible way.

- **Dental Health**, supports preventive care, basic care, and emergency care, with approximately 90 percent of services covering basic and emergency care. Basic services are prioritized over more complex rehabilitative care such as root canals, crowns and bridges, dentures, and surgical extractions. The demand for dental treatment remains high due to a high dental caries rate in American Indian and Alaska Native (AI/AN) children; however, a continuing emphasis on community oral health promotion and disease prevention is essential to impact long-term improvement of the oral health of AI/AN people.

- **Mental Health**, supports a community-oriented clinical and preventive mental health service program that provides outpatient mental health and related services, crisis triage, case management, prevention programming, and outreach services.

- **Alcohol and Substance Abuse**, supports an integrated behavioral health approach to collaboratively reduce the incidence of alcoholism and other drug dependencies in AI/AN communities.

- **Purchased/Referred Care (PRC)**, supports the purchase of essential health care services not available in IHS and Tribal healthcare facilities including inpatient and outpatient care, routine emergency ambulatory care, transportation, specialty care services (mammograms, colonoscopies, etc.), and medical support services (e.g., laboratory, pharmacy, nutrition, diagnostic imaging, physical therapy, etc.). The demand for PRC remains high as the cost of medical care increases. The PRC program continues to emphasize adherence to medical priorities, enrolling patients in alternate resources available to them (such as Medicare, Medicaid and private insurance), negotiating discounted rates with medical providers, and implementing improvements recommended by Tribes and oversight authorities.

The majority of clinical services funds are provided to 12 Area (regional) Offices that distribute resources, monitor and evaluate activities, and provide administrative and technical support to approximately 2.7 million AI/ANs through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations in service areas that are rural, isolated, and underserved.

**Performance Summary Table**

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

## OUTPUTS/OUTCOMES

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| 28 Unintentional Injury Rates: Age-Adjusted Unintentional injuries mortality rate in AI/AN population (Outcome) | FY 2012: 90.9 Target: Not Defined (Target Not In Place) | Not Defined | Not Defined | N/A |
| 71 Childhood Weight Control: Proportion of children, ages 2-5 years with a BMI at or above the 95th percentile. IHS-All (Outcome) | FY 2022: 23 % Target: 22.6 % (Target Not Met but Improved) | Not Defined | 23% | N/A |

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget /1 | +/- FY 2023 Budget |
| PL | $2,374,984 | $2,503,025 | $3,553,742 | +$1,050,717 |
| FTE* | 5,690 | 5,661 | 6,153 | +446 |

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

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

**FY 2024 Authorization**...........................................................................................Permanent

**Allocation Method**… ....................................Direct Federal, P.L. 93-638 contracts and compacts, Tribal shares, interagency agreements, commercial contracts, and grants

**PROGRAM DESCRIPTION**

Hospitals and Health Clinics (H&HC) funds essential, personal health services for approximately 2.8 million American Indians and Alaska Natives (AI/AN). The Indian Health Service (IHS) provides medical and surgical inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, and physical therapy. The IHS direct health care services integrates the Department's Strategic Goal to protect the health of Americans *(HHS Strategic Plan FY 2022-2026, Goal 2 Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.1.Improve capabilities to predict, prepare for, and respond to public health emergencies and threats in the nation and across the globe; Objective 2.2.Protect individuals, families, and communities against communicable, and infectious disease through effective, innovative, readily available and equitable delivery of treatments, therapeutics, medical devices, and vaccines; & Objective 2.3. Enhance promotion of healthy lifestyle choices to reduce occurrence and disparities in preventable injury, illness, and death)*. The IHS and tribes primarily serve small, rural populations with primary medical care and community health services, relying on the private sector for much of the secondary and most of the tertiary medical care needs. Some IHS and tribal hospitals provide secondary medical services such as ophthalmology, orthopedics, infectious disease, emergency medicine, radiology, general and gynecological surgery, and anesthesia.

The IHS system of care is unique in that personal health care services are integrated with community health services. The program includes public/community health programs targeting health conditions disproportionately affecting AI/AN populations such as diabetes, maternal and child health, and communicable diseases including influenza, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), and viral hepatitis. The health status of AI/AN people has improved significantly in the past 60 years since IHS's inception. However,

AI/AN people born today have a life expectancy that is 10.9 years less than the U.S. all races population, 65.2 years to 76.1 years, respectively.[1]

More than 60 percent of the H&HC budget is transferred under P.L. 93-638 contracts or compacts to tribal governments or tribal organizations that design and manage the delivery of individual and community health services through 22 hospitals, 330 health centers, 559 ambulatory clinics, 76 health stations, 146 Alaska village clinics, and 7 school health centers. The remainder of the H&HC budget is managed by direct federal programs that provide health care at the service unit and community level. The federal system consists of 21 hospitals, 53 health centers, 25 health stations, and 12 school health centers.

Collecting, analyzing, and interpreting health information is done through a network of tribally operated epidemiology centers in collaboration with a national IHS coordinating center leading to the identification of health conditions as well as promoting interventions. Information technology supports personal health services (including the Electronic Health Record and telemedicine) and public health initiatives (such as *Baby Friendly Hospitals* and *Improving Patient Care*) that are primarily funded through the H&HC budget.

The H&HC funds provide critical support for direct health care services, ensures comprehensive, culturally appropriate services, provides available and accessible personnel, promotes excellence and quality through implemented quality improvement strategies, and strengthens the IHS program management and operations to raise the health status of AI/AN populations to the highest level (*HHS Strategic Plan FY 2022-2026 Goal* 1, *Protect and Strengthen Equitable Access to High Quality and Affordable Health Care, Objective 1.3.Expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while recognizing social determinants of health & Objective 1.4. Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families).*

**BUDGET REQUEST**

The FY 2024 budget submission for Hospitals and Health Clinics is $3.6 billion, which is $1.1 billion above the FY 2023 Enacted level.

FY 2023 Base Funding of $2.5 billion - supports the largest portion of clinical care at IHS and Tribal health facilities, including salaries and benefits for hospital/clinic administration; salaries and benefits for physicians, nurses, and ancillary staff; pharmaceuticals; and medical supplies. These funds make up the lump sum recurring base distribution to the Areas each fiscal year. Funding to support IHS facilities to promote efficient, effective, high quality care to the AI/AN population is also included in the base.

FY 2024 Funding Increase of $1.1 billion includes:

- Indian Health Care Improvement Fund (IHCIF) Level of Need Funded Gap: +$74 million. The FY 2024 budget submission for IHCIF moves this from a separate budget line back into the H&HC budget line.

[1] https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf

- Direct Health Care Services Increase: +$495 million to expand access to direct health care services. These resources will support efforts to reduce health disparities and improve the overall health status for American Indians and Alaska Natives by increasing the availability of health care services in Indian Country. This funding level will support an estimated 45,670 inpatient admissions and 16,976,299 outpatient visits at IHS and Tribal facilities in FY 2024.

- Elimination of HIV, Hepatitis C, and Sexually Transmitted Diseases: +$47 million to support efforts to diagnose all HIV-positive IHS patients as early as possible after infection, treat those living with HIV rapidly to achieve and sustain viral suppression, and protect individuals at high risk of HIV using pre-exposure prophylaxis (PrEP). These resources will also help the IHS to effectively identify, treat, and prevent related conditions and risks for HIV infection, including hepatitis C virus (HCV) and sexually transmitted disease (STD) infections, and respond rapidly to growing HIV clusters to prevent new HIV infections.

  Rates of STDs other than HIV also continue to rise in Indian country and can increase risk for HIV transmission. Additionally, IHS serves a population that is disproportionately affected by HCV—the AI/AN population has more than twice the rate of HCV incidence and nearly three times the rate of HCV-related mortality as the general U.S. population (CDC 2018). Without concerted intervention that includes expanded HIV, STD, and HCV prevention, testing, and treatment, along with increased clinical and public health resourcing and infrastructure, including associated pharmaceuticals and data generation and analysis capacity, rates of AI/AN HIV, STDs, and HCV will likely continue to increase in FY 2024 and beyond. Additional health statistics about these priority diseases are provided in the program accomplishments section of this narrative.

  The additional $47 million requested above FY 2023 would:
  - Expand patient screening and treatment for those living with HIV, STDs, and HCV,
  - Provide targeted PrEP and expedited partner therapy to those at greater risk for acquiring HIV and other STDs,
  - Effectively screen and treat those patients living with HIV and HCV,
  - Sufficiently staff and resource oversight activities to ensure success,
  - Bolster public health surveillance and data infrastructure,
  - Evaluate these efforts, and
  - Support outreach, education, and training.

  The proposed funding level directly supports IHS's efforts to provide high quality health care across the Indian health system, as well as supporting the *HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.2 Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs Expand safe, high-quality healthcare options, and encourage innovation and competition, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health & Objective 1.5 Bolster the health workforce to ensure delivery of quality services and care*). IHS will concentrate efforts on building up its HIV and HCV infrastructure in the 12 Area Offices and Service Units.

- Maternal Health: +$3 million to expand the reach of this HHS-wide initiative in Indian Country. The new resources will:

- Support preventive, perinatal, and postpartum care,
  - Address the news of pregnant women with opioid or other substance use disorder,
  - Improve quality services and health outcomes to reduce maternal morbidity.

  Specifically, these funds will support expended efforts identified through Tribal Consultation and Urban Confer, and increase the number of maternal case managers in IHS and Tribal Health Programs to expand access to evidence-based training for health care professionals and patients.

- Assessments: +$27 million to offset the cost of central assessments charged to the IHS. These charges are significant and affect the amount of care that can be provided to American Indians and Alaska Natives. Current agency resources are unable to fully absorb these costs, which must then be distributed across the agency, resulting in decreased resources for health services.

- National Community Health Aide Program: +$20 million to support the training, certifying, and hiring of health aides, as well as national program management activities.

- Division of Telehealth: +$10 million to provide resources to appropriately manage and oversee a comprehensive telehealth program at the IHS that would expand telehealth services, develop governance structures, provide training to users, and integrate with clinical services.

  The IHS is the only major Federal healthcare organization that does not have a dedicated office or division to support policy, standardization, and coordination for enterprise-wide telehealth. This activity would provide resources to appropriately manage and oversee a comprehensive telehealth program at the Agency level that could expand telehealth services nationwide. This new Division would also incorporate the activities of the IHS Tele-Behavioral Health Center for Excellence (TBHCE), which is provides direct services and on-line education focused specifically on behavioral and mental health.

  During the COVID-19 pandemic, the IHS significantly expanded the use of Telehealth to sustain the provision of health care services while many facilities had to reduce their service provision and hours to prevent the further spread of COVID. In April 2020, IHS expanded the use of an Agency-wide video conferencing platform that allows for telehealth on almost any internet-connected device and in any setting, including patients' homes. Around the same time, IHS also permitted the emergency use of certain commonly available mobile apps to enable the provision of services remotely while minimizing exposure risk to both patients and staff. These actions, along with the actions taken by the Centers for Medicare and Medicaid Services to allow payment for previously non-billable services, made it possible for IHS to dramatically increase our use of telehealth from an average of under 1,300 visits per month in early 2020 to a peak of over 40,000 per month in June and July of that year. More recent data suggests a plateau of around 30,000 monthly telehealth visits. It is important to note that on average, about 80 percent of telehealth encounters across IHS are conducted using audio only, largely related to the limited availability of technologies and bandwidth capacity in the communities we serve across the country. IHS is currently working to implement an additional cloud-based telehealth platform to complement our existing solutions and distributed COVID-19 supplemental telehealth funds to sites for equipment and devices to improve access for more interactive telehealth encounters.

- Office of Quality: +$10 million - to support activities that ensure high-quality service

provision and that accreditation and CMS certification standards are met including a mock survey program, gap analyses for at-risk facilities, quality measures and reporting enhancements, training on medical quality issues, and expanded risk management activities.

The IHS has made significant progress in improving the delivery of safe and quality of patient care. However, gaps remain related to achieving and sustaining a highly reliable system that best meets the needs of AI/AN people. The IHS organizational structure has historically depended largely on local efforts to comply with quality standards. While successful at producing care tailored to local needs and circumstances, system-wide improvement has been uneven. A well-resourced national program focused on establishing and supporting a unified vision for quality and safety in health care is critical to creating the necessary consistency in excellence across the IHS's 21 hospitals and 53 health centers. While important progress had been made, sustainable change cannot be maintained without the resources to train and support the workforce and monitor the implementation of system redesign and improvement practices.

In addition, the GAO and OIG have recommended that the IHS establish a central owner quality oversight to improve accountability and compliance (OEI-06-14-00010: More Monitoring Needed to Ensure Quality Care; OEI-06-14-00011: Longstanding Challenges Warrant Focused Attention to Support Quality Care; OEI-06-19-00330: Indian Health Service Has Strengthened Patient Protection Policies but Must Fully Integrate Then Into Practice and Organizational Culture; OEI-06-16-00390: Organizational Challenges to Improving Quality of Care in Indian Health Service Hospitals; GAO-17-181: Actions Needed to Improve Oversight of Quality of Care; and, GAO-16-333: Actions Needed to Improve Oversight of Patient Wait Times).

Bolstering the resources to enable continuous organizational quality improvement is crucial. At the root of many of the past failures within the IHS are core organizational challenges that if identified, tested, and corrected, will create local and system-wide change. If such a program is not funded, IHS will remain at risk for future failures.

The structure of the IHS appropriation and statutory requirements governing the use of third-party collections make it extremely difficult to make needed investments in quality, oversight, and compliance activities without additional appropriated resources. Without the resources to support these national efforts, the IHS remains at risk of regression, recreating past challenges without the ability to address future challenges.

The proposed funding level directly supports *HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high-quality healthcare options, and encourage innovation and competition and the HHS Strategic Plan Goal One, Strategic Objective 1.2, Expand safe, high-quality healthcare options, and encourage innovation and competition; and, the HHS Strategic Plan Goal One, Strategic Objective 1.3, Improve Americans' access to healthcare and expand choices of care and service options.*

Requested funding for the Office of Quality would:

- Support expanded testing, mock surveying, training, education, and consultation activities with federal hospitals, critical access hospitals, behavioral health centers, and ambulatory care health centers.
    - Implement mock survey program:

- Conduct a program across IHS facilities of mock surveys, follow-up, and resurvey. These surveys would ensure early identification of accreditation issues and maintain survey readiness by IHS facilities. This would allow IHS management to provide critical resources and oversight to avoid more significant problems developing.

- Provide gap analyses for at-risk facilities:
  - Fund several more in-depth gap analyses at key IHS facilities to identify accreditation and other quality issues, and then fund the development of a corrective action plan and work with the facility leadership to implement and test improvements.

- Training and Education:
  - Funding would support the development and delivery of training/education (virtual and onsite) to IHS's federal system on medical quality issues to ensure consistency in health care quality across the agency.
  - Training would focus on:
    - Improving local oversight of quality assurance and performance improvement.
    - Performance improvement focused on monitoring and enhancing patient safety.
    - Methods for improving experience of care.
  - Provide training and resources to support compliance with required certifications/accreditations.
  - Where requested, provide similar services to Tribal and Urban Indian Organizations.

- Develop quality measures and reporting enhancements to existing information systems, to better leverage existing investments:
  - Funds will be used to design, refine/test, and implement quality measures, including making changes to existing data systems to automate collection/reporting, including improved Office ability to apply statistical rigor to tests of change.
  - In addition, work with existing IHS data systems, including Qlik reporting to enhance quality and oversight reporting.

- Early integration of quality reporting/metrics in the IHS's Electronic Health Record modernization efforts:
  - The requested funds would support contract hours, within the existing EHR project or with an outside contractor to ensure quality reporting/metrics are integrated within the EHR modernization project. This contractor would provide a technical bridge between the IT project staff and the programmatic staff within the Office of Quality.
  - As sites are "rolled out" within the new project, these funds would support site visits and user acceptance training on quality/reporting metric-specific issues, separate from the overall EHR implementation.

    - Improve internal IHS capacity to identify and sustain quality care improvement through working across the system to conduct quality improvement activities, train and advise facility-level staff in this area and provide critical technical expertise to facilities in key patient safety areas including patient safety, nursing, laboratory operation, and provider training.
    - Expanded risk management activities, implementing system improvements to promote safety and risk mitigation, both in healthcare and administrative programs. This would include Identifying high-risk activities that undermine the quality of care within IHS facilities and design/test system improvements.

- <u>Cancer Moonshot Initiative</u>: +$108 million to develop a nation-wide coordinated public health and clinical cancer prevention initiative to implement best practices and prevention strategies to address incidence of cancer and mortality among the American Indian and Alaska Native (AI/AN) population, in support of the President's Cancer Moonshot initiative. These funds would support:

    - Cancer Prevention and Treatment: +$68 million for cancer prevention and treatment services across the Indian health system to: 1) improve the provision of clinical prevention and treatment services, 2) facilitate planning among partners to promote evidence-based strategies in communities for prevention and treatment and 3) improve cancer surveillance. IHS, Tribal, and urban Indian health programs have limited access to cancer treatment services and rely heavily on Purchased/Referred Care, which often requires significant travel to cancer treatment centers. This additional funding ensures that cancer prevention and treatment services become available in rural areas where cancer prevention and treatment is often non-existent.

    - IHS Cancer Center of Excellence staff: +$8 million to develop and implement multi-level and multidisciplinary approaches to increase preventive screenings for early detection and treatment, to increase educational outreach, and to improve access to cessation services. Staff would be multidisciplinary and include staff at the regional and area levels to establish and manage the Center of Excellence. The cancer prevention team will develop a cancer prevention plan with input from key stakeholders to coordinate, implement, and monitor activities, provide technical assistance to demonstration sites and cooperative agreement grantees, and IHS, Tribal, and urban Indian health programs.

    - Establish Clinical/Community Demonstration Projects: +$30 million for the IHS Improved Patient Care (IPC) and community health programs (public health nursing, health education, Community Health Representatives) to implement evidence-based interventions to increase preventive screenings, enhance referrals for follow-up and/or treatment. These funds would support three activities and national infrastructure:

        - Award demonstration projects to coordinate patient care, enhance and expand preventive screenings, referrals, and follow up, as well to establish Patient Navigator positions;
        - Develop a Patient Navigation training program to train professionals and laypeople to coordinate patient care, connect patients with resources, and guide patients through the health care system; and
        - Support 8 FTEs to support the demonstration projects, Patient Navigation

training program, and Patient Navigator positions within the IHS Areas.

- Develop National Campaigns: +$2 million to increase awareness of behavioral risk factors that are associated with cancer risk. Campaigns using positive messaging related to healthy weight, not using commercial tobacco, limiting alcohol use, and increasing daily physical activity. Developing stories of individuals affected by cancer, prevention information, and social media to increase awareness of cancer and importance of preventive screenings.

- Division of Graduate Medical Education: +$4 million to expand and support Graduate Medical Education programs to create a pipeline for future physicians to address longstanding vacancy issues at IHS.

  Currently, two physician residency programs are in development at IHS-operated health programs. One program is at the Northern Navajo Medical Center at Shiprock, partnered with the University of New Mexico. The other is in the Rosebud Service Unit in the Great Plains Area, partnered with Mass General Hospital. In both cases, the partner academic affiliates have received HRSA rural residency program development planning grants. Once established, these residency programs will support recruitment and retention efforts of high quality health care professionals in Indian Country.

  The IHS must establish consistent policies and procedures for these programs, and provide appropriate oversight of these activities. An Agency-wide approach will allow for growth at other IHS service units, and will support consistency in how the IHS handles important business functions, like access to the IHS Electronic Health Record, and onboarding of medical residents. Funds are also necessary to develop these programs in the relevant IHS health programs, including for faculty development and other critical activities. The VA has a large Graduate Medical Education office, and these resources would help the IHS to develop a small, targeted effort.

  In addition to establishing the Office of Graduate Medical Education Programs, these funds will support the development of residency programs in up to four facilities per year.

- Nurse Preceptorship: +$1 million to create a new program to provide training, development, mentoring, and other on-the-job supports to improve placement rates of first year nurses in IHS and Tribal Health Programs.

  Analysis indicates that the IHS has difficulty placing newly graduated nurses in IHS and Tribal health programs, despite vacancy rates in the mid-20 percent range for nursing professions. IHS and Tribal health programs prefer to hire nurses with on-the-job experience to nurses who have just completed their studies, and are joining the IHS either through the Scholarship or Loan Repayment programs.

  This new program will improve placement rates for recently graduated nurses with Bachelors of Science in Nursing (BSN) and Master of Science in Nursing (MSN) by providing on the job development, training, and mentorship. Many IHS and Tribal health programs have a critical need for nurses, but do not have the resources or the capacity to provide the additional supports necessary to ensure a high level of success for recently graduated nurses. This new program will create that infrastructure at the local level, in partnership with federal, tribal, and relevant state entities. The proposed funding level will support *HHS Strategic Plan FY 2022-2026, Goal 2: Safeguard and Improve National and Global Health Conditions and*

*Outcomes, Objective 2.1 Improve capabilities to predict, prevent, prepare for, respond to, and recover from emergencies, disasters, and threats across the nation and globe, Objective 2.2 Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines, and Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death.*

Funds will support:

- Contract or IAA with Established Academic Preceptor Program. Leveraging an established program would allow for rapid implementation of the applicable infrastructure, training, and ladder toward advance certifications. One example of a similar program is the CDC Epidemic Intelligence Service program, which was established in 1951, and has a unique combination of on-the-job-learning and service.

- Two New FTE. These positions will oversee, monitor, and evaluate program activities.

    - There are currently no Nurse Consultant positions at HQ to oversee Nurse Recruitment or a Nurse Preceptorship program. Fully funding 2 FTE positions for a Nurse Consultant for Recruitment and a Nurse Consultant for a Preceptorship Program would allow for these individuals to focus more discriminately on newly hired Registered Nurses and Advance Practice Nurses onboarding and preparation via preceptorship program, and nurse recruitment and retention; particularly in rural areas, or those areas lacking a sufficient nursing workforce.

    - One FTE would establish and run the preceptorship program and one FTE would reestablish the link to recruiting and monitoring through the Nurse Education Center for Indians (NECI) program and oversee the IHS Nursing Scholarship recipients (for sections 103, 104, 105, and 112 programs).

    - The 2 FTEs would actively work with other OPDIVs to leverage preceptorship opportunities, monitor and track success rates, serve as the COR when needed for contracts with established academic preceptor programs and nurse recruitment and retention activities, and leverage what is offered in the federal, public and private sectors with organizations like HRSA, Uniformed Services University, John Hopkins University, etc.

- Current Services and Staffing of Newly Constructed Facilities: +$252 million. Information can be found on pages CJ-33 and CJ-35 respectively.

## FUNDING HISTORY

| Fiscal Year | Amount |
|---|---|
| 2020 | $2,323,898,000 |
| 2021 | $2,237,633,000 |
| 2022 Final | $2,374,984,000 |
| 2023 Enacted | $2,503,025,000 |
| 2024 President's Budget | $3,553,742,000 |

## TRIBAL SHARES

H&HC funds are subject to tribal shares and are transferred to Tribes when they assume responsibility for operating associated programs, functions, services, and activities, unless otherwise specified in the annual appropriations bill. A portion of the overall H&HC budget line is reserved for inherently federal functions and is therefore retained by IHS to perform the basic operational services of the Agency.

## PROGRAM ACCOMPLISHMENTS

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

<u>Office of Quality</u> – Established in FY 2019, the IHS Office of Quality (OQ) has made significant quality and patient safety improvements across the Agency. The OQ has three divisions: 1) Quality Assurance; 2) Patient Safety and Clinical Risk Management; and, 3) Innovation and Improvement that lead the work on oversight of policy and accreditation standards, implementation of quality improvement strategies, and monitoring accountability of federally-operated facilities.

*Accomplishments FY 2022*

In FY 2022, the Office's activities and accomplishments include the following:

During FY 2022, the OQ supported patient safety by standardizing patient safety and adverse event policies as well as continued implementing standardized credentialing practices both via software implementation and process training. In addition, the OQ improved regulatory compliance through the implementation of standardized facility governance across IHS direct health care programs.

*Strategic Plan Implementation* - The IHS Strategic Plan FY 2019-2023 provides the framework for how the IHS will achieve its mission (to raise the physical, mental, social, and spiritual health of AI/AN to the highest level) through three Goals, eight objectives, and 70 strategies. To monitor the implementation of the framework, the Office created a site that allows for IHS Area and Headquarters (HQ) Offices to report to a centralized location, the Strategic Plan Activity Repository (SPAR). Area and HQ Offices select high-bar activities to include in the SPAR. These activities are updated quarterly (or more frequently as appropriate) and tied to a strategy. The IHS Strategic Plan has focused IHS programs and activities on improving quality, safety, and sustained compliance across the IHS healthcare system. As of February 2023, 416 total activities from Areas and HQ offices are currently tied to the IHS Strategic Plan, and all 12 Areas and 12 HQ offices have contributed activities and updates. This activity meets the *IHS Strategic Plan Goal 2, Objective 2.2 Provide care to better meet the needs of American Indian and Alaska*

*Native communities, and the HHS Strategic Plan Goal 5, Advance Strategic Management to Build Trust, Transparency, and Accountability.*

Quality Assurance - The Division of Quality Assurance focused intently on ensuring the quality of care in IHS facilities through external accreditation and certification support. The OQ provides survey readiness support by making available tools, resources, and consultations for all IHS Area Offices and facilities. The OQ supported and assisted IHS facilities in all 12 IHS Areas to achieve and maintain The Joint Commission (TJC) and Accreditation Association for Ambulatory Health Care (AAAHC) accreditation standards and CMS regulations for IHS Hospitals, Health Centers, Behavioral Health facilities, Critical Assess Hospitals (CAH), and Youth Regional Treatment Centers (YRTC) As of February 2023, 100 percent of all IHS hospitals and CAHs have achieved and maintained CMS conditions of participation, 20 of 22 hospitals and CAHs have TJC accreditation. 30 of 31 eligible IHS health centers are accredited by TJC or the AAAHC. The one ambulatory facility without accreditation opened in April 2022 and has submitted its accreditation application. There is one additional health center that is ineligible for accreditation because it does not provide the services required to obtain accreditation.

The OQ monitors and provides oversight on certification and accreditation activities with the development and sharing of periodic IHS accreditation reports to communicate and share information and increase standardized accreditation preparedness efforts agency-wide. The information from the reports is shared with leadership to increase transparency and strengthen the planning and collaboration of continuous improvement efforts. Certification and accreditation activities promote the evidence of quality standardization of health care programs. These activities support the *HHS Strategic Plan Objective 5.1: Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices.*

The IHS has also directed that all ambulatory care facilities attain Patient-Centered Medical Home (PCMH) designation. As of February 15, 2023, 29 of 31 Ambulatory facilities, 12 of 15 Hospitals, and 7 of 7 CAHs have achieved PCMH designation. All five of the ambulatory facilities and hospitals needing PCMH designations have submitted applications and are awaiting survey availability. The remaining facilities without PCMH designation continue to be affected by the delay of accreditation organizations to conduct surveys due to the COVID-19 public health emergency.

During FY 2022, the OQ provided the software system Tracers with AMP® to support ongoing accreditation readiness activities for TJC-accredited hospitals, critical access hospitals, behavioral health, and ambulatory facilities. The OQ continues to provide training and support to the facilities to assist in preparation for TJC accreditation surveys. In-person and virtual training opportunities were provided agency-wide as well as regular meetings to provide ongoing technical assistance and collaboration opportunities. By the end of FY 2022, 1,778 completed observations had been recorded utilizing the standardized Tracers with AMP® tool.

Through February 2023, there were 63 successful surveys by TJC (including TJC Lab surveys), AAAHC, and CMS completed at IHS facilities. This activity meets the *HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.*

The IHS monitors the credentialing and privileging system and continuously optimizes its functions. In Calendar Year (CY) 2022, the OQ continued to improve the IHS credentialing and

privileging process through the optimization and standardization of Applied Statistics & Management (ASM) credentialing and privileging software products across all federal facilities. All 11 eligible Areas use the software to facilitate the hiring, verification, and ongoing monitoring of qualified practitioners. The OQ provides technical assistance through training and support to Areas and facilities for ASM use and promotes the transition to 100 percent paperless. The OQ is also facilitating a quality improvement project for standardization. For FY 2022, there have been 36,281 user logins processing 3,171 initial appointment and reappointment applications with 111,981 initial and ongoing verifications, along with 21,265 reports generated. Standardization phases 1 through 6 are complete across all IHS areas. In FY 2022, additional software standardization phases are focusing on MD-Staff file types, departments and combining duplicate provider records. The improved credentialing and privileging process meets the *HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.*

*Patient Safety and Clinical Risk Management* – The IHS Safety Tracking & Response (I-STAR), a system for reporting adverse events and good catches, is fully implemented across the Agency. A good catch event is an event or a potential safety hazard that is caught before it reaches a patient, worker, visitor, or facility. The IHS monitors the system and is continuously optimizing its functions. Since I-STAR was rolled-out in August 2020, events have been reported from each of the 12 IHS Areas and 197 facilities, and 50 Tribal facilities. In FY 2022, 22,405 events were entered with 8,078 medication good catch events entered. The OQ is responsible for the administration of the I-STAR application and for providing educational opportunities for I-STAR users. In FY 2022, the OQ held 18 office hours and provided 43 Q&A sessions; modified I-STAR to allow for enhanced efficiency and investigation of good catch medication category A/B events; developed a Patient Safety Dashboard that includes 22 standard reports commonly used for identifying facility level patient safety trends and for reporting to Area Governing Boards; added 2 new facilities as I-STAR users; developed and posted 16 new job aides to assist users; and added 28 new drugs to the I-STAR formulary. The patient safety team collaborated with National Combined Councils (NCC), area directors (ADs), and the Chief Medical Officer (CMO) to develop an agency patient and workforce safety strategy, the Total System Safety and Quality Strategy. This strategy is in line with the Department of Health and Human Services (HHS) initiative, the Action Alliance to Advance Patient Safety. In January of 2023, the patient safety team completed an agency-level patient safety policy that was submitted to the division of regulatory and policy coordination to undergo the agency policy vetting process. The patient safety program is actively collaborating with the Enterprise Risk Management (ERM) program to stratify and prioritize patient safety risks identified by the field. The team worked with area offices to conduct patient safety program assessments at all federal facilities to assess the maturity of the different components of facility patient safety programs and to collect baseline patient safety program data that will be used to identify agency-level patient safety priorities. The OQ Patient Safety team has increased its focus on communication. In May of 2022, the patient safety program created a safety alert listserv, Safety Advisory Facilitating Excellence (SAFE), which can be used to communicate important patient safety alerts to leadership, safety, and quality staff agency-wide. Currently, there are 70 staff subscribed to the listserv agency-wide, and two alerts have been issued. The Patient Safety Program has a forum to communicate routine patient safety information via a dedicated Patient Safety Corner in the Division of Nursing Newsletter. In January and February of 2023, the nurse consultant for patient safety provided patient safety updates to IHS senior leaders, chief medical officers (CMOs), area directors (ADs), the IHS Chief Nurse, facility chief executive officers (CEOs), and all IHS staff via an IHS all employee call.

Clinical Risk Management provides the inherent Federal Residual Function as mandated by statute. Major functions include:

- Coordinating the federally mandated processing of Medical Malpractice Federal Tort Claims Act (FTCA) filed against IHS, Tribal and Urban Providers
- Representing the Agency when paid claims are presented for mandatory review to the Department of Human and Health Services (DHHS) Medical Claims Review Panel
- Representing the Agency as Administrator for the National Practitioner Data Bank and responsible for submitting mandatory payment reports and review of subject matter statements
- Representing the Agency when filing mandatory reports to State Licensing Boards for the provider for whose benefit settlement was made.

These activities meet the *HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.*

The Infection Control and Prevention (IPC) program created an integrated assessment tool to assist facilities in reviewing their Infection Control Programs for key elements provided through the IHS Indian Health Manual Infection Control and Prevention (Chapter 33) policy awaiting approval. The purpose of the chapter is to establish infection control and prevention program policies, procedures, and responsibilities required for ensuring a comprehensive ICP program exists in all IHS healthcare facilities and Service Units. An ICP program is required to meet and maintain readiness with applicable healthcare accreditation standards. The IHS manages the ICP listserv with 260 I/T/U users that regularly distributes infection prevention and control resources, updates, and provides expert technical assistance across the health system. In FY 2021, the IHS concluded an Infection Control Assessment and Response (ICAR) project that provided 76 total COVID-19 infection control assessments at IHS and Tribal facilities in partnership with the Centers for Disease Control and Prevention (CDC). In conclusion of the ICAR COVID-19 project, the focus has now been shifted to ICAR assessments to assess ICP programs as a whole reviewing 10 critical elements of infection control including; training, audits and feedback, hand hygiene, transmission-based precautions, environmental services, high-level disinfection and sterilization, injection safety, point of care testing, wound care, healthcare laundry, and antibiotic stewardship. Another critical element of the ICP program is water management, which CDC is currently developing to be a part of the ICAR process as well. 5 of the ICP program review ICARs have been completed for FY 2022. Following the ICAR assessments, the IHS-CDC ICAR team provides a written report that identifies strengths and recommendations/resources for improvement opportunities. Facilities are advised to track improvements and implementation of best practices through local Governing Board Quality Management Programs. The ICP program has also integrated ICAR assessment results into a tracking tool system that is currently being used by the Office of Quality to analyze and track data trends from The Joint Commission (TJC) survey results in IHS facilities. This tool will be utilized to identify gaps in infection control practices and drive educational needs and provide resources to the I/T/U Infection Preventionists. ICARs have been designated as "best practice" by multiple accreditation surveyors and are of noted value in mitigating risk related to Occupational Health and Safety Administration (OSHA) investigations. In collaboration with the CDC and Partnerships to Advance Tribal Health (PATH), 21 Acute Care and Critical Access IHS Hospitals are reporting Hospital Associated Infection (HAI) data, healthcare personnel COVID vaccination, and healthcare personnel influenza vaccination data to the National Healthcare Safety Network (NHSN) meeting the Centers for Medicaid and Medicare (CMS) requirements. NHSN enables participating healthcare facilities to submit and analyze data on patient and healthcare personnel safety. It also provides analysis tools that enable users to generate a variety of reports, many of which use data for benchmarking purposes. The ICP program is currently collaborating with CDC to optimize the use of data entered to identify prevention and quality improvement opportunities. The ICP

program is also continuing to collaborate with other divisions within IHS such as the Environmental Health Division to provide training and educational opportunities for front-line staff. This activity meets the *HHS Strategic Plan Goal 1, Strategic Objective 1.24 Build, strengthen and sustain relationships.*

Innovation and Improvement – The Division of Innovation and Improvement (DII) develops and implements programs to increase quality improvement (QI) capacity in the Indian health system; leads change management to embrace new models of care delivery and enhance efficiency; and develops and implements programs for training, leadership development, and skill building.

The OQ continues the implementation of the accelerated model for improvement (Ami™) improvement science framework and provides Healthcare Improvement Professionals (HIP) training to support quality improvement initiatives throughout the IHS areas. 44 HIPs are implementing various improvement projects and Ami™. The OQ tracks improvement projects, which change throughout the year. As of December 2022, 38 quality improvement projects were actively being implemented on different stages across the Agency, with 43 projects completed, and nine change packages are available for Agency dissemination. The projects focus on improving both administrative and clinical processes, all project information is housed on a server that allows for sharing across the Agency resulting in increased transparency of new best practices. This activity meets *HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.*

The OQ manages the Innovations Projects, which began its 6th year on October 1, 2022. This opportunity is for IHS-operated Direct Service health care facilities and urban Indian organizations to receive assistance from the OQ to develop and implement a quality improvement project. These projects should meet the demonstrated need of the population served and represent a significant innovation in improving the quality of care and outcomes for AI/AN patients. This also represents an opportunity for the OQ to identify and develop proven innovative approaches that can have wider impacts as they can be replicated and adapted by other IHS Direct Service health programs. Sixteen federal sites and four urban Indian organization sites have been funded to date. The funded 2022-2023 Innovations Projects include Yakama Service Unit: Telehealth for chronic conditions, Gallup Indian Medical Center: Improving Quality of Heart Failure Care for Patients at Gallup Indian Medical Center, Chinle Service Unit: Improving Patient Experience of Care by Expanding Interpreter Services and Cultural Safety at Chinle Service Unit. This activity meets the *HHS Strategic Plan Goal 3 Strengthen Social Well-Being, Equity, and Economic Resilience.*

Improving Patient Care (IPC) Program **-** The purpose of the IPC Program is to promote the development and application of the quality improvement processes and to promote the implementation of the PCMH model of care to improve the health and wellness of AI/AN people. The IPC program provides a model of collaborative learning to develop proficiency in quality improvement methodologies, data management, and analysis; using these to drive improvements. The IPC program supports the continued learning of IHS staff. As of December 2022, the IPC program provides 250 subscriptions to the Institute for Healthcare Improvement (IHI) Open School to support I/T/U facility staff in their quality improvement efforts. In 2022, the IHS continued support of the web-based collaborative learning environment, the Quality Portal, to disseminate quality improvement and PCMH information. The portal includes subscription and notification settings, integration of a calendar invitation, the ability for the IHS staff to create "affinity groups" to manage quality improvement work, and the ability to upload resources when replying to a request in the Community Exchange. In 2022, subject matter experts responded to 110 questions and 460 documents were added to the Resources Section. The customer

experience continued to improve through functionality enhancements such as the workgroups to expand the Community Exchange. The IPC Program monitors areas for improvement through regular quality portal analytic reports. This activity meets *HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.*

The IPC program supports I/T/U facilities by providing them with the tools and resources needed to determine when a change is an improvement and to monitor the spread and scale-up of change using PCMH measures. The IPC program continues to develop an ambulatory care measure set integrated into the health information system in collaboration with the IHS Office of Information Technology (OIT). There are currently 20 approved measures and in FY 2022, the majority of these measures were available in our population health management tool (iCare) for facilities to view, monitor, and use to guide quality improvement measures. Additionally, the OQ, in collaboration with OIT, is working to deploy a dashboard demonstrating the performance of IHS facilities across multiple PCMH-supporting measures at the Area and National levels. This activity meets the *HHS Strategic Plan Goal 4, Strategic Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion.*

Starting in October 2022, the OQ is supporting a Learning Lab with 4 PCMH sites to test and develop capacity for the IHS to support health-related social needs (HRSN) screening as a component of the greater IHS SDOH Strategic Plan. This includes evaluation of HRSN screening tools, workflow, EHR integration, and data collection and analysis at the facility and beyond context.

<u>Establishment of the National Compliance Program</u>: In January 2020, the IHS initiated the development of a National Compliance Program (NCP). The establishment of the NCP is a significant step forward in strengthening IHS HQ oversight responsibilities, promoting and institutionalizing a continuous and robust compliance review process. The NCP is directly overseen by a senior official, the IHS Chief Compliance Officer.

The NCP provides IHS-wide and national-in-scope leadership, guidance, and support of compliance initiatives, including strategic planning, evaluation, and research related to quality-focused compliance. The NCP provides national leadership and consultation on compliance functions to ensure internal policies and procedures are properly authorized by and adequately implement applicable laws, regulations, and HHS policies and directives. The NCP leads key components of the agency's Enterprise Risk Management (ERM) efforts, and the related implementation of the Federal Managers Financial Integrity Act (FMFIA) including identifying, assessing, analyzing, mitigating, and monitoring mission-critical risk areas and forecasting the impact on the IHS. This activity meets *HHS Strategic Plan Goal 5, Strategic Objective 5.1 Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices.*

*Enterprise Risk Management and Internal Audit under OMB Circular A123*
In FY 2022, IHS implemented a qualitative approach to evaluating risks in nine business process areas to identify control areas for testing that were of the highest risk. As a result of the testing in FY 2022, the IHS confirms the correction of the significant deficiency in Information Technology General Controls reported in FY 2021 that impacted financial reporting and reported as a material weakness in FY 2020. IHS is developing an ERM Profile for FY 2023, that includes risk related to all aspects of the agency and will be used to inform compliance activities throughout the year. This activity meets *HHS Strategic Plan Goal 5, Strategic Objective 5.1, Promote effective enterprise governance to ensure programmatic goals are met equitably and*

*transparently across all management practices and Strategic Objective 5.2, Sustain strong financial stewardship of HHS resources to foster prudent use of resources, accountability, and public trust.*

*National HQ Oversight Reviews*
One of the major activities initiated by the NCP was HQ Oversight Reviews as a component of the ERM effort. Subjects included in the content of the 2020 HQ Oversight Reviews were chosen with the following considerations:

- High-Risk Areas identified in IHS ERM discussions.
- Un-remediated findings from prior year internal audits
- High frequency of findings by both GAO and OIG.

Reviews assessing compliance with regulatory areas, agency-wide policies in the Indian Health Manual, CMS Conditions of Participation, and accreditation standards for IHS hospitals. Results from these reviews will continuously inform further work and priorities of the NCP and the Agency. This activity meets the *HHS Strategic Plan Goal 5, Strategic Objective 5.1 Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices.*

*Quality Assurance/Risk Management*
In FY 2020, IHS established the Quality Assurance Risk Management Committee (QARMC) to provide senior-level oversight and management of complex, adverse patient safety events and administrative matters involving fraud, waste, abuse, and employee misconduct within IHS-operated hospitals and clinics; and perform Agency-wide clinical and administrative risk management to identify systematic changes needed to improve the quality of health care services and IHS-operated hospitals and clinics. The QARMC is a component of the overall ERM governance structure and is intended to ensure enterprise-wide accountability and effectiveness of those internal and external reporting systems, necessary management responses, and swift and effective corrective action.

All IHS Area Directors have developed local processes to coordinate with the HQ QARMC and to ensure all reporting requirements within each IHS Area are understood and followed. Excellent collaboration between the IHS and OIG with joint training opportunities for compliance and overall improvements is making reporting more timely, efficient, and responsive. This activity meets *HHS Strategic Plan Goal 5, Strategic Objective 5.1 Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices.*

<u>Nursing</u> – Nursing represents the largest category of health care providers in the Indian health system and has a major impact on patient safety and health care outcomes. Nurses are actively engaged in the transformation of the health care system by placing more emphasis on prevention, wellness, and coordination of care.

<u>Division of Nursing Services</u>
The Division of Nursing Services (DNS) coordinated the signing of a Memorandum of Agreement that allows medical, nursing, and graduate students at the Uniformed Services University of the Health Sciences (DOD in Bethesda) to do clinical rotations at IHS sites, marking the first time nursing was included in this MOA. In addition, DNS created and continued publication of the Quarterly Newsletter for IHS Nursing and the Nurse of the Month

recognition program to highlight important contributions I/T/U nurses make in caring for our patients and communities.

Emergency Medical Services for Children/Geriatric Emergency Department Accreditation
The IHS/HRSA Emergency Medical Services for Children funding for FY21/FY22 was put toward a contract with Children's Hospital of Philadelphia (CHOP) to build and implement a hybrid simulation training program. The simulation training program paired six Emergency Departments with Academic Medical Centers (AMC) to implement a curriculum of in-person or tele-simulations to prepare emergency room physicians and nurses to become competent in the care of children and newborns during pediatric emergency situations. Sites participating in the program have designated a Pediatric Emergency Care Coordinator (PECC) or Pediatric Champion to coordinate and implement pediatric specific activities such as pediatric care, education and training.

Thirteen (13) IHS and tribal EDs have a designated PECC, also known as Pediatric Champion. The PECC role is important to the sustainability of the training program. PECCs maintain the relationship with the AMC partner and coordinate the simulation training. The IHS Hybrid Simulation Training Project has established partnerships with ten AMCs among the 13 participating EDs. The AMC partners are Emergency Medicine attending physicians and fellows who volunteer their time to work with ED staff to run the hybrid simulations and to share evidence-based practices.

The National IHS Geriatric ED Accreditation (GEDA) Initiative workgroup partnered with ACEP Geriatric ED Accreditation Program to recruit 11 IHS and tribal EDs to pursue Bronze – Level 3 Geriatric ED Accreditation. Nine out of 11 participating EDs submitted their applications. Five of the nine EDs have already received Bronze – Level 3 accreditation. The remaining four sites have applications pending board vote and approval.
The IHS and tribal Geriatric ED teams implemented geriatric-focused policies or protocols for Fall Prevention, Depression and Suicide Screening, Medication Management/Reconciliation, Geriatric Trauma Considerations, and Decreasing Prolonged ED Stays.

Women's Health
DNS coordinated the purchase of 50 childbirth simulation models for emergency preparedness training for IHS service units, as well as 825 blood pressure monitors for patient home use, and started an internal multi-disciplinary Maternal Child Health (MCH) workgroup allowing for enhanced communications and coordinated efforts between the service units, area offices, and IHS HQ MCH stakeholders.

The WH Consultant continues to work in collaboration internally, and with our federal partners and other external agencies in order to improve health outcomes for AI/AN women and children, including: Federal Partners Maternal Health Working Group, Interagency Policy Committee, Agency Priority Goals working group, CDC Hear Her Campaign, OPHS/ASPE Congenital Syphilis Evaluation Project, Healthy Native Babies Project transition, United States Breastfeeding Committee, Maternity Care Coordinator Orientation (VA Model); CMS-Maternal Health Model Concept/HRSA Birthing Friendly Hospital designation; collaborating with USU as potential community partner in NIH IMPROVE initiative.

Forensic Nursing
A Forensic Nurse Consultant was hired. Their role will be to focus on forensic nursing policy and planning. This role will also focus efforts on providing training, education, and technical assistance across IHS to improve resources and enhance access to quality care delivery.

Advanced Practice Nursing

A Headquarters Advanced Practice Nurse (APN) Consultant was hired. Their role will be to focus on important issues facing IHS related to APNs including efforts in support of recruitment and retention, standardization of credentialing and role utilization of APNs across IHS to improve access to care with a focus on quality care delivery. Initial exploratory efforts for grant funding for APRN transition to practice program development for new graduates APRNs.
In addition, coordinated meetings with the Uniformed Services University of the Health Sciences (DOD in Bethesda) to discuss planning for graduate/APN students to do clinical rotations at IHS sites; drafted contact list to be utilized as a resource by USUHS personnel in clinical placement planning.

HIV Program – According to CDC's HIV Surveillance Report using data reported through December 2021, in 2020, 30,346 people received an HIV diagnosis in the United States and dependent areas. The overall HIV diagnosis trend shows a 22 percent decrease from 2015. The rate of diagnoses of new HIV infection among AI/AN adults and adolescents increased by 16.5 percent between 2015 and 2020. In 2020, the HIV diagnosis rate is approximately 9.9 per 100,000 for AI/AN compared to 4.6 per 100,000 for Whites. From 2015-2019, the HIV diagnosis increased by 24 percent among AI/AN men with male-to-male (MSM) sexual contact as the mode of transmission. Among AI/AN women, the main transmission route was heterosexual contact, accounting for 60 percent of new diagnoses, followed by injection drug use at 40 percent of new diagnoses.[2]

The CDC reported the death rate among AI/AN people living with HIV in 2019 was 19 percent lower than in 2015.[3] While IHS cannot infer direct causation on a national scale, the largest HIV treatment programs like those at the Phoenix and Gallup Indian Medical Centers show outstanding HIV testing, linkage to care, and viral suppression outcomes among their HIV patients. These sites use intensive and specialized case management to initiate care, adherence, and support for co-morbidities and social barriers that are unique to their patients' social and cultural contexts. As we have reported in prior justification documents, in IHS, HIV screening increases are plateauing at 50 percent to 60 percent of those who have used IHS clinics in the past three years, especially in large IHS hospitals. Some of IHS' primary care facilities reach screening rates over 90 percent, but not all IHS patients access primary care and therefore go unscreened for HIV. It is important to remember that while HIV screening programs in emergency departments, urgent care, and other non-primary care settings is crucial, these programs are difficult to start and sustain.

IHS data shows that from 2005-2014, there were 2,273 HIV diagnoses in IHS facilities.[4] CDC data ranks AI/AN people fourth in the nation for the estimated rate of new HIV diagnoses when compared with all other races and ethnicities. Diagnosing HIV quickly and linking people to treatment immediately are crucial to achieving further reduction in new HIV infections.

[2] Centers for Disease Control and Prevention. HIV Surveillance Report, 2019; vol. 32. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed August 10, 2021.

[3] Centers for Disease Control and Prevention. HIV Surveillance Report, 2019; vol. 32. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021. Accessed August 10, 2021.

[4] Reilley B, Haberling DL, Person M, Leston J, Iralu J, Haverkate R, Siddiqi AE. Assessing New Diagnoses of HIV Among American Indian/Alaska Natives Served by the Indian Health Service, 2005-2014. Public Health Reports. 2018 Mar;133(2):163-8. https://journals.sagepub.com/doi/full/10.1177/0033354917753118

Although the United States is making significant progress in improving HIV outcomes, significant challenges remain. Gaps in the HIV care continuum are driving HIV transmission. By ensuring that everyone with HIV is aware of their status, receives the treatment they need, and achieves and maintains viral suppression — key steps in the HIV care continuum — we can preserve the health of people with HIV, improve the quality of their lives, and drive down new HIV infections[5].

Primary care providers are the front line for detecting and preventing the spread of HIV. People with HIV who are aware of their status should be prescribed antiretroviral therapy (ART) and, by achieving and maintaining an undetectable (<200 copies/mL) viral load, can remain healthy for many years.[6] ART is now recommended for all people with HIV, regardless of CD4 count.[7] Studies show that the sooner people start treatment after diagnosis, the more they benefit from ART. Early diagnosis followed by prompt ART initiation[8]:

- Reduces HIV-associated morbidity and mortality;
- Greatly decreases HIV transmission to others; and
- May reduce risk of serious non-AIDS–related diseases.

An analysis from CDC shows the vast majority – or about 80 percent – of new HIV infections in the U.S. in 2016 were transmitted from the nearly 40 percent of people with HIV who either did not know they had HIV, or who had been diagnosed but were not receiving HIV care[9]. There is no reason to believe this statistic is different among American Indian and Alaska Native people. These data underscore the impact of undiagnosed and untreated HIV in the nation and also the critical need to expand HIV testing and treatment throughout Indian Country.

While IHS has done excellent screening in primary care, annual increases in screening are experiencing diminishing returns, and we are looking at ways to better screen patients who do not have — or use — a primary care provider, such as those individuals using only emergency departments and urgent care clinics.

According to the CDC, from 2015 to 2019, the annual number of HIV diagnoses increased 22 percent among AI/AN overall, and is the only race/ethnicity to record an increasing trend in this time period.

AI/AN living in the U.S. Southwest have more than 50 percent of all HIV diagnoses in the IHS system. Over 500 IHS patients are currently in HIV treatment in the Southwest, with over 85 percent viral suppression. IHS programs supported by the Minority HIV/AIDS Fund in the Southwest include PIMC, GIMC, Chinle, and Northern Navajo Medical Center (Shiprock). Data

[5] Source: https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/NHAS-2022-2025.pdf. Accessed 3/22/2022

[6] Bavinton B, Grinsztejn B, Phanuphak N, et al, for the Opposites Attract Study Group. HIV treatment prevents HIV transmission in male serodiscordant couples in Australia, Thailand and Brazilexternal icon. Presented at the 9th IAS Conference on HIV Science; July 25, 2017; Paris, France

[7] USDHHS. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. https://aidsinfo.nih.gov/guidelines/html/1/adultand-adolescent-treatment-guidelines/0/external icon. Accessed June 28, 2018

[8] Rodger AJ, Cambiano V, Bruun T, et al, for the PARTNER Study Group. Sexual activity without condoms and risk of HIV transmission in serodifferent couples when the HIV-positive partner is using suppressive antiretroviral therapy. *JAMA* 2016;316:171-181. PubMed abstractexternal icon.

[9] Source: https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview . Accessed 3/22/2022

from the Southwest show that viral suppression rates are above 85 percent and moving the needle positively on statewide AI/AN HIV statistics in those states.

The HIV Program goal is to prevent new HIV infections and ensure access to quality health services for AI/ANs living with HIV. The IHS increased overall prenatal HIV screening to 87 percent in FY 2016 – a 15 percent increase over FY 2006 data *(HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Health Care, Objective 1.3.Expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while recognizing social determinants of health*). To improve AI/AN access to healthcare in remote areas, the IHS HIV Program provides technical support to IHS, tribal, and urban Indian health sites on screening and treatment, and the use of telehealth.

In spring 2022, the IHS National HIV/HCV Program received $11.4 million from the competitive HHS Minority HIV/AIDS Fund to expand partnerships between the IHS and Native communities to End the HIV Epidemic in the U.S. National-level projects include the following:

1. National Continuum of Care ($750,000);
2. Project Red Talon ($1,567,501);
3. Enhancing Telehealth ($2,000,000);
4. Clinical Innovations ($2,000,000)
    a. Alaska Area Health Tech Case Management for HIV Care ($157,534);
    b. Chinle Health Tech Case Management for HIV Care ($75,000);
    c. Shiprock Health Tech Case Management for HIV Care ($75,000);
    d. GIMC: Health Tech Case Management for HIV Care, HIV Pharmacist, and HIV Case Manager ($442,848); and
    e. PIMC: HIV Pharmacist, HIV Case Manager, and HCV Pharmacist ($765,000)
5. Empowering Healthier Tribal Communities ($2,932,499)
    a. IHS published and funded a $2.4 million limited competition notice of funding opportunity for the TECs to support tribal communities in reducing new HIV infections and relevant co-morbidities, specifically STD and HCV infections, improve HIV-, STI- and HCV-related health outcomes, and to reduce HIV-, STI- and HCV-related health disparities among AI/AN people. *(HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.2 Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health, & Objective 1.4 Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families)*. The TECs will provide resources to help Native communities address the four main pillars of the Ending the HIV Epidemic plan: Diagnose, Treat, Protect, and Respond (*HHS Strategic Plan FY 2022-2026 Goal 4, Restore Trust and Accelerate Advancements in Science and Research for All, Objective 4.2 Invest in the research enterprise and the scientific workforce to maintain leadership in the development of innovations that broaden our understanding of disease, healthcare, public health, and human services resulting in more effective interventions, treatments, and programs, Objective 4.3 Strengthen surveillance, epidemiology, and laboratory capacity to understand*

*and equitably address diseases and conditions, & Objective 4.4 Improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience*). Only current TEC grantees were eligible to apply for the competing supplemental funding under this announcement and had to demonstrate that they have complied with previous terms and conditions of the TEC program. There were two separate, but related notices in the Federal Register. The first was for those Tribal Epi Centers that do not provide services in the 48 counties or 7 southern states of the EHE Phase One Jurisdictions. These "Group A" applicants could apply for up to $100,000. The second announcement – for "Group B" applicants – was for those TECs whose constituency contains one or more of the 48 counties or seven southern states in the Phase One jurisdictions of the EHE. These "Group B" applicants could apply for up to $275,000.

   b. The National Native HIV Network operated by the Albuquerque Area Indian Health Board for boots-on-the-ground coordinating and program direction to IHS ($360,000); and
   c. The Southern Plains Tribal Health Board "HIV Self-Testing" and "Tele-PrEP" pilot projects ($240,000).

6. OURStory – a digital story telling of the history of HIV/AIDS in Native Communities ($100,000)
7. National Council of Urban Indian Health to End the HIV & HCV Epidemics among urban-based Natives ($527,974)
8. ETHIC (Ending the HIV/HCV/STI Epidemics in Indian Country) strategic plan – a Congressional IHS set-aside ($1.5 million)

In addition, the FY 2023 final appropriation includes $5 million in Ending the HIV Epidemic in the U.S. for the IHS HIV and Hepatitis C initiative, which is the same funding level and purpose as FY 2022. The IHS has conducted tribal consultation and urban confer to understand priorities of Tribal and Urban Indian Organization leaders. The IHS will use the EHE funds for tribes, tribal organizations, and urban Indian organizations to address diagnoses, and prevention, activities or and treatment activities associated with HIV, HCV and sexually transmitted infections (STIs). Funds will also support clinical training, including funding for an ECHO model for ongoing case-based training and technical assistance, and will support national infrastructure and a national media campaign for HIV, HCV, and STI diagnosis, prevention, and treatment.

On April 18, 2022, the Federal Register published a notice by the Indian Health Service (IHS) announcing the availability of $2.5 million in cooperative agreements to End the HIV and hepatitis C (HCV) Epidemics in Indian Country (IHS calls this the ETHIC Program). The application deadline was June 17, and IHS received 12 complete applications. The Objective Review Committee scored seven of those at a level high enough to warrant funding. Thus, IHS awarded $1.2 million in Congressional-appropriated Ending the HIV Epidemic (EHE) funds to tribal and urban Indian organizations to work towards eliminating the syndemic of HIV, HCV, and sexually transmitted infections (STI). Below are grantee highlights framed by the EHE pillars of Diagnose, Treat, Prevent and Respond.

- Seattle Indian Health Board (SIHB) - Seattle, Washington

  ETHIC funding from IHS will allow SIHB to effectively respond to the HIV and HCV epidemics by reducing the number of new HIV and HCV infections in Seattle-King County's American Indian/Alaska Native (AI/AN) community.

This work is critical, as Seattle-King County is a focus jurisdiction for EHE and the most populous county in Washington State, home to approximately 7,000 individuals living with HIV. SIHB will use ETHIC to implement peer HIV testing in community-based locations to make more people aware of their HIV status. In addition, ETHIC will provide rapid linkage to care for AI/AN individuals diagnosed with HIV/HCV/STI, including treatment initiation. Finally, ETHIC funds will enable SIBH to hire an HIV/HCV/STI Care Coordinator to coordinate entry linkage to prevention services such as HIV pre-exposure prophylaxis (PrEP) and facilitate medical appointments and medication adherence.

- Albuquerque Area Indian Health Board, Inc. (AAIHB) - Albuquerque, New Mexico

  ETHIC funding will help 27 tribes in the Albuquerque Area heavily impacted by HIV/HCV/STIs. As many tribes are rural, access to HIV/HCV care, including HIV PrEP, remains limited. AAIHB will use ETHIC funding to purchase and distribute HIV/HCV testing and safer sex supplies directly to tribal communities. AIHB will also use ETHIC to certify public health staff as HIV/HCV/STI counselors/testers and conduct referral services. AAIHB will also train healthcare providers on HIV PrEP implementation while honoring spiritual and cultural values. Additionally, AIHC will use ETHIC funds to develop regional strengths-based and trauma-informed social marketing campaigns to raise community awareness of HIV/HCV/STI prevention and treatment strategies.

- Southern Indian Health Council, Inc. (SIHC) - Alpine, California

  ETHIC funding from IHS will expand the SIHC's Roaming Outpatient Access Mobile (ROAM) Program, a mobile clinic providing outpatient medical, dental, and behavioral health services to seven Consortium Tribal Reservations in Southern California. To increase access to care and to meet the needs of Native youth, ETHIC funding will help expand current ROAM services by adding hours of operation to include evenings and weekends and availability at youth-oriented events. Called R2R, the expanded ROAM will have (1) a full-time licensed vocational nurse onboard to provide free rapid testing for HIV/HCV/STI and counseling, (2) provide information and prescriptions for HIV PrEP and PEP, and (3) provide free human papillomavirus 9-valent vaccine. Funding will also allow the development of a Native Youth Sexual Health Advisory Board to disseminate youth-friendly sexual health messaging through social media channels.

- Native American Rehabilitation Association of the Northwest (NARA NW) - Portland, Oregon

  ETHIC funding from IHS will allow NARA NW to expand its HIV/HCV/STI testing by establishing a standalone STI clinic managed by a roving registered nurse manager. Funding will also increase NARA's ability to provide linkage to treatment services for individuals that test positive. The STI registered nurse and project coordinator hired with ETHIC will conduct frequent educational training on HIV/HCV/STI prevention, diagnosis, and treatment across all NARA NW sites. In addition, NARA NW will implement HIV PrEP and safe syringe programs and develop YouTube videos with medical providers, the Two-Spirit community, and youth for prevention and advocacy messaging.

- First Nations Community HealthSource (FNCH) - Albuquerque, New Mexico
  ETHIC funding from IHS will allow FNCH to reach the goal of reducing new HIV/HCV diagnosis rates by increasing the quantity and quality of HIV/HCV prevention, testing, and treatment services available to AI/AN people in New Mexico. FNCH will use ETHIC to hire three full-time HIV prevention specialists. These specialists will conduct HIV/HCV testing with counseling services, deliver HIV/HCV prevention education in the community, and rapidly link people to HIV/HCV/STI treatment and HIV PrEP services. Funding will also allow the ability to provide case management services to newly diagnosed people living with HIV to improve retention in care and reach sustained viral suppression.

- The Chickasaw Nation - Ada, Oklahoma
  ETHIC funding from IHS will allow the Chickasaw Nation to hire a full-time registered nurse/program coordinator and purchase thousands of HIV screening tests and phlebotomy supplies, resulting in significant increases in HIV screening. In addition, the Chickasaw Nation will (1) develop standardized HIV/HCV/STI screening tools for use in non-traditional settings, (2) create awareness campaigns to help promote sexual health education and PrEP services, (3) immediately link people testing positive for HIV/HCV/STIs, (4) and train additional medical and clinical staff on HIV/HCV/STI issues.

- Rosebud Sioux Tribe (RST) - Rosebud, South Dakota
  ETHIC funding from IHS will allow RST to address the HIV/HCV/STI syndemic by funding a project coordinator to work with the Rosebud Sioux Tribe correctional facility to support HIV/HCV screening and care navigation. This position is vital as Todd County, South Dakota, the seat of the Rosebud Indian Reservation, has the highest HCV rate among non-urban counties in South Dakota and the fourth highest of all US counties for liver-disease-related mortality. In addition, care navigation will result in less frequent delays and interruptions in treatment, leading to better medication adherence and the ability to achieve viral suppression rapidly.

The National HIV/HCV Program continues to collaborate with OIDP to ensure IHS pharmacies and patients have the best possible access to PrEP drugs under the Ready Set PrEP (RSP) program. OIDP and IHS have a draft RSP fact sheet for potential AI/AN PrEP users and a draft algorithm for IHS and tribal prescribers to help them navigate the RSP protocols.

In FY 2022, all of IHS' HIV projects and activities are supported by the Minority HIV/AIDS Fund, and that includes the $2.4 million in cooperative agreements to Tribal Epidemiology Centers. Following are some of their recent achievements:

- The Albuquerque Area Southwest Tribal Epidemiology Center developed an HIV/AIDS Resource Guide for the 27 tribal communities in New Mexico and southwestern Colorado. The guide contains data on HIV, Hepatitis C Virus, and other sexually transmitted infections in the geographic regions and highlights area resources in the communities that provide HIV testing and PrEP.

- The Alaska Native Epidemiology Center executed the Global Network of People Living with HIV Stigma Index survey in Alaska Native communities.

- The Urban Indian Health Institute's Trial Epi Center created a survey on HIV and PrEP knowledge, attitudes, and beliefs for staff at 41 urban Indian health organizations.

- The Oklahoma Area Tribal Epidemiology Center (OKTEC), in coordination with Northwest Portland Area Indian Health Board, launched a campaign to train providers and increase access to PrEP prescribers. The effort now counts more than 50 providers and represents 34 different tribes and tribal facilities.

- OKTEC and the Cherokee Nation are increasing HIV testing access through a text messaging system already in place and operational. This text messaging system will deliver HIV self-testing kits to doorsteps throughout Indian Country. OKTEC has a goal of a statewide reach by 2021 and a national reaching program by 2022.

- The Northwest Tribal Epi Center is using race-corrected HIV data from the Washington State Department of Health better to understand the HIV disease burden within NW tribal communities. Northwest Portland will use these data, along with virtual and in-person training on prevention, control, and outbreak investigation, to adopt HIV prevention and control methods on a local level that are de-stigmatizing and culturally appropriate.

- The IHS National HIV/HCV Program continually searches for ways to help the Area Offices and Service Units achieve their HIV and HCV goals. In the summer of 2020, the IHS National HIV/HCV Program created IHS Area-wide and Service Unit-specific report cards for nationally monitored HIV and HCV screening measures.

- In August, IHS, in partnership with the Northwest Portland Area Indian Health Board, released the fourth and final course in the learning module called "PrEP Navigator Training for Community and Public Health Staff." The learning module is available online. Go to www.ihs.gov and search "PrEP Navigator."

- The Northwest Portland Area Indian Health Board's Healthy Native Youth collaborative launched a Talking is Power campaign to help American Indian and Alaska Native parents and caring adults initiate difficult conversations about sexual health topics with their teens and young adults. Caring adults can text the word "EMPOWER" to 97779 to receive weekly text messages that include culturally appropriate tips and resources, covering sexual health, pregnancy, HIV/STDs, condoms, and consent.

- Northwest Portland recently began its second cohort of a six-month Trans & Gender-Affirming Care ECHO designed for IHS, tribal, and urban Indian health care providers.

- To assess the impact of COVID-19 on our HIV services, in May, August, and December IHS conducted a three-question survey of the clinical leads at our major anti-retroviral therapy programs – specifically those facilities receiving Minority HIV/AIDS Fund support. In total, we interviewed seven sites. The overall impression is that the impact of COVID has been moderate on the overall health of our patients with HIV as well as the impact on ART. However, many providers signaled that the quality of care is suffering and the effects will be manifest in time. A lack of in-person visits means some clinical indicators will go undetected. COVID is causing these HIV medical teams to work in silos more than ever before, and at least one site has reported new HIV patients since COVID-19. Still, one facility noted that resources going towards COVID-19 had actually

improved ART adherence, as a proportion of their HIV patient cohort were homeless, but emergency housing was made available as part of the COVID-19 response to stabilize their housing situation.

Other FY 2023 EHE progress includes:

- The Indigenous HIV/AIDS Syndemic Strategy (called "Indigi-HAS")
  - On December 1, 2022 (World AIDS Day) IHS and our tribal partners released a national Indigenous plan that weaves together three national strategies (1) The HIV National Strategic Plan for the United States: A Roadmap to End the Epidemic 2021-2025; (2) The Viral Hepatitis National Strategic Plan: A Roadmap to Elimination 2021-2025; and (3) The Sexually Transmitted Infections National Strategic Plan. Along with other HHS Agencies, IHS refers to these epidemics as "The syndemic." This Indigenous pathway – complementary to the national strategies – allows Indigenous stakeholders to formulate their own response to the syndemic in their communities by incorporating local governance and Indigenous knowledge. As members and leaders of our Indigenous communities, IHS will encourage the Indigi-HAS as a process-based roadmap for all stakeholders to guide the development of policies, services, programs, initiatives, and other actions to achieve the nation's vision of ending the syndemic by 2030.
  - IHS, the Northwest Portland Area Indian Health Board (NPAIHB), Native Hawaiian health care agencies, Cardea Services, and our tribal and urban Indian health partners combined energies to align the Indigi-HAS with the national strategies and maintain a focus on the 4 pillars of Ending the HIV Epidemic: Diagnosis, Treat, Prevent, and Respond.
  - The Minority HIV/AIDS Fund provided the resources to develop and promote the Indi-HAS, and the White House Office of National AIDS Policy buoyed its development.
  - Indigi-HAS focuses on promoting a holistic approach that emphasizes the balance between the spirit, mind, emotions, body, and relationship with land, community, and all creation.
- IHS's Office of clinical and Preventive Services, Division of Clinical and Community Services (OCPS/DCCS) hired two full-time public health advisors for the National HIV/HCV/STI Program in August 2022, bringing the program staff to three (3). In addition, DCCS plans to use FY 2023 EHE funds to hire a data coordinator and two pharmacists to advise on treating and preventing HIV, HCV, and STIs. DCCS also plans to hire at least one Area Office HIV/HCV/STI coordinator. Total personnel costs is $1,450,000.
- DCCS plans to to host two national HIV/HCV/STI meetings annually to provide public health care information, clinical training, and data.
- DCCS plans an annual media campaign around HIV/HCV/STI diagnosis, treatment, prevention, and response.
- DCCS will spend the remaining funds on responding to HIV/HCV/STI outbreaks and special projects of national significance.

In FY 2024, IHS plans to add eight new FTEs to support the Ending the HIV Syndemic in Indian Country initiative from IHS headquarters and at least four IHS Area Offices.
Hepatitis C Virus (HCV) infections can result in illness varying in severity from mild (lasting a few weeks), to serious (a lifelong illness ending in death by liver failure). The likelihood of liver damage is related to the duration and severity of untreated infection. In 2019, CDC reported

1,657 new diagnoses of chronic HCV infection among AI/AN, for a rate of 86.7 per 100,000 the highest of race/ethnicity, and more than double the next highest group (34 per 100,000 among Whites). In the same year, acute HCV infection among AI/AN at 3.6 per 100,000 was more than double the next highest group (1.4 per 100,000 among Whites).[10] The IHS National Patient Information Reporting System (NPIRS) data identifies 29,803 IHS patients from 2005-2015 with HCV, and estimates nearly 200 new cases each year; 53.4 percent were among persons born 1945–1965[11]. The overall HCV burden was higher among males than females. This data does not include up to 50 percent of patients who remain undiagnosed. AI/AN people have the largest increase in liver and intrahepatic bile duct cancer compared to any other race/ethnic groups. IHS data also identifies fewer than 1,000 HCV patients currently undergoing treatment. HCV death rates among AI/ANs are more than twice the national average compared to other ethnic groups.[12]

The CDC and the U.S. Preventive Services Task Force (USPSTF) recommends that all persons born from 1945-1965 should be screened for HCV. The IHS has sustained a steady increase in HCV screening. The national recommendations since 2012 are to screen persons born 1945-1965, or 'baby boomers.' More recently, the IHS screening recommendations were expanded to all persons 18 years and older – called 'universal screening' – in large part because of data emphasizing the importance and effectiveness of early diagnosis, treatment, and cure.

IHS tracks both the baby boomers and universal screening measures nationally. For boomers, IHS screening coverage increased from 11 percent in 2012 to 66 percent in 2019. These improvements in screening go hand-in-hand with changes at I/T/U facilities. Many have added clinical 'reminders' to ensure that patients who have never been tested are offered an HCV test. Just as important, if a patient tests positive, I/T/U facilities can treat in-house, rather than referring out. Drugs for HCV treatment are free to IHS patients and treatment for most patients is simple enough (a course of 1-3 pills per day, for 8 to 12 weeks) that it can be done in primary care. This course of treatment has more than a 95 percent cure rate.

IHS aligned program initiatives with the National Viral Hepatitis Action Plan (NVHAP) 2017-2020, to eliminate new viral hepatitis infections, increase knowledge of hepatitis diagnoses, improve access to high quality health care and curative treatments, and eliminate stigma and *discrimination (HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.2 Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs Expand safe, high-quality healthcare options, and encourage innovation and competition, & Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health).* IHS clinical data shows that screening for HCV among AI/ANs born from 1945-1965, increased from 8 percent in 2012, to 65.6 percent in 2019. This achievement is due in part to the *integration of the Department's Strategic Plan Goal 4: Restore Trust and Accelerate Advancements in Science and Research for All* through the development of technical support tools like electronic health record (EHR) clinical reminders, publication of IHS policy guidelines for HIV and HCV, and creation of clinical linkages to care *(HHS Strategic Plan FY 2022-2026 Goal 4, Objective 4.3 Strengthen*

[10] Centers for Disease Control and Prevention. 2019 Viral Hepatitis Surveillance Report. https://www.cdc.gov/hepatitis/statistics/SurveillanceRpts.htm. Published July 2021.

[11] Reilley, B., Leston, J., Doshani, M. et al. Assessing Disparities in the Rates of HCV Diagnoses Within American Indian or Alaska Native Populations Served by the U.S. Indian Health Service, 2005–2015. J Community Health 43, 1115–1118 (2018). https://doi.org/10.1007/s10900-018-0528-7

[12] https://www.cdc.gov/hepatitis/statistics/2016surveillance/commentary.htm

*surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions, & Objective 4.4 Improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience* ). IHS anticipates higher costs associated with HCV care in FY 2022 and FY 2023 associated with the increased rate of diagnosis (based on increased screening of Baby-Boomers and women of reproductive age) and the substantially high cost of curative medications.

In FY 2019, IHS established universal screening for HCV for all patients over the age of 18 years at least once in their lifetime, followed by guideline-based treatment, as appropriate. IHS GPRA data shows a 2021 calendar year IHS universal screening rate of 49.6 percent (IHS user population, defined as all patients living in defined area serviced by the facility with two or more medical visits in the past three years, and 67.5 percent rate of "baby boomers" (those born 1945-1965). (*HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.2 Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs Expand safe, high-quality healthcare options, and encourage innovation and competition, & Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health*).

Hepatitis C FY 2023 Accomplishments: With EHE funds, IHS established a "special program of national significance," and in January 2023, funded the Sault Ste. Marie Tribe of Chippewa Indians (Michigan) with $100,000 to develop their HCV Elimination Program.

Sexually Transmitted Disease (STD) rates continue to rise in Indian Country, and recurrent STDs can increase the likelihood of HIV transmission. Arguably, one of the next public health emergencies will be responding to the increase in STIs. Even before the COVID-19 pandemic, sexually transmitted infection (STI) rates were on the rise. As IHS returns to pre-pandemic delivery of services, the ongoing upward trajectory of STIs is coming into focus. Syphilis is particularly worrisome because it can mimic other infections; some people do not even know they have it. Even among clinicians, knowledge of the disease is low. Congenital syphilis, which affects babies born to mothers who had the disease while pregnant, is also increasing. Gonorrhea and syphilis often present as co-morbid conditions with HIV diagnosis, particularly among men who have sex with men (MSM). Data show that the incidence rates of chlamydia and gonorrhea among AI/AN people are approximately four times that of whites, and AI/AN have the second highest overall rates for both conditions when compared to all other races and ethnicities.[13] Regional differences in STDs in Indian Country are also observed, and AI/AN youth and AI/AN women, particularly women of reproductive age, have a disparate and increased STD burden.[14] Recent and sustained outbreaks of syphilis have also been observed among AI/AN communities, some related to injection drug and methamphetamine use, and both are recognized risk factors for HIV transmission.

Based on preliminary 2021 CDC data, American Indian and Alaska Native (AI/AN) congenital syphilis rates are higher than other racial and ethnic groups. For example, in 2020, the primary and secondary syphilis rate for AI/AN females was 21.3 per 100,000 (vs. the White rate of 2.9). These disparities have led to concern within the Indian health system.

[13] https://www.cdc.gov/std/stats17/minorities.htm

[14] https://www.ihs.gov/sites/epi/themes/responsive2017/display_objects/documents/std/Indian_Health_Surveillance_Report_STD_2015.pdf

For AI/AN women, the incidence of primary and secondary syphilis in 2019 was three-fold higher than that for non-Hispanic White women (15.4 vs. 2.3 per 100 000). Congenital syphilis cases among AI/AN were higher than for any other race or ethnicity in the US, increasing from 10.7 cases per 100 000 in 2015 to 154.9 per 100 000 in 2019, a 1348 percent increase. These disparities have led to concern within the Indian health system and IHS HIV/STI/HCV team.

Since April 2022, IHS representatives have visited 5 Phoenix Area, 7 Great Plains Area, 5 Billings Area, and 6 Bemidji Area sites. All but three sites noted a serious concern with syphilis and congenital syphilis. During the visits, the IHS staff and representatives collected data to generate a list of best practices. Then, they synthesized these practice responses with peer-reviewed best practices to create guidelines for IHS sites with increasing syphilis rates.

Strategies and activities developed include:

- Improving syphilis surveillance and outbreak response with stronger state collaboration;
- Creating disease intervention services capacity within local clinics and communities;
- Increasing access to presumptive treatment for symptomatic persons and sexual contacts;
- Improving clinical practices by optimizing electronic health records with automated screening reminders and treatment flags;
- Expanding access to testing beyond routine clinic appointments;
- Tailoring interventions to the different outbreaks (by priority populations); and
- Expanding partnerships.

In addition, sites need tailored interventions to rapidly reach syphilis-positive people, such as field-based treatment of benzathine penicillin and health services for people who use drugs. The IHS team discussed reverse algorithm testing and rapid testing to expedite lab results and identify patients quickly for treatment. In addition, IHS suggested reassessment of listed penicillin allergies to increase support for field treatment.

Specific considerations are necessary to develop a syphilis elimination strategy within Indian Country. In addition, IHS representatives identified a further need for support of actions developed within Indian Country to reach those most affected by the current increase in syphilis: women, people who use drugs, and pregnant people.

<u>Special Consideration Notes</u>

- While the IHS has made some progress towards the EHE goals, the agency will not meet these goals unless the agency:
  - Adopt policies and procedures that eliminate the lag time in onboarding Headquarter, Area, Service Unit, and facility-level positions that provide seamless access to diagnosis, prevention, treatment, and response to the syndemic and its accompanying social determinants of health;
  - Adequately address the broader STI and Substance Use Disorder (SUD) disparities that drive the HIV epidemic; and
  - Intentionally adopt policies that support trans and gender affirming medical care.

FY 2023 Accomplishments:

- IHS HIV/STI/HCV Program has been following syphilis and HIV in the Great Plains and Billings Areas over the summer of 2022. In the week of October 10th, there were 11 new cases of primary and secondary (5) and latent (6) syphilis in Roosevelt County/Fort Peck in Montana. Year to date, there have been 65 latent and 47 primary and secondary cases in Roosevelt County/Fort Peck. In a follow up conversation with the Community Health

Nurse at Fort Peck, IHS discovered that 3 of the cases were congenital stillbirth deaths. From a visit to Fort Peck in July of 2022, IHS identified that Community Health Nursing was very understaffed and they do not have access to everything they need for increasing screening and treatment. IHS also know there is a very real gap in prenatal care access for pregnant people in Billings and Great Plains Areas.

After a series of site visits FY 2022, the IHS National HIV/HCV/STI Program volunteered their Public Health Advisor, Andrew Yu, RN, to remain on site at the Ft. Peck Reservation in Montana for two weeks to help organize and deliver a community-wide syphilis screening and treatment effort.

- Adopt an agency-wide, national express STI On-Demand Testing policy.

FY 23 and FY24 plans include:

- Indigenous I Want The Kit
  - IHS partners with the Northwest Portland Area Indian Health Board and Johns Hopkins University to provide access to free self-administered sample collection with laboratory testing for STI screening to Native communities with plans to reach all 50 states by 2025.
  - The website I Want The Kit (IWTK) (https://iwantthekit.org/), developed by Johns Hopkins University, provides confidential, home-based access to STI/HIV testing. Individuals visiting iwantthekit.org can order self-administered sample collection kits for chlamydia, gonorrhea, and trichomonas, and self-screening kits for HIV testing. All testing kits are provided free of charge (due to support by relevant grant funding) and arrive in a discrete package in the mail along with a postage-paid return envelope. Individuals access their confidential results for chlamydia, gonorrhea, and trichomonas on the website and are referred to treatment at their clinic of choice if indicated. In addition, the Johns Hopkins Center for Indigenous Health assessed the feasibility and acceptability of self-administered STI screening among young adults in a tribal community in Arizona. 14 results demonstrated high feasibility and acceptability: 88 percent stated self-collection was comfortable and easy to use; 69 percent preferred the self-administered method over venue-based screening; 75 percent would encourage their friends to use this method; and 100 percent would use it again. Notably, 44 percent of this sample tested positive for at least one STI, underscoring the urgency for non-clinic-based STI self-testing alternatives for Native communities.
  - Individuals who request an HIV test complete the OraQuick self-screen. The testing kit provides results within 20 minutes of sample collection. Testing guidelines suggest participants with a positive result complete a confirmatory test at their local provider's office.

Domestic Violence Prevention (DVP) Program – Domestic and intimate partner violence has a disproportionately large impact on AI/AN communities. According to a 2016 report by the National Institute of Justice,[15] more than four in five AI/AN women (84.3 percent) have experienced violence in their lifetime. In fact, Data from the National Institutes for Justice and the

[15] https://www.ncjrs.gov/pdffiles1/nij/249736.pdf

Center for Disease Control show that more than 1.5 million American Indian and Alaska Native women have experienced violence, including sexual violence in their lifetimes[16] with 66.4 percent of AI/AN reported having experienced psychological aggression by an intimate partner. Intimate partner violence is preventable and many of the projects supported by the DVP program address this public health problem.

The DVP program was established in 2015, as a nationally coordinated program that provides culturally appropriate domestic violence and sexual assault prevention and intervention resources to AI/AN communities with a focus on providing trauma informed services. In FY 2022, the IHS awarded $7,400,000 in funding for the DVP grant program. This new five-year cohort will support thirty-seven (37) Tribal, Tribal organization, and Urban Indian Organization projects. The IHS also awarded $1,000,000 in funding for a new grant program for Forensic Health Care (FHC) services. This five-year cohort will support four Tribal, Tribal organization, and Urban Indian Organization facilities in the advancement of their forensic services. The DVP program supports HHS *Goal 3: Strengthen Social Well-Being, Equity, and Economic Resilience, Objective 3.4: Increase safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence.*

1. IHS currently funds 37 DVP grants that focus on supporting the development and/or expansion of a current program by incorporating prevention efforts addressing social, spiritual, physical, and emotional well-being of victims through the integration of culturally appropriate practices and trauma-informed services for Tribes, Tribal organization and UIOs. This program aims to promote prevention efforts that address domestic and sexual violence, including sexual exploitation and human trafficking, and child maltreatment.

DVP program achievements from the previous cohort include increased number of tribal communities that developed coordinated community responses through the integration of traditional healing, faith-based and culturally competent services. This program is unique in that while a majority of projects (80.5 percent) implemented one evidence-based practice, they also emphasized the importance of community and culturally based, projects. Disseminating lessons learned and best practices is a priority and prior to the Domestic Violence Prevention Program and IHS anticipates hosting a platform for monthly collaborative learning session to make available as spotlight videos available on-demand[17]. In FY 2022, IHS released a series webinars focused on prevention, services and resources for victims of domestic violence and sexual assault.

The Forensic Health Care (FHC) program established in 2009 has developed multiple policies within the Indian Health Manual to increase recognition of and prevention of sexual assault and child maltreatment (all forms including sexual abuse). The FHC team works with the DVP program to enhance intimate partner violence efforts, and strategy and resources to address human trafficking. The FHC program currently funds 4 grants that focus on providing access to treatment for AI/AN victims of domestic and sexual violence by supporting the development of and/or expansion of FHC services that are culturally appropriate and trauma-informed. The intent is to impact FHC services provided by Tribes, Tribal organizations, and UIOs, which also includes promoting treatment, intervention, and prevention efforts for the social, spiritual, and emotional well-being of victims, including victims of child maltreatment.

[16] https://www.whitehouse.gov/presidential-actions/missing-murdered-american-indians-alaska-natives-awareness-day-2019/

[17] https://www.youtube.com/watch?v=UZ9FkcO843E

The FHC team provides subject matter expertise and high-quality staff training, assistance to local facilities to create or sustain appropriate acute forensic care services, and strengthen on-going comprehensive services that enhance survivor healing. In November 2022, the Division of Nursing Services (DNS) filled the National Forensic Nurse Consultant position. The Forensic Nurse Consultant coordinates policy development, planning, including training, education, and provides technical assistance for forensic nurses and other stakeholders working throughout Indian Country. DNS updated the position description for the Forensic Nurse Coordinator and this position is projected to be filled in FY 2023. The Forensic Nurse Consultant and the Forensic Nurse Coordinator will work in tandem to provide training, education, and technical assistance, and assist in providing forensic healthcare services and support for patients who have experienced violent crimes such as sexual assault, sexual abuse, intimate partner and domestic violence, human trafficking, elder abuse, and child maltreatment. The forensic nursing program will ensure I/T/U healthcare providers have the necessary training and education to care for patients, families, and communities affected by violence, and ensure patients have access to appropriate resources, such as patient-centered, trauma-informed medical forensic examinations, including additional pathways to connect with advocates and the criminal justice system.

The Division of Nursing Services Forensic Nurse Consultant announced a *Forensic Healthcare Funding Opportunity – Building Capacity to Develop and/or Expand Forensic Services*. The funding opportunity was made available to all federal IHS sites (e.g., IHS Service Units, IHS Clinics, or IHS hospitals), and was designed to support building a community's capacity by forensic nursing program development and/or expansion through training opportunities for healthcare providers. Funding will ensure services such as a medical forensic examination and resources are available to all individuals affected by violence in Native communities. A total of ten million dollars will be awarded to applicants over a five-year funding cycle. These funds will be dispersed to each of the awardees beginning in February, 2023.

The Indian Health Service (IHS) Forensic Healthcare Program was established by the Division of Behavioral Health in 2011 to address sexual assault, intimate partner violence, child sexual abuse, and elder maltreatment within American Indian and Alaskan Native (AI/AN) communities. The program, through a contract with the International Association of Forensic Nurses (IAFN), trained providers in medical forensic examinations, evidence collection techniques, and in developing a coordinated community response to address violence. The Division of Nursing Services will compete and reinstate the contract in 2023. This contract will allocate four million dollars over a five-year cycle, and will ensure programs and healthcare providers receive specialized training to care for patients who have experienced violent crimes such as sexual assault, sexual abuse, intimate partner and domestic violence, elder maltreatment, among other victimizations.

<u>National Community Health Aide Program (CHAP)</u>: provides a network of health aides trained to support licensed health professionals while providing direct health care, health promotion, and disease prevention services. These providers work within a referral relationship under the supervision of licensed clinical providers that includes clinics, service units, and hospitals. The program increases access to direct health services, including inpatient and outpatient visits through a focus on primary, emergency, behavioral, and dental health to equip Tribal communities with a network that expands the system of care and aids in the mobilization of healthcare in America's most rural and remote communities where access to care is few and far in between. In 2016, the IHS begun the efforts to expand the program nationally and in July 2020, the IHS announced the policy that formally established the national CHAP which sees to the use of health aides in the field of primary care, behavioral health, and oral health. In January 2022, the Division of Clinical and Community Services hired the Community Health Aide (CHA)

Specialist to support the development of the CHA workforce. *(HHS Strategic Plan FY2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Health Care, Objective 1.3.Expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while recognizing social determinants of health & Objective 1.5 Bolster the health workforce to ensure delivery of quality services and care*).

<u>Maternal Health - Obstetrics</u>

In the OIG Report, dated 09/08/2020; OEI-06-19-00190: Instances of IHS Labor and Delivery Care Not Following National Clinical Guidelines or Best Practices, three final recommendations were made as follows:

1. Assess labor and delivery practices and consider practice improvements
2. Ensure that IHS providers employ best practices in diagnosing and treating postpartum hemorrhage
3. Encourage and support greater adoption of Alliance for Innovation on Maternal Health (AIM) bundles of maternal-safety best practices

To provide the safest care possible, IHS and Tribal sites have engaged in implementation of the Alliance for Innovation on Maternal Health (AIM) bundles, with an early emphasis on implementation of the Obstetric Hemorrhage and Hypertension bundles and other bundles as prioritized by the individual sites. Limitations on data sharing have precluded full AIM enrollment for IHS and Tribal hospitals but all sites performing planned births are otherwise engaged in AIM quality improvement efforts and in their respective State Perinatal Collaboratives where available.

Some facilities, particularly the more rural or remote sites without a planned birthing unit, or those sites with planned birth units but low volume and/or delayed transport may be faced with additional challenges in obstetrical emergency preparedness. There is currently a large body of evidence surrounding implementation of simulation drills for obstetrical emergency preparedness and thus sites are encouraged to engage in regular simulation training. Many IHS clinicians have completed the Advanced Life Support in Obstetrics (ALSO) course, and ALSO courses are offered regularly at regional sites across the I/T/U system. IHS' Division of Nursing Services has purchased and disseminated 50 childbirth simulation models for use in these emergency drills and in conducting local ALSO courses to enhance obstetric readiness. Further support of rural Emergency Departments (E.D.s) to ensure obstetric readiness includes working closely with individual facilities to develop and support appropriate staff training and ensuring access to necessary supplies and equipment. IHS is working with tertiary care facilities to provide telehealth support via video link for E.D.s without on-site maternity care providers. IHS piloted an Obstetric Readiness in the Emergency Department simulation training program for 100+ staff at Phoenix Indian Medical Center (PIMC) resulting in increased staff confidence with management of obstetric emergencies. IHS will standardize this training in collaboration with other Areas and scale up to provide low resource high yield training at additional sites. This simulation program is following the Emergency Medicine principles of quality improvement, emphasizing attention to tools, training, and tracking.

IHS has supported self-efficacy in prenatal care and provided glucometers, continuous glucose monitors (CGMs), and blood pressure cuffs when indicated. A recent MCH initiative will increase blood pressure cuff access for many more prenatal patients. 825 automatic blood pressure cuffs were purchased and provided to several service units for patient home use and monitoring. Providing these cuffs to patients helps to increase access to care by removing barriers such as transportation and/or childcare. IHS will continue to explore partnerships with the Pre-

Eclampsia Foundation in order to facilitate greater access to self-monitored blood pressure equipment throughout Indian Country.

IHS has had a consultative relationship with the American College of Obstetricians and Gynecologists (ACOG) Committee on American Indian and Alaska Native Women's Health for over 50 years. ACOG provides quality-benchmarking site visits, guidance on maternity care and women's health best practices, and ongoing training for IHS, Tribal, and Urban staff. ACOG, along with the Canadian SOGC, sponsors a biennial "Meeting on Indigenous Women's Health" which provides an important forum to address common themes and share solutions. The ACOG Committee work includes liaisons from the American College of Nurse Midwives (ACNM), the American Women's Health, Obstetric, and Neonatal Nurses (AWHONN) and the American Academy of Pediatrics (AAP).

Current maternal-child health efforts support the Indian Health Service (IHS) strategic plan and Goal One: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people; to (1.1) Recruit, develop, and retain a dedicated, competent, and caring workforce, to (1.2) Build, strengthen, and sustain collaborative relationships and to (1.3) Increase access to quality health care services. Specifically, utilizing these funds for access to enhanced training will improve provision of maternity care services in rural areas, with the aim of reducing maternal morbidity and mortality. The efforts also align with ASFR-identified Priorities of emergency preparedness, equity, and maternal health, and the HHS strategic plan Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare and Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes.

Breastfeeding

All federal hospitals providing planned birth services have earned the "Baby Friendly" designation by Baby-Friendly USA. Comprehensive breastfeeding education and continued lactation support are mainstays of this designation. The Baby Friendly Hospital designation ensures education is provided during prenatal care and lactation support is routinely offered throughout the hospital stay and postpartum. IHS further promotes breastfeeding opportunities through the Baby Friendly Hospital Initiative, building organizational capacity and practice-based resources, developing partnerships to advance breastfeeding, and incorporating breastfeeding into its robust public health programs. Breastfeeding education has also been included in many trainings offered to IHS, Tribal, and Urban Health staff, including those offered in partnership with the ACOG Committee on American Indian and Alaska Native Women's Health.

Baby-Friendly hospital designation naturally leads to education and support of breastfeeding to become engrained in daily operations of the hospitals. Education on early warning signs, how to recognize these warning signs, when to return to care, whether that should be for routine or emergent care, and information on a large network of resources available for new mothers are important pieces of this breastfeeding support post-discharge. In addition to efforts specifically related to maintaining the BF Hospital designation, IHS continues to monitor Government Performance and Results Act (GPRA) rates and several sites have initiated intensive QI projects around breastfeeding. IHS has built partnerships between Tribes and the AIM Community Care Initiative (AIM CCI), and has enjoyed a long standing partnership with the American Academy of Pediatrics-Committee on Native American Child Health (CONACH) and works closely with these entities in implementation of any recommendations to improve infant feeding outcomes and resultant child health indicators.

IHS partners with Tribes, urban Indian organizations, and local and state governments in order to ensure comprehensive, culturally appropriate lactation services are provided for the American Indian and Alaskan Native women and families served. One example includes linking patients with postpartum resources available to them after discharge, which include a variety of ways to access support, online, by phone, or in person including home visitation programs. Postpartum visits are also offered by public health/community health programs in many communities; offering 1:1 assistance and support, in home, which helps to remove access to care barriers such as transportation or child care for other children, and also helps to ensure cultural sensitivity for those patients practicing traditional beliefs and customs surrounding childbirth. Several certified lactation consultants and counselors are employed by IHS, and sites have offered incentives for this continued education and certification. Referrals can be placed by the public health/community health programs for additional lactation support or other resources as needed.

IHS offers resources about breastfeeding promotion and support on the Baby Friendly webpage. This public facing page is available on the general website for patients, staff and other interested individuals to access freely. The page includes information about breastfeeding promotion and support, standard of care, breastfeeding benefits, common problems, clinical challenges, and a toolkit on providing education on breastfeeding.

The Baby Friendly designation efforts support IHS Strategic Plan Goal One: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people, and HHS Strategic Plan Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes.

Alzheimer's and Elder Care

According to the CDC, Alzheimer's disease was the 6th leading age-adjusted cause of death in the U.S. population and the 11th cause of death for American Indian and Alaska Native populations in 2018.[18] As many as one in three American Indian and Alaska Native people age 65 and older will develop dementia in their lives.[19] By 2060, the number of Alzheimer's and related dementias (ADRD) cases is predicted to more than double to an estimated 14 million people, with minority populations being affected the most.[20] A five-fold increase in cases among American Indian and Alaska Native people are projected from 2015 to 2060. However, as many as six in 10 older American Indian, Alaska Native, Hispanic, and other historically underserved groups with probable dementia remain either undiagnosed or are unaware of their diagnosis.[21]

The GAO estimates 9.3 percent of the IHS total service population was age 65 and older,[22] and IHS reports a most recent total user population of 2.7 million.[23] This yields an older adult cohort

[18] Heron M. Deaths: Leading causes for 2018. National Vital Statistics Reports; vol 70 no 4. Hyattsville, MD: National Center for Health Statistics. 2021. DOI: https://doi.org/10.15620/ cdc:104186.
[19] Mayeda, E. R., Glymour, M. M., Quesenberry, C. P., & Whitmer, R. A. (2016). Inequalities in dementia incidence between six racial and ethnic groups over 14 years. Alzheimer's & dementia : the journal of the Alzheimer's Association, 12(3), 216–224. https://doi.org/10.1016/j.jalz.2015.12.007
[20] Alzheimer's Association, 2022. Alzheimer's Disease: Fact and figures. Special report more than normal aging: Understanding mild cognitive impairment.
[21] Amjad, H., Roth, D. L., Sheehan, O. C., Lyketsos, C. G., Wolff, J. L., & Samus, Q. M. (2018). Underdiagnosis of Dementia: an Observational Study of Patterns in Diagnosis and Awareness in US Older Adults. Journal of general internal medicine, 33(7), 1131–1138. https://doi.org/10.1007/s11606-018-4377-y
[22] U.S. Government Accountability Office, 2018. Indian Health Service: Spending levels and characteristics of IHS and three other federal health care programs. https://www.gao.gov/assets/gao-19-74r.pdf
[23] Indian Health Service, 2022. Justification of estimates for appropriations committees. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2023BudgetJustificaton.pdf

numbering in the hundreds of thousands within IHS service areas, and likely tens of thousands of older Native people potentially living with diagnosed or undiagnosed dementia. A collaborative effort with the IHS Division of Epidemiology and Disease Prevention, CDC, and Alzheimer's Association to document dementia incidence and prevalence from the IHS National Data Warehouse is underway, with an anticipated peer-reviewed journal submission in FY 2023. Preliminary analysis indicates that ADRD is underdiagnosed and/or underdocumented across the I/T/U system relative to existing population-specific and national data. Other population-specific data is sparse and data limitations exist. Among American Indian and Alaska Native Medicare Fee-for-Service beneficiaries age 65 and older, the unadjusted prevalence of ADRD was 10.5 percent in 2014. According to the Alzheimer's Association, the current prevalence of dementia is 11 percent for all people age 65 and older. The percentage of people with ADRD increases with age, with up to 33.2 percent of people age 85 and older in the U.S. living with ADRD.[24] The age-adjusted annual incidence (new cases) of dementia among American Indian and Alaska Native people in a large insured population aged 60 years and older in California was 2.22 percent (22.2/1,000), second only to African Americans in that study.[25]

It is widely acknowledged that Native people are less likely to have access to timely and accurate diagnosis or access to specialty services to support diagnosis and management. This is a problem made worse by fear, stigma, discrimination, lack of awareness, and cultural misinterpretations about the disease symptoms.[26] Proper screening and diagnosis of ADRD with linkages to treatment and care for associated behavioral symptoms, education, support, and care planning for both patients and their caregivers are crucial to achieving improved outcomes and quality of care for older Native people. Although the U.S. is making progress, significant challenges remain. Gaps in the ADRD care continuum contribute to a hastening of poor health, social, spiritual, and financial outcomes for American Indian and Alaska Native people, their caregivers, and communities. This includes a lack of prevention for crisis-driven care, including preventable hospitalizations, which is a key goal of care for persons living with dementia.

Not only does ADRD take a significant toll on the person diagnosed with the disease and their caregiver(s), it is costly to the U.S. and Tribal-serving health systems. According to the Alzheimer's Association, average per-person Medicare spending for older adults with ADRD is more than three times higher than average per-person spending for all other older adults. Under Medicaid, spending is, on average, more than 23 times higher. An analysis of 2013 Indian Health Service data found that the average treatment costs for adults with dementia are significantly higher than costs for adults without dementia. Total treatment costs for adults with dementia were $13,027 in a single year, which is $5,400 higher than for adults without dementia. The majority of excess costs were attributed to differences in hospital inpatient costs.[27] Native adults with dementia also have a higher prevalence of costly co-occurring chronic conditions that yield higher overall costs and increase the complexity of care. These costs will increase as the

[24] Alzheimer's Association, 2022. 2022 Alzheimer's Disease facts and figures. More than normal aging: Understanding cognitive impairment. https://www.alz.org/media/Documents/alzheimers-facts-and-figures.pdf
[25] Mayeda, E.R., Karter, A. J., Huang, E.S., Moffet, H.H., Haan, M.N., Whitmer, R.A, 2014. Racial/Ethnic differences in dementia risk among older type 2 diabetic patients: The Diabetes and Aging Study. Diabetes Care. 37 (4): 1009–1015. https://doi.org/10.2337/dc13-0215
[26] Alzheimer's Association, 2021. Race, Ethnicity, and Alzheimer's in America. https://www.alz.org/media/Documents/alzheimers-facts-and-figures-special-report.pdf
[27] O'Connell, J., Grau, L., Goins, T., Perraillon, M., Winchester, B., Corrada, M., Manson, S. M., & Jiang, L. (2022). The costs of treating all-cause dementia among American Indians and Alaska native adults who access services through the Indian Health Service and Tribal health programs. Alzheimer's & dementia : the journal of the Alzheimer's Association, 18(11), 2055–2066. https://doi.org/10.1002/alz.12603

population of older American Indian and Alaska Native people increases in the coming decades, to a projected doubling by 2060. [28]

In 2022, the federal National Alzheimer's Project Act (NAPA) added a new goal to reduce the risk of dementia, now recognizing that cognitive impairment begins earlier in life. According to the CDC, one in five American Indian and Alaska Native people over age 45 report symptoms of subjective cognitive decline (SCD), an early sign of progressive memory loss. This compares with one in nine in the U.S. population.[29] At the same time, eleven of the most common conditions and risk factors for ADRD disproportionally affect younger Native people, such as diabetes, hypertension, hearing loss, traumatic brain injury, and physical inactivity. Among type 2 diabetic patients followed for 10 years, African American and Native American people had a 40–60 percent greater risk of dementia compared with the Asian population, and a rate higher than for non-Hispanic Whites and Latinos.[30] A recent CDC study examined how common eight modifiable dementia risk factors were among adults 45 years and older. American Indian and Alaska Native populations had the highest and second highest prevalence of six modifiable risk factors among all groups studied. Native people were second only to people who identify as multi-racial in the prevalence of reported depression.[31]

For FY 2021, IHS received first-time appropriations of $5 million to address ADRD. The funding increased to $5.5 million in both the FY 2022 and FY 2023 budgets. This marks the first time IHS allocated funds for this critical need. Tribal consultation and Urban confer, initiated by IHS in FY 2021, elicited Tribal leader feedback on Alzheimer's and dementia priorities. A Dear Tribal Leader and Urban Indian Organization Leader Letter posted on the IHS website on March 24, 2022, announcing the IHS funding decisions.

Subsequently, the new IHS Alzheimer's Program was established within the Division of Clinical and Community Services (DCCS) in the Office of Clinical and Preventive Services (OCPS). Pursuant to the FY 2021 Consolidated Appropriations Act, the IHS established the Alzheimer's Grant Program to target resources directly to Tribes, Tribal organizations, Urban Indian organizations, and IHS direct service hospitals and clinics. The Alzheimer's Program is also developing initiatives to support workforce development, education, and training aimed at improving the diagnosis and management of dementia and developing caregiver support services, and efforts to increase awareness and recognition.

As part of new program development efforts, the IHS remains committed to partnering with agencies across the federal government and non-governmental organizations to address ADRD. Three program goals guide this new work:

1. Achieve alignment in support of NAPA's National Plan to Address Alzheimer's, Healthy Brain Initiative Road Map for Indian Country (RMIC), and the IHS agency strategic plan.
2. Develop and support multi-disciplinary, cross-divisional, and external federal and public-private initiatives that promote healthy aging across the lifespan and reduce common risk

[28] O'Connell, J., Grau, L., Goins, T., Perraillon, M., Winchester, B., Corrada, M., Manson, S. M., & Jiang, L. (2022). The costs of treating all-cause dementia among American Indians and Alaska native adults who access services through the Indian Health Service and Tribal health programs. Alzheimer's & dementia : the journal of the Alzheimer's Association, 18(11), 2055–2066. https://doi.org/10.1002/alz.12603

[29] Centers for Disease Control and Prevention, (n.d.). Subjective Cognitive Decline Infographic. https://www.cdc.gov/aging/data/infographic/index.html

[30] Mayeda, E.R., Karter, A. J., Huang, E.S., Moffet, H.H., Haan, M.N., Whitmer, R.A, 2014. Racial/Ethnic differences in dementia risk among older type 2 diabetic patients: The Diabetes and Aging Study. Diabetes Care. 37 (4): 1009–1015. https://doi.org/10.2337/dc13-0215

[31] Omura J.D., McGuire L.C., Patel R., et al., 2019. Modifiable risk factors for Alzheimer disease and related dementias among adults aged ≥ 45 years—United States. MMWR Morb Mortal Wkly Rep. 2022;71:680–685. DOI: http://dx.doi.org/10.15585/mmwr.mm7120a2

factors for chronic diseases, including dementia and Alzheimer's, and other illnesses and injuries for AI/AN elders.

3. Enhance the skills, competency, capacity, and knowledge of the I/T/U workforce to provide culturally relevant geriatric and dementia care, enabling timely and high quality support for elders and their family members for the spectrum of elder health and healthy aging issues.

Program Infrastructure Accomplishments

- With the combined FY 2021 and FY 2022 Congressional allocation, DCCS onboarded two public health advisors for the new Elder Health team in late FY 2022. An additional management analyst position (in process) with an anticipated FY 2023 hire date will bring the team to three (3) full-time equivalents.
- The IHS Chief Medical Officer announced a Memorandum of Understanding with the Alzheimer's Association in 2022 to identify areas of collaboration to improve health and well-being of AI/AN people living with ADRD and their caregivers. In FY 2023, the MOU was extended to 2027.
- The Alzheimer's Program represented IHS and supported development of an update to the 2022 annual release of the HHS *National Plan to Address Alzheimer's Disease*: *22, RAISE Council National Strategy to Support Family Caregivers* report, and participated on ACL's Elder Justice Interagency Workgroup, Council for Grandparents Raising Grandchildren, NAPA Council, and CDC's leadership committee for the National Healthy Brain Road Map.

Alzheimer's Grants and Program Awards Accomplishments

- In FY 2022, IHS established the Alzheimer's Grant Program, receiving and funding all four first-time proposals for two year cooperative agreements totaling $1.3M. These funds support the development of comprehensive and sustainable clinical models and promising practices addressing ADRD in Tribal and Urban communities. FY 23 and FY 24 funding will continue to support the grantees.
- In FY 23 and FY 24, established technical support for awardees will continue, incorporating monthly and in-person peer-to-peer learning collaborative approaches.

Training, Education and Technical Assistance Accomplishments

- In FY 2022, 19 Indian Health Geriatric Scholar (IH GeriScholars) pilot award recipients were accepted into the inaugural class of a program modeled on and being developed in conjunction with the VA Office of Rural Health. IH GeriScholars represent nine IHS regions, 12 states, and a range of clinical disciplines, including physicians, nurse practitioners, physician assistants, and pharmacists. Sixteen scholars completed geriatric and palliative care training programs and proceeded to identify local elder-focused quality improvement projects with intensive technical assistance and support from IHS. In FY23 and FY 24, new cohorts of IH Geri Scholars will be established.
- In FY 2022, a multi-year collaboration with the IHS Division of Nursing Services on the Geriatric Emergency Department Accreditation (GEDA) initiative resulted in nine final applicants.
- In FY 2023, Alzheimer's Program staff began a collaboration with the IHS Division of Oral Health to provide training and technical assistance for a six-month small-scale dementia screening pilot that includes five IHS and Tribal dental sites. In FY 2024, expansion of the pilot is anticipated.
- In FY 2023, Alzheimer's Program staff will initiate two new Dementia teleECHO (ECHO) series in partnership with the Indian Country ECHO program of the Northwest

Portland Area Indian Health Board. The program will provide clinical training and support case-based education and mentorship for I/T/U staff providing clinical care and caregiver support. ECHOs are an evidence-based approach to clinical training and support. In FY 2024, the ECHOs will continue.

- In FY 2023, acquisition planning is underway to support a national training and education initiative for I/T/U staff to include support for existing and planned dementia workforce development efforts for providers, nurses, public health, and community health staff. Funding opportunity announcement is planned for May 2023.
- In FY 2023, a multi-disciplinary internal working group is planned to identify, assess, and prioritize existing evidence-based dementia caregiver support interventions and programs based on usability and adaptability for I/T/U programs. Results from the FY 2023 working group will inform FY 2024 special projects.
- In FY 2023 and FY 2024, a brief series of IHS sponsored publicly available webinars will highlight successful approaches to dementia care and management.
- Planning and collaboration is underway for FY 2023 and FY 2024 meetings for Alzheimer's Program awardees and I/T/U staff to promote peer-to-peer learning, collaboration, training, and sharing of promising dementia practices.

Outreach to Increase Community Recognition of Dementia

- In FY 2023, culturally relevant National Caregiver month social media resources were developed, with future plans (including FY 2024) for content creation and dissemination for 10 new national observances for older adults and caregivers, including three specific to ADRD.
- In FY 2023, acquisition planning is underway to support Alzheimer's Program communications start-up, development, support, and resource creation. Funding opportunity announcement is planned for May 2023.
- In FY 2023, Mini-Cog dementia screening tool lunch and learn webinars were successfully piloted with oral health pilot participants, IH Gerischolars, and Alzheimer's grantees to increase screening and early recognition of signs and symptoms of ADRD as screening triggers. Staff will support the continuance of the early recognition trainings in FY 2024.
- In FY 2023, the IHS Alzheimer's webpage received updates to the existing structure and content, and page content was elevated to a separate program site within the IHS web architecture, with plans for additional content creation in FY 2023 and 2024.
- In FY 2023, conducted five presentations about dementia and the IHS Alzheimer's Program efforts. Staff will continue to provide presentation in FY 2024.
- In FY 2023, IHS Listserv technology was modified to enhance dissemination opportunities and create individual communities of practice among IHS program participants, that resulted in a nearly 60 percent increase in subscribers since November, 2022. Continued expansion of participants is planned for FY 2024.

Data to Inform Program Priorities and Improve Clinical Care

- In FY 2023, work will continue on development and peer-reviewed publication of a journal article identifying dementia incidence and prevalence rates from IHS data sources, developed in collaboration with IHS, CDC, and Alzheimer's Association staff.
- In FY 2023, research and development is underway to inform creation of an Alzheimer's and Elder Care Data Dashboard and inform older adult health priorities in the IHS EHR Modernization efforts. Aim to have the dashboard public facing in FY 2024.

- In FY 2023, new processes to facilitate the collection and use of quantitative and qualitative data elements from Grant Program participants and other new and emerging Alzheimer's Program initiatives and activities are under development. These are designed to support evaluation, possible pilot expansions, increase evidence-based knowledge, and drive program enhancements, which will continue in FY 2024.

The proposed funding level directly supports IHS's efforts to provide high quality health care across the Indian health system, as well as supporting the *HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.2 Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health, Objective 1.5 Bolster the health workforce to ensure delivery of quality services and care, Objective 2.2 Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death, Objective 3.3 Expand access to high quality services and resources for older adults and people with disabilities, and their caregivers to support increased independence and quality of life, Objective 4.1 Improve the design, delivery, and outcomes of HHS programs by prioritizing science, evidence, and inclusion, and Objective 4.4 Improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience.*

Emergency Medical Services

The Indian Health Service (IHS) Emergency Medical Services for Children (EMSC) Program is working to expand and improve pediatric emergency care for American Indian and Alaska Native (AI/AN) children and youth. AI/AN children and youth are at greater risk for unintentional injuries which are the leading cause of mortality and morbidity in tribal communities. IHS EMSC Program and HRSA Maternal Child Health Bureau work collaboratively through an Inter-Agency Agreement (IAA) to bring resources, expertise and supported efforts to improve EMSC in IHS and Tribal Healthcare programs. This collaboration through the IAA ensures that quality pediatric emergency care and resources continue to be improved for and are accessible to AI/AN children and youth.

The IHS EMSC Program efforts align with IHS Strategic Plan *Goal 1: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people*. The IHS EMSC Program funds ($150,000) from the IAA between IHS and HRSA are put toward a contract with Children's Hospital of Philadelphia to set up a hybrid simulation training program. The hybrid simulation training program pairs emergency departments with Academic Medical Centers (AMCs) to implement a curriculum of in-person and tele-simulations to prepare emergency room physicians, nurses, ancillary staff, and pre-hospital EMS personnel to become competent in the care of children and newborns during pediatric emergencies. Each ED is partnered with an AMC Emergency Medicine physician(s) who volunteer to work with IHS and tribal ED staff to conduct simulations and share current and evidence-based practices. The participating EDs designated a Pediatric Emergency Care Coordinator (PECC), also known as Pediatric Champion, who coordinates and implements pediatric-specific activities such as pediatric care, education, and training; and will help ensure the sustainability of pediatric readiness efforts. The goal is to

replicate the hybrid simulation training program and develop the Pediatric Emergency Care Coordinator (PECC) role for all IHS emergency departments and pre-hospital EMS partners to ensure safe, high-quality emergency care and EMS transport.

**FUNDING HISTORY: IHS – HRSA INTERAGENCY AGREEMENT**

| Fiscal Year | Amount |
|---|---:|
| 2020 | $150,000 |
| 2021 | $150,000 |
| 2022 | $150,000 |
| 2023 | $150,000 |
| 2024 | $150,000 |

For fiscal years 2021 – 2023, the IHS EMSC Hybrid Simulation Program gained 13 participating IHS and tribal emergency departments (EDs), seven pilot sites in year one and six new sites in FY 2022-2023.

The IHS Hybrid Simulation Program pilot outcomes for 2022 were: 1) 100 percent compliance with curriculum by AMC-PECC dyads at 7 sites, 2) 100 percent PECC and AMC retention for FY 2022 – 2023, 3) A Net Promoter Score of 79/100 – participants would recommend the program to colleagues, 4) Demonstrated change in provider knowledge, attitudes, and teamwork during simulations, and 5) Obtained Pediatric Readiness Score for each site. IHS has also established partnerships with ten AMCs among the 13 participating EDs. The IHS EMSC Hybrid Simulation Program has had positive and direct impact to pediatric emergency care and met essential training needs during the COVID-19 pandemic. As newer public health threats evolved with Respiratory Syncytial Virus (RSV) and influenza (flu), the hybrid simulation program incorporated simulations to address bronchiolitis caused by the aforementioned viruses.

Pediatric investments in 2024 include expanding the IHS EMSC Hybrid Simulation Program to six more IHS/tribal emergency departments. Additional pediatric investments will also include pediatric-specific education and training for emergency department staff to acquire and maintain advanced certifications such as the Neonatal Resuscitation Program, Certified Pediatric Emergency Nurse, and Pediatric Advanced Life Support. Other important use of funds will be used for equipment and supplies to help provide specialized pediatric equipment for ambulance transports of pediatric and special needs infants and children. IHS will continue to engage and promote concerted outreach to IHS and Tribal sites to support their participation in National Quality Improvement Projects hosted by the EMSC Innovation and Improvement Center and the Regional Pediatric Pandemic Network – collaboratives include: the EMSC Mental Health QI Collaborative project, the EMSC Pediatric Readiness Quality Collaborative, the PECC Workforce Development Collaborative, the Disaster Networking QI Collaborative, and the ED STOP Suicide Collaborative.

Many EDs across IHS are serviceably unprepared to respond to pediatric emergency situations in rural areas. A joint policy statement and technical report from the American Academy of Pediatrics (AAP) and several other EMS agencies recommended the development of EMS infrastructure and oversight that includes evidence-based, pediatric-specific equipment, training, skills standards to support the care of pediatric patients[32].

[32] https://publications.aap.org/pediatrics/article/145/1/e20193308/36984/Pediatric-Readiness-in-Emergency-Medical-Services

**OUTPUTS/OUTCOMES**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| 20 100 percent of hospitals and outpatient clinics operated by the Indian Health Service are accredited or certified (excluding tribal and urban facilities). (Outcome) | FY 2022: 98 % Target: 100 % (Target Not Met) | 100 % | 100 % | Maintain |
| 44 Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native population (Outcome) | Discontinue | Discontinued | Discontinued | N/A |
| 45 Hospital admissions per 100,000 service population for long-term complications of diabetes (Efficiency) | Discontinue | Discontinued | Discontinued | N/A |
| 55 Nephropathy Assessed (Outcome) | FY 2022: 41.0 % Target: 43.7 % (Target Not Met) | 45.1% | 45.1% | Maintain |
| 56 Retinopathy Exam (Outcome) | FY 2022: 41.8 % Target: 41.2 % (Target Exceeded) | 44.7% | 44.7% | Maintain |
| 66 American Indian and Alaska Native patients, aged 19-35 months, receive the following childhood immunizations: 4 DTaP (diphtheria, tetanus, and acellular pertussis); 3 IPV (polio); 1 MMR (measles, mumps, rubella); 3 or 4 Hib (Haemophilus influenzae type b); 3 | FY 2022: 36.1 % Target: 47.8 % (Target Not Met) | 40.9% | 40.9% | Maintain |

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| HepB (hepatitis B); 1 Varicella (chicken pox); 4 Pneumococcal conjugate. (Outcome) | | | | |
| 67 Influenza Vaccination Rates among children 6 months to 17 years (Outcome) | FY 2022: 18.5 % Target: 29.7 % (Target Not Met but Improved) | 19.8% | 19.8% | Maintain |
| 68 Influenza vaccination rates among adults 18 years and older (Outcome) | FY 2022: 20.0 % Target: 28.0 % (Target Not Met but Improved) | 19.7% | 19.7% | Maintain |
| 69 Adult Composite Immunization (Output) | FY 2022: 36.1 % Target: 44.4 % (Target Not Met) | Discontinued | Discontinued | N/A |
| 70 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease among American Indians and Alaska Natives (Outcome) | FY 2022: 42.7 % Target: 40.6 % (Target Exceeded) | 37.8% | 37.8% | Maintain |
| 72 Tobacco Cessation Intervention (Outcome) | FY 2022: 25.0 % Target: 29.8 % (Target Not Met but Improved) | 24.4% | 24.4% | Maintain |
| 73 HIV Screening Ever (Outcome) | FY 2022: 38.0 % Target: 38.0 % (Target Met) | 38.9% | 38.9% | Maintain |
| 74 Breastfeeding Rates (Outcome) | FY 2022: 39.3 % Target: 42.0 % (Target Not Met but Improved) | 42.6% | 42.6% | Maintain |
| 75 Controlling High Blood Pressure - MH (Outcome) | FY 2022: 45.5 % Target: 40.9 % (Target Exceeded) | 45.8% | 45.8% | Maintain |
| 81 Increase Intimate Partner (Domestic) Violence screening among American | FY 2022: 28.3 % Target: 36.3 % | 29.6% | 29.6% | Maintain |

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| Indian and Alaska Native (AI/AN) Females (Outcome) | (Target Not Met but Improved) | | | |
| 87 Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. (Output) | FY 2022: 29.2 % Target: 39.7 % (Target Not Met but Improved) | 28.7% | 28.7% | Maintain |
| 88 Colorectal Cancer Screening Rate (Outcome) | FY 2022: 23.7 % Target: 23.7 % (Baseline) | 23.7% | 23.7% | Maintain |
| 89 Cervical Cancer Screening (Outcome) | FY 2022: 33.2% Target: 33.2% (Baseline) | 33.2% | 33.2% | Maintain |
| 91 Adult Composite Immunization (Output) | FY 2023: Result Expected Jan 31, 2024 Target: Set Baseline (Pending) | Maintain Baseline | Maintain Baseline | N/A |

**GRANT AWARDS -** H&HC funds support the Healthy Lifestyles in Youth Project,[33] a $1.3 million cooperative agreement with the National Congress of American Indians. This grant program promotes healthy lifestyles among AI/AN youth using the curriculum "Together Raising Awareness for Indian Life" at selected Boys and Girls Club sites across the country and represents responsiveness to Tribal input for more prevention activities.

H&HC also funds 83 DVP Program grants.

| *(whole dollars)* | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget |
|---|---|---|---|
| Number of Awards | 84 | 84 | 84 |
| Average Award | $148,207 | $148,207 | $148,207 |
| Range of Awards | $49,750-$1,250,000 | $49,750-$1,250,000 | $49,750-$1,250,000 |

**AREA ALLOCATION**

**Hospital and Health Clinics**

(dollars in thousands)

| DISCRETIONARY SERVICES | FY 2022 Final | | | FY 2023 Enacted /1 | | | FY 2024 Estimated /1 | | | FY '23 +/- FY '22 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Federal | Tribal | Total | Federal | Tribal | Total | Federal | Tribal | Total | Total |
| Alaska | $7,854 | 427,903 | $435,757 | $8,278 | 450,972 | $459,250 | $11,753 | $640,281 | $652,034 | $192,783 |
| Albuquerque | 55,429 | 39,202 | $94,631 | 58,418 | 41,315 | $99,733 | 82,940 | 58,659 | $141,599 | $41,866 |
| Bemidji | 24,913 | 104,644 | $129,557 | 26,256 | 110,286 | $136,541 | 37,277 | 156,581 | $193,859 | $57,317 |
| Billings | 56,858 | 19,001 | $75,859 | 59,924 | 20,025 | $79,949 | 85,078 | 28,431 | $113,510 | $33,561 |
| California | 6,086 | 90,065 | $96,151 | 6,414 | 94,921 | $101,335 | 9,106 | 134,767 | $143,873 | $42,538 |
| Great Plains | 150,355 | 50,601 | $200,956 | 158,461 | 53,329 | $211,790 | 224,979 | 75,715 | $300,694 | $88,905 |
| Nashville | 14,569 | 81,535 | $96,104 | 15,355 | 85,931 | $101,285 | 21,800 | 122,003 | $143,803 | $42,517 |
| Navajo | 200,495 | 89,899 | $290,394 | 211,304 | 94,746 | $306,050 | 300,005 | 134,519 | $434,524 | $128,473 |
| Oklahoma | 123,454 | 324,922 | $448,375 | 130,109 | 342,439 | $472,548 | 184,727 | 486,187 | $670,914 | $198,366 |
| Phoenix | 122,678 | 95,013 | $217,691 | 129,292 | 100,136 | $229,427 | 183,566 | 142,171 | $325,736 | $96,309 |
| Portland | 27,937 | 68,455 | $96,393 | 29,444 | 72,146 | $101,589 | 41,803 | 102,431 | $144,234 | $42,645 |
| Tucson | 2,482 | 24,250 | $26,732 | 2,616 | 25,557 | $28,173 | 3,714 | 36,286 | $40,000 | $11,827 |
| Headquarters | 166,383 | 0 | $166,383 | 175,353 | 0 | $175,355 | 248,963 | 0 | $248,965 | $73,609 |
| **Total, H&HC** | **$959,494** | **$1,415,490** | **$2,374,984** | **$1,011,222** | **$1,491,803** | **$2,503,025** | **$1,435,712** | **$2,118,030** | **$3,553,742** | **+$1,050,717** |

1/ Note: 2023 and 2024 are estimates.

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget /1 | FY 2024 +/- FY 2023 |
| PL | $2,374,984 | $2,503,025 | $3,553,742 | +$1,050,717 |
| *Epi Centers* | *$24,433* | *$34,433* | *$34,443* | - |

1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

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

**FY 2024 Authorization** ........................................................................................ Permanent

**Allocation Method**..................................................................................... Cooperative Agreements

**PROGRAM DESCRIPTION**

The Indian Health Service (IHS) Tribal Epidemiology Center (TEC) Program was first authorized by Congress in fiscal year (FY) 1992. The IHS program supporting TECs was first funded in FY 1996. The program was founded to develop public health infrastructure by augmenting existing Tribal organizations with expertise in epidemiology and public health via Epidemiology Centers. Funding is distributed to the TECs through cooperative agreements to Tribes and Tribal organizations such as Indian Health Boards.

The TECs play a critical role in IHS' overall public health infrastructure. Operating within Tribal organizations and governments, TECs are uniquely positioned to provide support to local Tribal disease surveillance and control programs, and assess the effectiveness of public health programs. All TECs monitor the health status of their constituent Tribes, produce a variety of reports annually or bi-annually that describe activities and progress towards public health goals, and provide support to Tribes who self-govern their health programs.

The TEC program funds eleven TECs that provide comprehensive geographic coverage for all IHS administrative areas and one additional TEC serving American Indian and Alaska Native (AI/AN) populations residing in major urban centers nationally. The IHS Division of Epidemiology and Disease Prevention (DEDP) functions as the national coordinating center and provides technical support and guidance to TECs. The DEDP and TECs collect, analyze, interpret, and disseminate health information in addition to identifying diseases to target for intervention, suggesting strategies, and evaluating the effectiveness of implemented health interventions. The TEC Program supports Tribal communities by providing technical training and assistance in applied public health practice and prevention-oriented research, and by promoting public health career pathways for Tribal members. Beginning in FY 2021, a significant portion of TEC activities have been devoted to supporting Tribes in confronting the COVID-19 public health emergency.

Annually, approximately 95 percent or more of the TEC Program budget is distributed to TECs through cooperative agreements based on a 5-year competitive award cycle. In the current 5-year award cycle beginning FY 2021, the average annual award across all 12 TECs was $699,073, increasing to $1,747,000 in FY 2022.

The TECs are fundamental to the IHS' partnership with Tribes through support for essential epidemiology and public health functions that complement direct healthcare services. Independent TEC goals are set as directed by their constituent Tribes and health boards. The DEDP tracks these goals and objectives as written in their cooperative agreements (e.g., surveillance of disease and control programs; collecting epidemiological data for use in determining health status of Tribal communities).

The TEC funds provide critical support in strengthening the collaborative partnerships among the 12 TECs' constituent AI/AN communities as a part of the Agency's work to address the HHS Strategic Plan 2022-2026 Objective 4.3 (Strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions).

The work of the TECs to collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the IHS, Indian Tribes, Tribal organizations, and urban Indian organizations in each IHS service area is an essential part of reducing health disparities in the AI/AN population by highlighting disparities in the AI/AN population so they can be addressed through Public Health efforts. This includes the significant and disproportionate impacts of many health conditions, including the COVID-19 pandemic, the Opioid crisis in Indian Country, and the epidemic of HIV/AIDS, HCV, and sexually transmitted infections in AI/AN communities. Significant improvements in reducing the burden of each of these and many other health disparities in this population strongly supports the HHS Strategic Goal 2: *Safeguard and Improve National and Global Health Conditions and Outcomes*.

**BUDGET REQUEST**

The FY 2024 budget submission for the TECs under Hospitals and Health Clinics (H&HC) is $34 million and is the same as the FY 2023 Enacted level.

The funding per TEC covers the salaries of a Director, staff epidemiologists, administrative assistance/support, evaluation capacity, Public Health response and collaboration capacity, comprehensive local Public Health planning efforts, special projects specific to disease states or local outbreaks, and the execution of additional pressing disparity projects or tribal priorities.

| **Tribal Epidemiology Centers and Locations** | | |
|---|---|---|
| 1 | Alaska Native Tribal Health Consortium | Anchorage, AK |
| 2 | Albuquerque Area Indian Health Board | Albuquerque, NM |
| 3 | Great Lakes Inter-Tribal Council | Lac du Flambeau, WI |
| 4 | Inter-Tribal Council of Arizona | Phoenix, AZ |
| 5 | Rocky Mountain Tribal Leaders Council | Billings, MT |
| 6 | Navajo Nation Division of Health | Window Rock, AZ |
| 7 | Great Plains Tribal Chairmen's Health Board<br>Northern Plains – Great Plains Area | Rapid City, SD |
| 8 | Northwest Portland Area Indian Health Board | Portland, OR |
| 9 | Southern Plains Tribal Health Board Foundation | Oklahoma City, OK |
| 10 | Seattle Indian Health Board | Seattle, WA |
| 11 | United South and Eastern Tribes, Inc. | Nashville, TN |
| 12 | California Rural Indian Health Board | Sacramento, CA |

## FUNDING HISTORY

| Fiscal Year | Amount* |
|---|---|
| 2020 | *$5,433,361* |
| 2021 | *$10,433,361* |
| 2022 Final | *$24,433,361* |
| 2023 Enacted | *$34,433,361* |
| 2024 President's Budget | *$34,433,361* |

*Funded under the Hospitals & Health Clinics budget.

## PROGRAM ACCOMPLISHMENTS

The TEC funds provide critical support in strengthening the collaborative partnerships among the 12 TECs, AI/AN communities, and the IHS. Below are key TEC activities.

*Technical Assistance and Tribal Support*

Technical assistance and trainings offered by the TECs are designed to be responsive to the needs and interests of the communities they serve. This focus on Tribal and community requests is balanced by comprehensive epidemiological work to educate communities on the conditions and disparities that affect their citizens.

*Nationally-Managed Data Projects that Engage Local Resources*

Data generated locally and analyzed by TECs enable Tribes to evaluate Tribal and community-specific health status for planning the needs of their Tribal membership. Immediate feedback is provided to the local data systems and leads to improvements in Indian health data overall. The Indian Health Care Improvement Act (Section 130) includes language that designates the TECs as public health authorities in regards to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This designation permits TECs to access IHS-generated data sets used to support various public health activities.

This use of nationally managed local data supports TECs in the analysis of many topics, including: arthritis; asthma; atrial fibrillation; behavioral health; cancer (non-metastatic); chronic ischemic heart disease; chronic kidney disease; chronic pulmonary disease; diabetes mellitus; elder health; heart failure; injury; obesity; hypertension; liver disease; sexually transmitted diseases; oral health; foodborne/diarrheal illnesses; airborne infectious diseases (COVID-19, tuberculosis, pertussis, influenza, pneumonia); and, hepatitis.

*Continued COVID-19 Response Activities*

As the COVID-19 response has evolved, TECs have continued to collaborate with each other, IHS, other agencies, and the communities they serve. Notable activities and successes of TECs have included the development and dissemination of culturally appropriate COVID-19 informational products, case and testing information, analysis and dissemination of morbidity and mortality statistics, and the production and distribution of public communication informed by community-specific concerns. TECs have assisted tribal health programs with their response by distributing masks/face coverings, hand sanitizer, forehead thermometers, and posters and by providing training on syndromic surveillance practices. One TEC reported offering air quality monitoring and motivational interviewing training to their sites.
Some programs offered real-time online outreach to the public, including Facebook Live events on topics including: COVID-19 virus and transmission, COVID-19 myth busting, and COVID-19 vaccination. Programs reported participation in in-person community events to promote infectious disease prevention,

including youth-oriented events where they offered Safe Back-to-School kits. The kits included educational materials on COVID-19 safety guidelines, COVID-19 vaccination, and, influenza vaccination. All of the TECs have continually contributed to the resources posted on their common COVID-19 website at https://tribalepicenters.org/tec-covid-19-resources/.

All 12 TECs have undertaken activities to evaluate and support Area-wide interventions that promote COVID-19 vaccine uptake. These have included a wide range of program activities: monitoring AI/AN vaccination rates in their service Area, running a telephone hotline for the public staffed by AI/AN operators, developing and disseminating culturally centered communications products, coordination with other public health authorities to strengthen relationships and avoid duplication of effort, and, developing videos about vaccine hesitancy including interviews from traditional healers and other local thought leaders,

COVID 19 Contact Tracing work has continued. IHS headquarters developed a data sharing agreement for implementation on the Area level which supports local COVID-19 contact tracing efforts. This data sharing requires sharing of patient-level, identifiable data from the IHS electronic health record (EHR) to effectively support contact tracing efforts. To date, one IHS Area-TEC partnership has established such an agreement serving the Oklahoma City Area. Other TECs have also continued or expanded their contact tracing work using other relationships.

*Disease Surveillance, Evaluation, and Publications*

In the expanding environment of Tribally-operated health programs, TECs provide additional public health services, such as disease control and prevention programs, in areas such as sexually transmitted disease control, HIV, and cancer prevention.

TEC efforts build capacity in the Indian health system by evaluating and monitoring the effectiveness of health and public health programs. This allows TECs to assess access, use, and/or quality of care, and to develop recommendations for the targeting of services needed by the populations served. They manage public health information systems, investigate diseases of concern, manage disease prevention and control programs, communicate vital health information and resources, respond to public health emergencies, and coordinate these activities with other public health authorities.

Notable publications and data products included aggregate reports, fact sheets, health education materials, and formal manuscripts. TECs further contributed to the Public Health literature by preparing more than twenty peer reviewed publications on topics including opioid deaths; COVID-19 disparities; cancer; improving health system quality; tobacco use; hepatitis treatment and care; nutrition equity; maternal and child health concerns; adolescent health behaviors; interventions supporting mental wellness; and, sexual health. Further, one TEC published a Morbidity and Mortality Weekly Report using local case data to describe the inequities in severe COVID-19 outcomes among AI/AN people.

*TEC roles in the establishment and/or expansion of Tribal Public Health Departments*

In 2021, six TEC programs successfully competed for supplemental funding to support the establishment and/or expansion of Tribal Public Health Departments (TPHDs). In FY 2022, they reported progress on providing trainings to TPHDs on a variety of topics, including grant writing, COVID-19 response, cancer prevention and control, motor vehicle safety, injury prevention, and, behavioral health. They provided further support to TPHDs in analyzing, evaluating, and improving their programs and services to improve AI/AN health.

## DISCUSSION

The TECs provide critical support to the communities they serve. In FY 2022, TECs responded to 3,369 requests for technical support (EPI-4) and completed 1,197 TEC-sponsored trainings for tribal public health capacity building (EPI-5). Recent increases in technical support and trainings from prior years likely reflect expanded Tribal Public Health activities and needs during the COVID-19 response. Technical support delivery showed a decrease from 2021 activity levels.

TEC funding strengthens the capacity to translate emerging public health strategies, resources, and information, which are critical in providing support to Tribes and necessary in quickly responding to the COVID-19 pandemic and in general public health decision-making.

Completed trainings and technical support to Tribes and Tribal organizations show the sustained efforts of the TECs to engage, train, and collaborate with the Tribes in their service area. These efforts are responsive to Tribal priorities as they are driven by Tribal requests and invitations and not directed by the IHS.

## OUTPUTS AND OUTCOMES

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| EPI-4 Number of requests for technical assistance including data requests for T/U organization, communities, or AI/AN individuals responded to. (Output) | FY 2022: 3369 Target: 1897 (Target Exceeded) | 1897 | 1897 | Maintain |
| EPI-5 Number of TEC-sponsored trainings and technical assistance provided to build tribal public health capacity. (Output) | FY 2022: 1197 Target: 89 (Target Exceeded) | 89 | 200 | +111 |

## GRANTS AWARDS

| *(whole dollars)* | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget |
|---|---|---|---|
| Number of Awards | 12 | 12 | 12 |
| Average Award | $1,747,000 | $2,547,000 | $2,547,000 |
| Range of Awards | $1,732,500 - $1,757,100 | $2,532,500 - $2,557,100 | $2,532,500 - $2,557,100 |

* Administrative and technical support of the TEC's is provided by the 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 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget /1 | FY 2024 +/- FY 2023 |
| PL | $2,374,984 | $2,503,025 | $3,553,742 | +$1,050,717 |
| *HIT* | *$182,149* | *$182,149* | *$182,149* | - |

1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**.........................................................................................Permanent

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

**PROGRAM DESCRIPTION**

The Indian Health Service (IHS) Health Information Technology (HIT) Portfolio uses secure and reliable information technology (IT) in innovative ways to improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions. IHS HIT provides support for the IHS, Tribal, and Urban (I/T/U) programs that care for 2.6 million American Indian and Alaska Native (AI/AN) people across the Indian health system. IHS provides the technology infrastructure for a nationwide health care system, including a secure wide area network, enterprise e-mail services, and regional and national Help Desk support for approximately 20,000 network users. IHS HIT also supports the mission-critical health care operations of the I/T/U with comprehensive health information solutions including an Electronic Health Record (EHR) and more than eighty applications. IHS' EHR received 2015 certification for meeting requirements set by the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC), which established standards and other criteria for structured data that EHRs must use. The IHS HIT portfolio directly supports better ways to: 1) care for patients, 2) pay providers, 3) refer care when needed, 4) recover costs, and 5) distribute information, resulting in better care, wiser spending of our health dollars, and healthier communities, economy, and country.

The HIT Portfolio is dedicated to providing the most innovative, effective, cost-efficient, and secure HIT system in the federal government. The HIT portfolio is comprised of two Mission Delivery IT investments: 1) Health Information Technology Systems and Support (HITSS); 2) National Patient Information Reporting System (NPIRS); and eight Standard investments: 1) IT Management; 2) IT Security and Compliance; 3) Data Center and Cloud Standard Investment; 4) Network Standard Investment; 5) Platform Standard Investment; 6) Delivery Standard Investment; 7) End User Standard Investment; and 8) Application Standard Investment.

1) **Health Information Technology Systems and Support (HITSS)** investment provides an enterprise health information system supporting IHS Strategic Goal 2, *"To promote excellence and quality through innovation of the Indian health systems into an optimally*

*performing organization" and* Goal 3, *"To strengthen IHS program management and operations."* The HITSS enterprise information system is the underlying IT layer of the clinical, practice management and revenue cycle business processes at I/T/U facilities across the country and supports Objective 2.1, *"Creates quality improvement capability at all levels of the organization" and* Objective 2.2, *"Provides care to better meet the health care needs of American Indian and Alaska communities."* The HITSS investment encompasses the Resource and Patient Management System (RPMS) EHR that is certified according to criteria published by the ONC and is in use at approximately 430 health care facilities across the country in support of Objective 3.1*, " Improve communication within the organization with Tribes, Urban Indian Organizations and other stakeholders, and with the general public,* Objective 3.2, *"Secures and effectively manages the assets and resources",* and Objective 3.3, "*Modernizes information technology and the information systems to support data driven decisions."* In pursuit of expanding capabilities, the HITSS investment supports IHS Strategic Goal 1, *"To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people."* The RPMS Network is evolving to support health information sharing within the I/T/U enterprise, external connections through the eHealth Exchange, and better patient engagement to support quality initiatives and the Medicare Access & Children's Health Insurance Program Reauthorization Act (MACRA) of 2015 in support of Objective 1.3, *"Increase access to quality health care services."*

2) **National Patient Information Reporting System (NPIRS)** investment supports IHS Strategic Goal 2, "*To promote excellence and quality through innovation of the Indian health system into an optimally performing organization."* and Goal 3, *"To strengthen IHS program management and operations"*. NPIRS is an enterprise-wide data warehouse and business intelligence environment that produces standardized 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. The NPIRS investment hosts an enterprise business intelligence and business analytics platform that promotes a data centric approach to data mining, discovery, reporting and analytics. The NPIRS BI/BA platform enables actionable insights into primary care, disease management and promotes outcome improvements that are aligned with the agencies strategic and tactical business objectives. Reporting and analytics are available at the site, area and national levels. The NPIRS enterprise information strategy leverages Business Intelligence (BI) technology to collect, manage, govern and turn data into formation for use across the agency in support of Objective, *2.1 Create quality improvement capability at all levels of the organization.* This enterprise information strategy promotes collaboration between IHS, tribes and urban stakeholders for posturing data for enterprise reporting, data sharing and assures data confidence to support I/T/U and supports Objective, *2.2 Provide care to better meet the health care needs of American Indian and Alaska Native communities".* This investment is evolving to mature the analytic platform, adding additional data domains, defining a data governance framework, adopting industry standards and best practices to exploit Business Intelligence capabilities, and is enabling IHS to produce and make more informed, quality decisions against agency-level measurement, performance and enterprise data. The NPIRS enterprise business intelligence environment leverages technology and industry best practices for enterprise information and data management to promote data accuracy and availability in support of Objective 3.3, *"modernize information technology and information systems to support data driven decisions."* In an effort to support collaboration for the expansion of services the NPIRS investment supports Strategic Goal 1, *"To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people."* The NPIRS investment is expanding services

within the BI environment in a continued effort to provide reusable, shared reporting solutions that are made available in a collaborative platform to communicate enterprise reporting solutions globally, across IHS, tribal organizations and Urban Indian programs in support of Objective 1.2, *Build, strengthen, and sustain collaborative relationships.*

3) **IT Operations** investments support IHS Strategic Goal 3, *"To strengthen IHS program management and operations"* by providing the technical infrastructure for federal, and limited tribal, healthcare facilities that is the foundation upon which all health IT services are delivered. The IT Operations program consists of six IT investments: Data Center and Cloud Standard Investment, Network Standard Investment, Platform Standard Investment, Delivery Standard Investment, End User Standard Investment, and Application Standard Investment. These investments enhance and maintain critical IT infrastructure required for HIT modernization and support Objective 3.3, *"modernize information technology and information systems to support data driven decisions."* The IT Operations program includes a highly available and secure wide area network that includes locations with unique telecommunication challenges, a national e-mail and collaboration capability that is designed specifically to support health care communication and data sharing, enterprise application services and supporting hardware including servers and end-user devices in support of Objective 3.1, *"improve communication within the organization with Tribes, Urban Indian Organizations, and other stakeholders, and with the general public."* This program incorporates government and industry standards for the collection, processing, storage, and transmission of information and is poised to respond to new and pioneering opportunities by adopting the IT Infrastructure Library (ITIL) IT Service Management (ITSM) framework to optimize the delivery of IT services in support of Objective 3.2, *"secure and effectively manage assets and resources."*

4) **IT Security and Compliance** investment supports IHS Strategic Goal 3, *"To strengthen IHS program management and operations."* The IHS Cybersecurity Program implements security controls and assesses the efficacy of those controls annually while managing information security risk on an ongoing basis. The IHS Cybersecurity Program protects the information and information systems that support IHS operations by implementing cybersecurity policy, securing centralized resources, and providing cybersecurity training for all employees and contractors. The IHS Cybersecurity Program supports Objective 3.2, "*secures and effectively manages the assets and resources"* and Objective 3.3, *"Modernizing information technology and information systems to support data driven decisions."*

5) **IT Management** investment supports IHS Strategic Goal 3, *"To Strengthen IHS program management and operations,* Objective 3.3, *"Modernize information technology and information systems to support data driven decisions."* This investment is an enterprise-wide IT Governance program that provides IT Management, Capital Planning Investment Control, Strategic Planning, Enterprise Architecture, IT Finance, and IT Vendor Management activities for all IHS IT investments. These essential activities promote compliance with federal laws and regulations to improve efficiency and effectiveness of all IHS HIT portfolio investments.

**BUDGET REQUEST**

The FY 2024 budget submission of $182 million for Health Information Technology is the same as the FY 2023 Enacted level.

This funding will continue progress made in past years by minimizing infrastructure costs and maintaining a high level of productivity and commitment by both federal and contractor staff supporting the IHS-developed health information solutions. IHS uses open-source tools where possible to minimize acquisition costs. Following the VA announcement to sunset their VistA EHR application the IHS and HHS CTO began an analysis of alternatives to assess the sustainability of the entire RPMS HIT platform. The HHS-IHS HIT Modernization Research Project was completed in FY 2020 to examine alternatives to replace or modify RPMS as the IHS HIT platform. The HIT Modernization Project identified the need to change the current EHR platform to a modern commercial-off-the-shelf (COTS) EHR that will improve the impact and quality of direct patient care, increase cost recovery and promote continuous health improvements such as, expanded telehealth care services and predictive population health analytics. These potential returns highlight the value of health IT and its impact on the agency mission.

**FUNDING HISTORY**

| Fiscal Year | Amount* |
|---|---:|
| 2020 | $182,149,000 |
| 2021 | $182,149,000 |
| 2022 Final | $182,149,000 |
| 2023 Enacted | $182,149,000 |
| 2024 President's Budget | $182,149,000 |

*Funded under the Hospitals & Health Clinics budget.

**TRIBAL SHARES**

H&HC (IT is funded out of H&HC) funds are subject to tribal shares, currently at approximately 25 percent, and are transferred to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities. A small portion of the overall H&HC budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

**PROGRAM ACCOMPLISHMENTS**

The Office of Information Technology (OIT) successfully provided a secure and effective suite of technology solutions to support the agency and its mission throughout the country. Collaboration with tribal health programs and other federal agencies is key to the success of the HIT Portfolio. IHS works closely with the ONC, CMS, Agency for Healthcare Research and Quality, VA, and other federal entities on IT initiatives to ensure the direction of its HIT systems is consistent with other federal agencies. In addition, IHS has routinely shared HIT artifacts (e.g., design and requirement documents, clinical quality logic, etc.) with both public and private organizations.

The Health Information Technology Systems and Support (HITSS) program completed development for the 2015 Edition Cures Update for the Certified Electronic Health Record criteria required for 2022. IHS will continue development work to meet the remaining ONC requirements for 2023. Deployment of the certified software is complete for 2022. The HITSS program supported rapid development and deployment of software updates in response to the COVID-19 pandemic to support new diagnoses code sets, laboratory testing and results, and vaccine administration and reporting to the Centers for Disease Control (CDC). The program's work to support COVID includes major development to provide mechanisms for centralized reporting through the AIMS portal for COVID lab testing, as well as the development of a

centralized COVID vaccine reporting system, which also feeds a national dashboard available to IHS stakeholders. As part of the Agency's effort for stabilization and modernization, the HITSS program completed the 4 Directions Hub pilot project focused on health information exchange within the government as well as the eHealth Exchange. Pilot sites were onboarded and completed testing with the Veteran's Administration (VA). The HITSS program certified our software to the FY 2022 eCQM certification requirements, and also completed the bi-annual re-certification of Electronic Prescribing of Controlled Substances (EPCS) capabilities. The HITSS program completed a major software infrastructure database upgrade, which facilitates the ability for sites to participate in planned health information exchange and interoperability requirements that were delivered with the 21 Century Cures Act initiative. HITSS also successfully implemented a replacement for the Immunization Forecasting software used across our facilities.

For 2023 and 2024, the HITSS program will continue to develop software to comply with new requirements for the ONC Certification. The development will continue with the USCDI application for the ONC SVAP requirement, the Electronic Health Information Export, and the Antimicrobial Resistance capability reporting. Other initiatives include development and testing software for the new Windows 11 desktop platform, mandated IPv6 transitions, implementing the Zero Trust Architecture, O&M for server database vendor updates, and implementing Project US@ - Unified Specification for Address in health care.

In addition to the high-velocity response to COVID, our HITSS program staff delivered 10 full version updates and 114 required maintenance updates across the health IT portfolio for FY 2022 and 9 full version updates, and 42 required maintenance updates as of January FY 2023.

In response to the social distancing guidance, IHS adjusted the delivery of training to focus on virtual offerings. The program provided 317 HIT training courses to 11,919 I/T/U users in FY 2022. As of January 2023, the program provided 108 HIT training courses to 4,917 I/T/U users. Over 528,287 messages were exchanged between patients, providers, administrators, message agents, and external HISPs through approximately 55,236 unique direct e-mail addresses since Sept 2015. The IHS Personal Health Record (PHR) has approximately 51,827 total users, and 49 percent of these registered PHR users were verified/linked to their IHS Medical Record. The remaining 51 percent are registered but not yet verified/linked.

The National Patient Information Reporting System (NPIRS) investment continues to enhance the IHS Disease Surveillance solutions in response to the COVID-19 pandemic. The initial NPIRS COVID surveillance data was captured from manual entry in the COVID-19 data collection portal. The agency's COVID-19 data collection and reporting solutions enable data collection for over 300 federal, tribal, and urban sites and provides immediate insight into testing results at the site, area, and national levels. During FY22 and FY23, NPIRS has transitioned seven Areas that utilize the RPMS software from the manual data collection portal to the automated BDW Covid data feed. NPIRS anticipates completing the transition of the remaining Areas by the end of FY23. NPIRS also created customized BI reports that are auto-generated and distributed to tribal and urban partners unable to access the national dashboard. As part of the COVID-19 vaccination initiative, NPIRS worked closely with the HITSS Investment and the Centers for Disease Control (CDC) to define the strategy for immunization collection and reporting. Since the initial release of the COVID-19 Immunization dashboard, NPIRS has implemented various enhancements to the business intelligence/business analytic solution to support extended vaccine administration (patient and employee), vaccine manufacturer, dosage, demographic and population information. In FY22 NPIRS integrated the IHS AI/AN user population into the dashboard to provide statistics on vaccinations across Indian country. The Vaccine Task Force (VTF) has FY23 requirements to enhance the dashboard to promote better patient and population management of immunizations. NPIRS is working on the phase II requirements of the Opioid

Surveillance dashboard for the National Committee on Heroin Opioids and Pain Efforts (HOPE) to promote appropriate and effective pain management, reduce overdose deaths from heroin and prescription opioid misuse, and improve access to culturally appropriate treatment. Eight new measures are planned for release in FY23 and an additional 4 measures are planned for FY24. NPIRS continues to maintain and support the Enterprise BI/Analytic solutions within the Qlik Enterprise Environment to include user access support, data refresh activities and enhancements for the agency. FY23 plans include environment upgrades and extending the security framework to support onboard of new tribal users. FY24 plans are to transition several legacy solutions to the Enterprise BI tool, in addition to working with sites to convert Qlikview solutions to Qliksense. Enterprise BI solution support is provided to headquarters program offices, trial, urban, area, service unit, and facility stakeholders. This support enables reporting, data discovery, data mining, predictive analysis and trending of key performance indicators supporting patient care and patient care management by providing strategic actionable information to key stakeholders. NPIRS continues to facilitate and improve reporting capabilities for programs, such as the Office of Urban Indian Health Program (OUIHP) Uniform Data Set (UDS) reporting requirements, the Office of Clinical and Preventive Services (OCPS) GPRA/GPRAMA national reporting, Maternal Child Health, Partnership to Advance Tribal Health, Behavioral Health, Pharmacy reporting, and Quality initiatives. Quality initiatives include, but are not limited to the Inpatient/Outpatient Quality Reports, National Accountability for Quality, Wait Time and Improved Patient Care. In addition, extensive support has been provided to the Office of Finance and Accounting (OFA) national reporting efforts for budget execution and monitoring solutions. These efforts are ongoing and support national adhoc and recurring reporting requirements.

The IT Operations program implements new enterprise technologies while sustaining and providing customer support for hundreds of IT services. In FY2022, IT Operations completed over 450 significant IT initiatives/projects and acquired over 100 products and services. The number of significant IT initiatives/projects increased 25% in FY2022 compared to the previous year. Notable projects and accomplishments are as follows:

- Replaced the legacy IT Access Control (ITAC) system with SailPoint and improved access control and auditing across the IHS.
- Implemented Okta Authentication-as-a-Service to provide a secure means to authenticate users to any IT system we purchase or develop in the Agency.
- Implemented the AA RingMD Clinical Video Telehealth service.
- Established a Zero Trust initiative and hired a new federal employee to oversee Cybersecurity tool management in IT Operations.
- Upgraded network circuits at 31 facilities and one Data Center, adding an additional 16Gb of bandwidth to support access to administrative and Health IT applications.
- Enabled 4G/LTE service as a supported connection option for IHS mobile health vans to access health IT applications when providing patient care.
- Upgraded the Wide Area Network architecture to incorporate Software-Defined Network (SD-WAN) features.

In FY 2023, IT Operations is improving data sharing and collaboration within the IHS and between the IHS and HHS, Tribal entities, Business partners, and other government agencies. The most significant investment for IT Operations in FY2023 is an upgrade to our Microsoft Enterprise Agreement and expansion of Microsoft 365 tools such as Microsoft Teams and SharePoint. A key factor to share data is developing the skills and tools necessary to protect the data from unauthorized disclosure or corruption. IT Operations is making significant investments in cybersecurity this year to better protect sensitive data as we expand access to information within our IT platforms.

The forecasted activities for IT Operations in FY2024 are focused on IT Modernization and improving cybersecurity by adopting a Zero Trust cybersecurity framework and enhanced capabilities. Specifically, IT Operations will make measurable progress toward enhancing visibility into IHS IT assets and associated vulnerabilities as required by the Cybersecurity and Infrastructure Security Agency (CISA) Binding Operational Directive 23-01 (BOD 23-01).

IT Cybersecurity Program has three new cybersecurity policies pending approval: Security Assessment and Authorization; Audit and Accountability; and Configuration Management. Implementation of these new policies will help ensure cybersecurity activities are defined and executed consistently across the IHS enterprise to protect both information and information systems. In response to increased demand for telehealth services, the IHS Cybersecurity Program, in conjunction with Operations and the Chief Health Informatics Officer, sponsored a cloud service provider, RingMD, through the Federal Risk and Authorization Management Program (FedRAMP) to authorize its use not only at IHS, but at federal agency. In addition, the IHS Cybersecurity Program is enhancing the threat analysis capability by adding tools to improve the security posture of domain joined endpoints. This tool is able to detect patch status as well as other metrics and quarantine the device from the network in the event of noncompliance. By quarantining the device, we have reduced the attack surface of the network. Additionally, we are in compliance with new directives from the Department of Homeland Security regarding patch compliance. This tool has allowed us to implement USB drive controls preventing the use of unencrypted USB media, preventing data leakage as well as compliance with existing security policies. We are also leveraging a new cloud based centralized data integrator for log management, capturing and analyzing threats and creating automated alerts to make informed and timely decisions. We continue to remediate open audit findings and weaknesses within OIT. In FY22, a total of 100 Plan of Action and Milestones were closed. IHS has responded timely to all Emergency Directives and Cybersecurity Executive Orders to ensure compliance levels are met as mandated. The IHS Cybersecurity Program responded to over 8,300 incidents and requests for assistance in the past year.

IT Management continues improving IT governance through enhanced configuration and utilization of the Planview Portfolio Resource Management (PRM) System that provides an enterprise IT portfolio and project management capability enabling IHS to improve project performance oversight and monitoring corrective actions through to completion. The Planview PRM system also provides a comprehensive Enterprise Architecture capability enabling line-of-sight linkage between IHS strategic goals & objectives, business capabilities, and the IT requirements needed to support those capabilities. These continued enhancements provide management tools to help ensure IHS prioritizes IT spending on investments that directly support strategic goals. OIT staff provided virtual presentations on HIT initiatives at various tribal or tribal health board conferences and meetings such as TribalNet, National Tribal Health Conference, Tribal Technical Advisory Group, National Indian Health Board (NIHB), NIHB Medicare, Medicaid, and Health Reform Policy Committee, IHS Tribal Self Governance Advisory Committee, and the Direct Service Tribes Advisory Committee quarterly meetings, etc. OIT staff regularly participated in Tribal Delegation Meetings and the Alaska Area Pre-negotiation/Negotiation meetings to address IT/HIT issues. The OIT Healthcare Connect Fund Program provided support to 109 federal and 75 tribal locations to collect $3.18 million.

**Immediate Priorities and Challenges**

The IHS HIT Portfolio continues to face increased demand for systems improvements and enhancements, rising costs, and increased IT security requirements driven in part by medical advances, and ever-growing and more complex requirements for health information technology

capabilities. These requirements come from government and industry initiatives, needs of health programs, and operational requests of I/T/U health care facilities. Each new program initiative has information technology requirements for functionality, modality, data collection, and reporting which then must be added to a clinician's work flow and managed within the HIT portfolio.

A major priority of and challenge to the current HIT Portfolio is continuous improvement to and sustainment of the RPMS suite while simultaneously engaging in HIT Modernization. As described elsewhere in this document, IHS has embarked on a major, multi-year initiative to modernize its HIT solutions. The intent is to fully replace RPMS, which has its origins in the 1970s, with a modern, commercial off-the-shelf suite of applications that address the full range of capabilities that RPMS currently supports. The build and rollout of a new system to replace RPMS is expected to take 7-10 years, during which RPMS must be continuously maintained to support high-quality, safe healthcare services and revenue cycle management nationwide. This will inevitably include enhancements to remain current with the ever-changing regulatory environment, as well as to meet evolving program needs at IHS. Many of the core components of RPMS are derived from the VA's VistA system, which is also scheduled for retirement over the next several years. Choices made by the VA regarding maintenance and enhancement of VistA will affect IHS, and possibly even shift a maintenance burden to IHS if we remain dependent on components that VA no longer supports. In any case, the requirement to support a legacy system while simultaneously designing and implementing a modernized one will substantially challenge the capacity of information technology staff at all levels of the organization.

CyberSecurity challenges include minimizing unsecured systems and data to reduce the possibility of data loss, ransomware infections, identity theft, risk to patient health data, system breaches, and loss of business continuity in the event of a disaster. System breach or intrusion into an unsecure network puts patient data at risk, impacts the IHS mission by delaying or halting patient care, and harms IHS patients leading to a lack of trust in patient services.

Human resource shortages and slow staff backfill contributes to challenges in keeping up with evolving technology and new Federal, Department and Operating Division projects/initiatives including FITARA Implementation. OIT has a persistent vacancy rate of 40 percent.

**OUTPUTS / OUTCOMES**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| HIT-1 OMB IT Dashboard - All IHS Major Investments will Maintain a score of 4/5 or greater (Outcome) | FY 2022: 3.0<br>Target:<br>4.0[1]<br>(Target Not Met)<br>FY 2021: 3.0<br>Target:<br>4.0[2]<br>(Target Not Met) | 3.0 | 3.0 | Maintain |

[1] >= out of 5 for all investments.

[2] >= out of 5 for all investments.

**FY 2024 Cyber Activities - Government-wide Tracking of Resources**

(Dollars in Millions)

| Indian Health Service | FY2022 Actual | FY2023 Enacted | FY2024 President's Budget | FY24 President's Budget - FY23 Enacted |
|---|---|---|---|---|
| Detect - Data Loss Prevention | 0.155 | 0.565 | 0.565 | -- |
| Detect - Intrusion Prevention | 0.050 | 1.590 | 1.590 | -- |
| Detect - Other Detect Capabilities | 1.543 | 1.228 | 1.228 | -- |
| Identify - Data Categorization and Classification | 5.531 | 7.006 | 7.006 | -- |
| Identify - Other Identify Capabilities | 0.275 | 0.415 | 0.415 | -- |
| Protect - Counterintelligence | 0.850 | 3.000 | 3.000 | -- |
| Protect - Credentialing and Access Management | 0.390 | 0.373 | 0.373 | -- |
| Protect - Security Log Management | 2.186 | 2.497 | 2.497 | -- |
| Protect - Security Training | 0.080 | 0.088 | 0.088 | -- |
| Protect - Trusted Internet Connections | 1.963 | 3.138 | 3.138 | -- |
| Respond - Incident Management and Response | 0.029 | 0.010 | 0.010 | -- |
| Respond - Other Respond Capabilities | 2.097 | 2.500 | 2.500 | -- |
| Indian Health Service Total | 15.149 | 22.410 | 22.410 | -- |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
**ELECTRONIC HEALTH RECORD SYSTEM**

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget /1 | FY 2024 +/- FY 2023 |
| PL | $145,019 | $217,564 | $913,186 | +$695,622 |
| FTE* | 6 | 6 | 206 | +200 |

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**...........................................................................................Permanent

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

## PROGRAM DESCRIPTION

Electronic Health Record System Modernization - The health information technology (HIT) system currently in use at IHS is the Resource and Patient Management System (RPMS), a comprehensive health information suite that supports a broad range of clinical, population health, and business processes from patient registration through the billing cycle. RPMS was internally developed by IHS, leveraging a decades-long collaboration with the Department of Veterans Affairs (VA), and is certified to the 2015 Edition criteria published by the Office of the National Coordinator for Health Information Technology (ONC). In recent years, advances in health-related standards and technologies, an increasingly complex regulatory environment around HIT, and the decision of the VA to move to a commercial off-the-shelf HIT solution have combined to make the current approach to IHS HIT development and support non-sustainable going forward. In 2018-19, IHS, in collaboration with HHS, engaged in comprehensive research and analysis of the current state of its HIT infrastructure and options for modernization. Informed by the outcomes of that project, IHS has published its intent to move forward with modernization by transitioning from its legacy RPMS to state-of-the-art, commercial off-the-shelf systems. The approach to modernization is not limited to an Electronic Health Record (EHR), but must support a true enterprise approach to HIT, enabling the highest quality inpatient, ambulatory, behavioral health, dental, pharmacy, laboratory, imaging, referral, and revenue cycle services, with standards-based interoperability and analytics capabilities, positioning IHS in the best possible way to accomplish its mission in the coming years. The replacement of RPMS supports the HHS Strategic Goal 4 "Restore Trust and Accelerate Advancements in Science and Research for All" and HHS Strategic Goal 5 "Advance Strategic Management to Build Trust, Transparency, and Accountability."

## BUDGET REQUEST

The FY 2024 budget submission for Electronic Health Record Modernization is $913.2 billion. This is an increase of $696 million above the FY 2023 Enacted level.

FY 2024 Funding Increase of $696 million includes:

EHR Increase: +$691 million will support the ongoing modernization of the Health IT infrastructure. OIT will use the funds for licensing, hosting, training, site remediation, implementation, and support costs to implement a modernized system.

The current IHS electronic health record is over 50 years old, and the GAO identifies it as one of the 10 most critical federal legacy systems in need of modernization. The IHS relies on its electronic health record for all aspects of patient care, including the patient record, prescriptions, care referrals, and billing public and private insurance for over $1 billion reimbursable health care services annually. The IHS expects to begin the site implementation phase in FY 2023, which will require significant additional resources to analyze the needs of hundreds of sites, implement the new system, replace outdated equipment, and other related steps.

This funding will lay the groundwork to improve the quality of care, reduce the cost of care, promote interoperability, simplify IT service management, increase the security of patient data, enhance cybersecurity, and update infrastructure across rural locations to enable a successful Electronic Health Record transition. This will include the continuation of project management operations, acquisition planning, EHR selection, additional tribal consultation, initial infrastructure build, site implementation planning, and continued RPMS stabilization and support. The project will follow industry standards for modernization or replacement of Electronic Health Record systems to leverage expertise and experience in the private sector (HHS Objective 5.3: Uphold effective and innovative human capital resource management resulting in an engaged, diverse workforce with the skills and competencies to accomplish the HHS mission.)

- Health Information Technology Modernization – The IHS Health Information Technology Modernization effort will use the additional FY 2024 resources to execute several core activities in FY 2024. Specifically, the IHS expects to address the following:

    - RPMS Stabilization: IHS will complete updates to the legacy systems to achieve compliance with the 21st Century Cures updates for 2015 Edition ONC certification. Significant development, testing, patching, rollout and training efforts will be required, using expanded contract resources.
    - Interoperability: The IHS will complete its interoperability pilot in FY 2023, and then begin a national rollout to enable exchange both within the IHS enterprise and with external referral network partners. This effort will require substantial testing with partners as sites are on-boarded in order to ensure seamless and accurate interoperability (HHS Objective 4.4: Improve data collection, use, and evaluation, to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience.)
    - Immunization Information Systems: The IHS is planning additional initiatives to move certain capabilities from the local to the enterprise level, including centralized systems to accomplish exchange with state immunization information systems and reporting to public health agencies (HHS Objective 2.2: Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines.)
    - Initial Build of EHR Environment: With a vendor selection for the new EHR system in FY 2023, work will begin on the design and build steps, to prepare the commercial system for operation in the IHS environment. This activity typically

takes twelve months with significant resources required to convene and gather input from subject matter experts across a range of disciplines and move decisions that could number in the thousands through governance processes to meet the agency's configuration requirements.
  - Local Needs: Once the IHS selects an EHR product, the Agency can define the technology architecture required for optimal performance of and support for the system. The IHS can then target identified gaps at local facilities and in the wide area network and hosting systems. This effort will include both capital (equipment) and resource (contract) costs.
  - Initial Site(s) Transition Planning: Resources will support the development of a core planning template and master deployment schedule. This will also accommodate individual site planning using the template to address technology infrastructure remediation, site configuration, end user training, change management, communication, and stakeholder engagement at the local level near the deployment target for each site. Many of these activities need to be completed in a short amount of time immediately prior to a site's go-live.

The IHS anticipates building the enterprise solution and preparing and planning site deployments in FY 2024.

  - This project holds an extremely high degree of mission criticality given the ability to provide much-anticipated clinical and administrative capabilities used in modern systems for the delivery of timely and impactful healthcare. Expected benefits from adopting and implementing a modernized system include, but are not limited to: improved patient safety, improved patient outcomes, better disease management, enhanced population health, improved clinical quality measures, opioid tracking, patient data exchange, third party revenue generation, agency performance reporting, and more. Additionally, the IHS intends to achieve the best possible interoperability with the Department of Veterans Affairs, Department of Defense, Tribal and Urban Indian health programs, academic affiliates, and community partners, many of whom use different HIT platforms.

    The IHS must acquire a state-of-the-art EHR system that supports a true enterprise approach to HIT, enabling the highest quality inpatient, ambulatory, behavioral health and other ancillary healthcare and business office services, with standards-based interoperability and analytics capabilities, positioning IHS in the best possible way to accomplish its mission in the coming years.

    During the implementation, IHS expects to temporarily increase the HIT workforce to acquire and implement this system (HHS Objective 1.5: Bolster the health workforce to ensure delivery of quality services and care.)

- IHS Legacy EHR System Modernization - The current IHS EHR, Resource and Patient Management System (RPMS), has been identified by the Government Accountability Office as one of HHS's top three systems in most need of modernization due to lack of development and enhancement work over the past decade. IHS must maintain the existing EHR system until implementation of the new system is complete.

- IT Infrastructure and Operations Modernization - These IT Infrastructure Modernization initiatives are required to provide the platform for which the EHR operates and support redundancy capacity.

IHS will build a mature governance body to ensure the enterprise HIT investment is properly maintained and configured nationwide.

The Dentrix software will be upgraded nationwide to coordinate care in a national enterprise HIT environment. Additionally, funding will allow for improved recruitment and retention of providers and reduced industry risk by adopting standards and systems used by a broader base of healthcare systems.

Funding will allow for improved revenue from third-party payers, improved training through standardized user interfaces and integration across health facilities, reduced workload to support the infrastructure, and improved quality and operational oversight through improved national reporting and data analytics (HHS Objective 5.2: Sustain strong financial stewardship of HHS resources to foster prudent use of resources, accountability, and public trust.)

- Current Services: +$5 million. Information can be found on page CJ-33.

## FUNDING HISTORY

| Fiscal Year | Amount[1] |
|---|---:|
| 2020 | $8,000,000 |
| 2021 | $34,500,000 |
| 2022 Final | $145,019,000 |
| 2023 Enacted | $217,564,000 |
| 2024 President's Budget | $913,186,000 |

## PROGRAM ACCOMPLISHMENTS

The Health IT Modernization Program achieved significant milestones in 2022. IHS released IHS Circular 22-06, Health Information Technology Modernization Executive Steering Committee Charter approved on March 10, 2022, as an important component of Governance.

The Program developed four critical modernization acquisition packages: Program Management Office, Organizational Change Management Services/Support, EHR Product and Integrator Services, and a new Mitre Task Order.

IHS conducted four Tribal Consultation and Urban Confer sessions with more than 900 participants over the calendar year to discuss the Acquisition Strategy, Governance Strategy, Data Management Strategy, and Lessons Learned from Tribal and Urban Partners.

IT Infrastructure and Operations Modernization - Significant improvements are required in order for the information technology (IT) infrastructure at IHS to fully support the deployment of a new, modern HIT solution. IHS must enhance cybersecurity, improve IT service management, expand storage and computing capacity, and increase network bandwidth at dozens of rural locations to enable a successful EHR transformation. IT operations throughout IHS will need to be managed and coordinated more effectively to successfully execute a complex modernization project. (HHS Objective 5.4: Ensure the security and climate resiliency of HHS facilities, technology, data, and information, while advancing environment-friendly practices.)

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

Current active projects in support of the modernization goal include rolling out a national hub for connection to the eHealth Exchange in order to support health information exchange (HIE) with the VA, Department of Defense, and other external partners, as well as leveraging the experience of COVID-19 to improve the agency's capabilities for enterprise reporting of immunizations, laboratory results, and public health notifications to state and federal entities (HHS Objective 2.2: Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines.)

The IHS Modernization of Health IT System & Support (mHITSS) investment is the primary mechanism IHS will utilize to modernize HIT in support of IHS Strategic Plan Goal 3, Objective 3.3, *"Modernize information technology and information systems to support data driven decisions" (HHS Goals 1,2,4&5)*.

**OUTPUTS/OUTCOMES**

As IHS reviews options, costs, and potential benefits; output and outcome measures will be developed. The new EHR environment will support existing measures for the Government Performance and Results Act (GPRA)/GPRA Modernization Act and electronic quality measures to support healthcare accreditation.

**GRANT AWARDS**

Not applicable to this funding.

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget /1 | FY 2024 +/- FY 2023 |
| PL | $232,566 | $248,098 | $319,029 | +$70,931 |
| FTE* | 510 | 508 | 539 | +31 |

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**..........................................................................................Permanent

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

## PROGRAM DESCRIPTION

The purpose of the Indian Health Service (IHS) Dental Health Program (DHP) is to raise the oral health status of the American Indian/Alaska Native (AI/AN) population to the highest possible level through the provision of quality preventive and treatment services, at both community and clinic sites. The DHP is a service-oriented program providing basic dental services (e.g., diagnostic, emergency, preventive, and basic restorative care), which represents approximately 90 percent of the dental services provided. In FY 2022 the DHP provided a total of 3,114,480 basic dental services, an 8 percent increase from FY 2021, in which the DHP provided 2,880,745 services. This marked a continued slow recovery from the diminished services during the pandemic major periods of FY 2020 and FY 2021. More complex rehabilitative care (e.g., root canals, crowns and bridges, dentures, and surgical extractions) is provided where resources allow and accounted for the additional 205,980 dental services in FY 2022, a 4 percent increase from FY 2021 where 197,994 higher level services were performed. The DHP provided these services through 983,055 dental visits in FY 2022, an 11 percent increase from FY 2021 (886,266 dental visits), another sign of a slow emergence from the pandemic accompanied by increased patient confidence in the safety of dental services.

Across all age groups, AI/ANs suffer disproportionately from dental disease. When compared to other racial or ethnic groups, AI/AN children 2-5 years old have more than double the number of decayed teeth and overall dental caries experience as the next highest ethnic group, U.S. Hispanics, and more than three times that of U.S. white children.[1] In the 6-9 year-old age group, 8 out of 10 AI/AN children have a history of dental caries compared with only 45 percent of the general U.S. population, and almost half of AI/AN children have untreated tooth decay compared

[1] Phipps KR, Ricks TL, Mork NP, and Lozon TL. The oral health of American Indian and Alaska Native children aged 1-5 years: results of the 2018-19 IHS oral health survey. Indian Health Service data brief. Rockville, MD: U.S. Department of Health and Human Services. Indian Health Service, 2019.

to just 17 percent of the general U.S. population in this age group.[2] In the 13-15 year-old age group, three out of four AI/AN dental clinic patients have a history of tooth decay, compared to half of 13-15 year-olds in the general U.S. population, and almost three times as many 13-15 year-old AI/AN youth have untreated decay compared to the general U.S. population.[3] In adults, the disparity in disease is equally as pronounced. 56 percent of AI/AN adults 35-49 years have untreated decay compared to just 26 percent of the general U.S. population, and across all other age groups studied (50-64 years, 65-74 years, and 75 and older), AI/AN adults have more than double the prevalence of untreated tooth decay as the general U.S. population. In addition, the rate of severe periodontal disease in AI/AN adults is double that of the general U.S. population.[4]

Prevention activities improve health and reduce the amount and cost of subsequent dental care. The DHP measures performance in part through the delivery of preventive services. The DHP maintains data and tracks three key program objectives:

1. Increase the proportion of 2-15 year-olds with dental sealants;
2. Increase the proportion of 1-15 year-olds receiving at least one application of topical fluorides; and
3. Increase access to care across all age groups.

The DHP funds provide critical support for direct health care services focused upon strengthening the collaborative partnerships among direct care providers, patients, communities, and internal and external stakeholders. Funds are utilized to ensure IHS, Tribal, and urban Indian health organizations have comprehensive, culturally appropriate services and personnel available and accessible, promotes excellence and quality through implemented quality improvement strategies, and strengthens the IHS program management and operations to address health disparities and raise the health status of AI/AN populations to the highest level possible.

The DHP provides critical services in support of the HHS Strategic Plan (HHS SP). The DHP provides essential services to increase dental health access and education which supports the HHS SP Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Health Care, and Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability. The program accomplishments section below provides details about DHP efforts.

**BUDGET REQUEST**

The FY 2024 budget submission for Dental is $319 million which is $71 million above the FY 2023 Enacted level.

FY 2023 Base Funding of $248 million will support oral health care services provided by IHS and tribal programs, maintain the program's progress in raising the quality of and access to oral care through continuing recruitment of oral health care professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2024 Funding Increase of $71 million includes:

[2] Phipps KR and Ricks TL. The Oral Health of American Indian and Alaska Native children aged 6-9 years: results of the 2016-2017 IHS oral health survey. Indian Health Service data brief. Rockville, MD: U.S. Department of Health and Human Services. Indian Health Service 2017.
[3] Phipps KR, Ricks TL, Mork NP, Lozon TL. The Oral Health of 13-15 year old American Indian and Alaska Native (AI/AN) Dental Clinic Patients – A Follow-Up report to the 2013 Survey. Indian Health Service data brief. Rockville, MD: Indian Health Service 2020.
[4] Phipps KR , Ricks TL, Mork NP, and Lozon TL. The Oral Health of American Indian and Alaska Native adult dental patients; a follow-up report to the 2015 survey. Indian Health Service data brief. Rockville, MD: Indian Health Service 2022.

- Direct Health Care Services Increase: +$45 million to expand access to dental care services. These resources will support efforts to reduce health disparities and improve the overall health status for American Indians and Alaska Natives by increasing the availability of health care services in Indian Country. This increase would allow for 167,119 additional patient visits and 529,462 additional services provided.

- Current Services and Staffing of Newly Constructed Facilities: +$26 million. Information can be found on pages CJ-33 and CJ-35 respectively.

**FUNDING HISTORY**

| Fiscal Year | Amount |
|---|---|
| 2020 | $210,602,000 |
| 2021 | $214,687,000 |
| 2022 Final | $232,566,000 |
| 2023 Enacted | $248,098,000 |
| 2024 President's Budget | $319,029,000 |

**TRIBAL SHARES**

Dental funds are subject to tribal shares and are transferred to tribes when they assume the responsibility for operating the associated programs, functions, services, and activities, unless otherwise specified in the annual appropriations bill. A portion of the overall Dental budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

**PROGRAM ACCOMPLISHMENTS**

Dental Clinical and Preventive Support Centers

In recent years, the DHP has utilized field dental programs in conjunction with its Dental Clinical and Preventive Support Centers (DSC) to achieve national performance objectives, support IHS Area initiatives, and support the (*Supports HHS SP Objective1.2.*). The DSCs were designed and implemented in FY 2000 to augment the dental public health infrastructure necessary to best meet the oral health needs of AI/AN communities. The current five-year funding cycle began December 1, 2020, with six DSCs funded through grants and three DSCs funded through program awards. In FY 2021, the Division of Oral Health received an additional $1,000,000 to increase the number of DSCs. The increase in FY 2021 funding allowed for the establishment of a ninth DSC and allowed each DSC to receive an increased amount of annual funding, resulting in an expansion of services to AI/AN communities in all twelve IHS Areas. Expansion of the number of DSCs, utilizing best practices learned from the existing DCSs, will assist in controlling oral disease and decrease oral health disparities experienced in susceptible or high-risk populations. In FY 2022 an additional $1,000,000 was received and is assisting the 9 DCPSCs to continue to expand the services provided to AI/AN communities. The primary purpose of a DSC is to provide technical support, training, and assistance in clinical and preventive aspects of dental programs providing care to AI/AN communities. As a direct result of the advocacy efforts of the DSCs, the number of key preventive procedures such as fluoride and sealant applications have been maintained throughout the last decade. In FY 2013, the DHP began tracking the coverage or prevalence of children and adolescents receiving sealants and topical fluoride, rather than simply

counting dental procedures. These assessments allow improved comparisons with data from the U.S. population compiled by the Healthy People 2030 initiative.

DSCs were initially funded in FY 2000. In the ensuing years, the DSCs have had an immediate positive impact on the direct delivery of dental care in a number of ways:

- All DSCs advocated for an appropriate focus on the dental Government Performance and Results Act (GPRA) performance objectives to increase specific clinical and community-based oral health services.
- All DSCs provided continuing education opportunities for clinical staff to enhance the quality of care delivered.
- Several DSCs provided on-site clinical and community based program reviews to enhance the quality of care, assuring that field programs maintain a high level of expertise with respect to challenges such as infection control, preparing for program accreditation and certification reviews, and patient scheduling practices aimed at maximizing access to care.
- Several DSCs 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 and quantity of IHS oral health education efforts throughout Indian Country.
- Several DSCs provided or arranged for direct clinical services that otherwise would not have been provided.

Dental Health Data

Access to dental services is a prerequisite to the control of oral disease in susceptible or high-risk populations. The access to care GPRA objective is aligned with the Healthy People 2030 methodology as a percentage of patients who have visited the dentist within the previous 12 months. (*GPRA measure data supports the HHS SP Objective1.3.*) Unfortunately, the COVID-19 pandemic greatly affected dental care to the AI/AN population. Most IHS facilities ceased routine care, including preventive services, beginning in mid-March 2020, and while a few began to re-open routine care in late May 2020, a substantial number of dental facilities continued to provide emergency or scaled back services well into FY 2022. Overall access to care increased from 19.48 percent in FY 2021 to 22.33 percent in FY 2022, one of the largest percentage increases ever experienced by the DHP in access to dental services, but still far below the record 29.96 percent access rate recorded in the pre-pandemic FY 2019.

The dentist to population ratio in the IHS system continues to be very low when compared to the ratio in the U.S. private sector. This low dentist to population ratio and an increase in population growth in the AI/AN population will continue to present a challenge in achieving the access rate goal. In FY 2022, the IHS has 1,046 dentists (including part-time) in the system, according to the IHS Dental Directory,[5] a decrease of 12 from FY 2021. In 2022, there were 3,092,940 AI/AN registrants in the U.S., according to the most recent user population estimate.[6] That means that the IHS system has approximately 1 dentist per 2,957 patients served. According to the American Dental Association, there were an estimated 201,927 dentists in the U.S. in 2021[7] serving a

[5] Indian Health Service, Department of Health and Human Services. IHS Dental Directory Report. www.ihs.gov/doh, accessed 10 February 2023.
[6] Indian Health Service, Department of Health and Human Services. User Population Estimates – FY 2022 Final, 5/17/2021.
[7] American Dental Association. Dentist Workforce. https://www.ada.org/resources/research/health-policy-institute/dentist-workforce, accessed 10 February 2023

population of 333,287,557,[8] meaning that there is approximately 1 dentist per 1,650 people served. This disparity shows the understaffing of dentists in the DHP.

The DHP continues to assess the care provided by its programs through a robust, continuing oral health surveillance program that started in 2010 and is planned through 2030. (*Supports the HHS Strategic Plan Goal 4: Restore trust and accelerate advancements in science and research for all through HHS Objective 4.3: Strengthen surveillance, epidemiology, and laboratory capacity to understand and equitably address diseases and conditions.)* 0-5 year-old AI/AN children were surveyed in 2010, 2014, and 2018-19; 6-9 year-old children were surveyed in 2011-12 and 2016-17: 13-15 year-old youth were surveyed in 2013 and 2019-20; and AI/AN adults were surveyed in 2015 and 2021-22. In FY 2023, the DHP is once again conducting surveillance of 6-9 year-old AI/AN children with over 80 programs participating and a final data brief expected in late 2023. The surveillance program has been used as a model nationally and helps highlight disparities in disease burden and distribution in the AI/AN population. Results of all surveys can be found in data briefs located on the IHS Dental Portal at www.ihs.gov/doh, and data from this surveillance program is also included in the CDC National Oral Health Surveillance System, allowing public health advocates to compare AI/AN disease prevalence with individual state or national data.

Dental Health Service Delivery Improvements

The DHP continues to make significant improvements in the way dental services are delivered. Through support of implementation of an electronic dental record (EDR), over 82 percent of IHS Federal, Tribal, and Urban (I/T/U) dental clinics have transitioned to an EDR system to support the delivery of effective quality dental services. The IHS Dentrix Enterprise (DXE) EDR program has been successfully implemented at 304 of these I/T/U dental clinics. There remains approximately 20 IHS clinics that have not transitioned to an EDR system. The EDR capability provides accurate data collection and dissemination through the IHS National Data Warehouse. This data supports evaluation of Oral Health Initiatives such as the Early Childhood Caries collaborative and future data development could improve outcome measurements. In FY 2020, the DHP received a $2 million appropriation to supplement the DHP-provided funds for the EDR project to complete additional implementations. For FY 2021, a funding increase of $500,000 was received to support new EDR implementations, enhance the EDR including interfaces with multiple electronic health record (EHR) and other healthcare network systems. In FY 2022, a funding increase of $1,000,000 was received to continue to support new EDR implementations and continue to enhancements to the EDR and provide necessary updates. In FY 2022, the DHP EDR Program implemented the IHS DXE EDR for 18 additional I/T/U dental clinics. The continuous EDR upgrade support for the more than 300 I/T/U dental clinics using the IHS DXR EDR is essential to maintain data integrity, cybersecurity, and ensure the IHS provides state-of-the-art electronic records support for both direct patient care quality and safety as well as provider/clinic effectiveness and efficiency. As the funds are recurring annually, the plan is to enhance the EDR as follows: in addition to the 10-20 more new EDR implementations each year, the DHP expects to support all I/T/U clinics to upgrade to the most current versions of the IHS Dentrix Enterprise EDR system. The additional funding will also be used to enhance reporting capability for the IHS individual patient-based Oral Health Status (OHS) measure that allows the local clinic to identify patients in need of urgent and/or preventive oral health care. As patient oral health data becomes aggregated at higher levels, IHS leadership will also have appropriate data for decisions to support effective oral healthcare initiatives. Additional IHS-specific EDR development in FY 2021-2022 included the development of additional interfaces between IHS

[8] U.S. Census Bureau. Population Estimates, July 1, 2022. https://www.census.gov/quickfacts/fact/table/US/PST045217, accessed 10 February 2023.

Dentrix EDR to EHR systems used by Tribal and Urban medical clinics that do not use the IHS Resource, Patient, and Management System (RPMS) EHR program. Other IHS Dentrix EDR developments include: standardized Provider Clinical Notes templates (to streamline accurate patient treatment notes in the EDR); standardized data reporting updates; Dentrix scanned document QA review; and additional Quality of Care review reports. Additional improvements in billing capabilities could increase third party collections for all I/T/U dental clinics. (*Supports the HHS Strategic Plan Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability through HHS Objective 5.2: Sustain strong financial stewardship of HHS resources to foster prudent use of resources, accountability, and public trust.)* A second way the DHP has improved the delivery of care is through ongoing support of long-term training (LTT) of general dentists to build the cadre of dental specialists in the IHS and tribal dental programs. (*The DHP LTT program supports the HHS SP Objective1.5: Bolster the primary and preventive health care workforce to ensure delivery of quality services and care.*) Dentists completing DHP-sponsored LTT to become specialist such as pediatric dentists, periodontists, and endodontists have a service payback obligation to serve AI/AN patients. In the past 6 years, an oral maxillofacial surgeon, an endodontist, a periodontist, and seven pediatric dentists have returned from LTT to serve AI/AN patients. In FY 2023 the DHP will support 2 programs in the IHS Great Plains Area that will utilize DHP-sponsored LTT to increase the number of pediatric dental specialists serving AI/AN patients. A third way the DHP is improving the delivery of services is through the adoption of an integrated care model, specifically in promoting depression screenings by dental health providers through a collaboration with the IHS Behavioral Health Program. (*The collaborative efforts between the DHP and the IHS Behavioral Health Program to improve the delivery of services support the HHS SP Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families.)*

The DHP continues to improve the delivery of services and retention of staff through a sustained (20+ years) continuing dental education (CDE) program. The IHS CDE program provides high quality continuing education accredited through the American Dental Association Continuing Education Provider Recognition Program. In FY 2022, despite a continued decrease of in-person educational opportunities due to the ongoing pandemic, the IHS CDE program held 374 courses, a 42 percent increase in courses from the 263 offered in FY 2021, and the most courses offered in the history of the CDE program. A total of 3,364 dental health professionals participated in the CDE program, with 22,642 CDE participant hours awarded to dental staff working in IHS, Tribal, and Urban dental programs. In the past, one CDE credit has been estimated to be valued between $100 -$200. This valuation includes the equivalent tuition cost that would be incurred seeking CDE in the private sector and the cost of the time and travel away from the office to attend CDE outside the IHS CDE program. Therefore, the total financial benefit to the IHS from the CDE Program in FY 2022 was between $2.2 and $4.4 million. Since 2016, the IHS CDE Program has awarded 204,568 participant CDE hours, amounting to an estimated $20-$40 million in free CDE through almost 2,000 CDE courses. The accomplishments of this program over the last 7 years ranks it as one of the largest CDE programs in the country within and outside of the federal government.

The DHP has also been the largest trainer of expanded function dental assistants (EFDA) in the Nation. The EFDA workforce model was introduced to the profession in 1961 by the IHS. EFDAs are trained and certified dental assistants with competencies to allow them to perform simple dental cleanings and fillings under the general supervision of a dentist, thereby increasing productivity , efficiency, and effectiveness of IHS, tribal, and urban dental programs. Since 2016, the IHS CDE Program has held 133 different in-person EFDA courses that have resulted in 645 dental assistants initiating EFDA training (over one-fourth of the dental assistant workforce) and

over 550 completing the training and certification requirements. The models of expanded function dental assistants have been shown to increase access to dental care in the DHP by up to 3.0 percent, increase total services delivered by dental programs up to 5.1 percent, and increase the total services per patient visit by up to 14 percent. *(The DHP continues to evaluate training efforts and staff implementation of improvements, as appropriate. The DHP CDE program also supports the HHS SP Objective 1.2.)*

The DHP continues to be on the forefront of hot issues in public health dentistry. The DHP, through the CDE Program, addressed public health issues such as antibiotic stewardship, opioid overdose reversal in dental settings, managing opioid use disorder through medication-assisted therapy, the growing threat of e-cigarettes in adolescents, community water fluoridation, the phase-down of dental amalgam, the new periodontal disease classification standards, improving oral health literacy, silver diamine fluoride (SDF), continued addressing pandemic-related issues, and the integration of oral health and primary care.

The DHP continues to provide guidance to dental programs on pandemic-related issues. The pandemic increased dental programs' interest in infection control and prevention procedures, and the DHP infection control committee developed a series of continuing education courses, weekly infection control tips, and infection control competency assessments for dental staff related to improving safety and infection control in I/T/U dental programs. In addition, the DHP promoted and supported the new IHS "3E" initiative of talking to patients about recommended vaccinations (including the COVID-19 vaccine) with "every patient, every encounter, every recommended vaccine."

The DHP continues to lead federal dental programs in the integration of oral health and overall health. In FY 2022, the DHP began several groundbreaking initiatives to improve integrated care and overall health of AI/AN patients. One example is the introduction of silver diamine fluoride applications by medical providers. Since 50 percent of AI/AN children under 6 years of age see a medical provider in the IHS system but not a dental provider, a pilot was developed to teach medical providers how to apply the tooth decay-stopping silver diamine fluoride to young AI/AN children, and then referring them to the dental department for follow-up care. This was designed to prevent tooth decay from progressing in young children where eventual treatment would have led to care needing to be rendered in an operating room environment. Another example of integrated care includes the implementation of training emergency department physicians on how to better triage and treat patients with dental pain and infection reducing the need to prescribe opioids, part of the overall IHS opioids stewardship program. A final example was the development of a cognitive assessment in older AI/AN patients in a dental setting, designed to improve early detection of Alzheimer's disease and other dementias, as well as improve collaboration between dental and medical providers. A summary of initiatives and guidelines can be viewed at the IHS Dental Portal at www.ihs.gov/doh under the "initiatives" tab. (*HHS SP Objective 1.3.*)

**OUTPUTS / OUTCOMES**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| 61 Topical Fluorides (Outcome) | FY 2022: 20.9% Target: 26.8 % | 21.1% | 21.1% | Maintain |

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| | (Target Not Met but Improved) | | | |
| 62 Access to Dental Services (Outcome) | FY 2022: 22.3 % Target: 28.8 % (Target Not Met but Improved) | 24.4% | 24.4% | Maintain |
| 63 Dental Sealants (Outcome) | FY 2022: 9.0 % Target: 13.7 % (Target Not Met but Improved) | 9.9% | 9.9% | Maintain |

**GRANTS AWARDS**

The DHP solicited, through a Federal Register Notice of Funding Opportunity in June 2020, applications for the Dental Clinical and Preventive Support Centers (DSC) Program. For a five-year cycle starting December 1, 2020, six grant awards were made, at an annual funding level of $350,000 each, with the purpose being to establish DSC Programs. $1,000,000 of new FY 2021 funding for DSCs was utilized to increase the number of DSCs and the grant funding to each DSC, resulting in an expansion of services to AI/AN communities. In FY 2022, the DSC Program received an additional $1,000,000 to allow the DSCs the ability to expand the services provided to the AI/AN communities. The additional funding now allows each of the DSC's to be supported annually at the $444,444 funding level. The DSCs combine IHS and tribal resources and infrastructure in order to address challenges faced by I/T/U dental programs. DSCs provide support through conduction of oral health surveillance, assisting dental programs with health fairs and special prevention initiatives such as the Give Kids A Smile Campaign (one-day events designed to provide preventive procedures on AI/AN children), supporting continuing dental education to standardize care across IHS Areas and to help recruit and retain quality oral health care professionals, and in developing educational resources for AI/AN communities to help improve oral health literacy and promote access to culturally-competent dental care in I/T/U dental programs.

| *(whole dollars)* | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget |
|---|---|---|---|
| Number of Awards | 6 | 6 | 6 |
| Average Award | $444,444 | $444,444 | $444,444 |
| Range of Awards | $444,444 | $444,444 | $444,444 |

## AREA ALLOCATION

**Dental Health**

(dollars in thousands)

| DISCRETIONARY SERVICES | FY 2022 Final | | | FY 2023 Enacted /1 | | | FY 2024 Estimated /1 | | | FY 24 +/- FY 23 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Federal | Tribal | Total | Federal | Tribal | Total | Federal | Tribal | Total | Total |
| Alaska | $392 | $42,222 | $42,614 | $418 | $45,042 | $45,460 | $537 | $57,920 | $58,457 | $12,997 |
| Albuquerque | 5,472 | $4,821 | 10,293 | 5,838 | 5,143 | 10,981 | 7,507 | 6,614 | 14,120 | $3,139 |
| Bemidji | 2,335 | $3,044 | 5,379 | 2,490 | 3,248 | 5,738 | 3,203 | 4,176 | 7,378 | $1,640 |
| Billings | 6,631 | $2,195 | 8,826 | 7,074 | 2,341 | 9,415 | 9,096 | 3,011 | 12,107 | $2,692 |
| California | 434 | $2,306 | 2,740 | $463 | 2,460 | 2,923 | 595 | 3,164 | 3,759 | $836 |
| Great Plains | 11,724 | $9,373 | 21,097 | 12,507 | 9,999 | 22,506 | 16,083 | 12,858 | 28,941 | $6,435 |
| Nashville | 829 | $7,679 | 8,508 | 885 | 8,192 | 9,077 | 1,138 | 10,534 | 11,672 | $2,595 |
| Navajo | 28,667 | $10,632 | 39,300 | 30,582 | 11,342 | 41,924 | 39,325 | 14,585 | 53,910 | $11,986 |
| Oklahoma | 10,895 | $41,506 | 52,401 | 11,623 | 44,277 | 55,900 | 14,946 | 56,936 | 71,882 | $15,982 |
| Phoenix | 9,896 | $10,872 | 20,768 | 10,557 | 11,598 | 22,155 | 13,576 | 14,914 | 28,489 | $6,334 |
| Portland | 4,978 | $4,436 | 9,413 | 5,310 | 4,732 | 10,042 | 6,828 | 6,085 | 12,913 | $2,871 |
| Tucson | 44 | $2,547 | 2,590 | 47 | 2,717 | 2,763 | 60 | 3,493 | 3,554 | $790 |
| Headquarters | 8,636 | $ | 8,636 | $9,213 | 0 | 9,213 | 11,846 | 0 | 11,846 | $2,634 |
| **Total, Dental** | **$90,933** | **$141,633** | **$232,566** | **$97,006** | **$151,092** | **$248,098** | **$124,740** | **$194,289** | **$319,029** | **$70,931** |

1/ Note: 2023 and 2024 are estimates.

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $121,109 | $127,171 | $163,992 | +$36,821 |
| FTE* | 168 | 168 | 200 | +32 |

* FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**...........................................................................................Permanent

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

**PROGRAM DESCRIPTION**

The Indian Health Service (IHS) Mental Health/Social Services (MH/SS) program is a community-based clinical and preventive service program that provides ongoing vital outpatient mental health counseling and access to dual diagnosis services, mental health crisis response and triage, case management services, community-based prevention programming, and outreach and health education activities. The MH/SS program supports several of the HHS Strategic Plan goals and objectives, including *Objective 1.3: Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health;* and, *Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families.* The most common MH/SS program model is an outpatient service staffed by one or more mental health professionals providing individual, family, and group psychotherapeutic services and case management. After hours emergency services are generally provided through local emergency departments and contracts with non-IHS hospitals and crisis centers. Inpatient services are generally purchased from non-IHS hospitals or provided by state or county hospitals providing mental health services. Intermediate level services such as group homes, transitional living support, intensive case management, and related activities are typically offered through state and local resources. Additionally, slightly more than one-half of the Tribes administer and deliver their own mental health programs.

IHS continues to support Tribal communities in their ability to address the mental health disparities experienced among the AI/AN population. In partnership with Tribal community entities, a collaborative community of learning will support IHS efforts to promote excellence and quality through the development of innovative, community-based projects to expand mental health services and treatment in integrated clinical settings.

## BUDGET REQUEST

The FY 2024 budget submission for Mental Health is $164 million, which is $37 million above the FY 2023 Enacted level.

FY 2023 Base Funding of $127 million – This funding will maintain the program's progress in addressing mental health needs by improving access to behavioral health services through tele-behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

FY 2024 Funding Increase of $37 million includes:

- Direct Health Care Services Increase: +$25 million to expand access to mental health care services. These resources will support efforts to reduce health disparities and improve the overall health status for American Indians and Alaska Natives by increasing the availability of health care services in Indian Country. This increase would allow for 145,779 additional outpatient visits.

- Current Services and Staffing of Newly Constructed Facilities: +$12 million. Information can be found on pages CJ-33 and CJ-35 respectively.

## FUNDING HISTORY

| Fiscal Year | Amount |
|---|---|
| 2020 | $109,036,000 |
| 2021 | $115,107,000 |
| 2022 Final | $121,109,000 |
| 2023 Enacted | $127,171,000 |
| 2024 President's Budget | $163,992,000 |

## TRIBAL SHARES

Mental Health funds are subject to Tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities, unless otherwise specified in the annual appropriations bill. A portion of the overall Mental Health budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

## PROGRAM ACCOMPLISHMENTS

Suicide Prevention: Suicide rates among AI/ANs are historically higher than other racial minorities within the U.S. population. Suicide rates have increased in 2021 with AI/AN people having the highest suicide rates overall, and the biggest increase (26 percent) between 2018 to 2021[1].As of 2020, AI/AN have the highest rate (23.9 per 100,000),[2] and the rate has increase 55.7

[1] US Department of Health and Human Services, Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report, Notes from the Field: Recent changes in suicide rates by race, ethnicity, and age group, United States 2021. https://www.cdc.gov/mmwr/volumes/72/wr/mm7206a4.htm?s_cid=mm7206a4_w

[2] US Department of Health and Human Services, Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report, February 25, 2022. Changes in Suicide Rates – United States, 2019 and 2020.

percent over the past ten years.[3] As of 2020, suicide rates for AI/AN adolescents and young adults has reached all-time highs, with 24.6 suicides per 100,000 among 15 to 24 year old AI/AN, and 29.8 per 100,000 among 25 to 34 year old AI/AN. The adolescent rates are 1.9 times higher than the national average for others in the same age group, and 2.1 times higher than the national average for other young adults.[4] Suicide is the eighth leading cause of death among all AI/AN across all ages.[5] Strategies to address behavioral health, alcohol, substance use disorder, and suicide prevention require comprehensive clinical strategies, and approaches.

In 2019, AI/AN adolescents (12 to 17 year olds) had the highest prevalence (11.5 percent) of major depressive episode with severe impairment compared to other ethnicities.[6] In 2019, AI/AN adults had the highest prevalence (9.4 percent) of major depressive episode with or without severe impairment compared to other ethnicities.[7] Furthermore in 2019, AI/AN adults had the second highest prevalence (18.7 percent) of serious mental illness among U.S. adults compare to other ethnicities.[8]

The IHS utilizes and promotes collaborations and partnerships with patients and their families, including Tribes and Tribal organizations, Urban Indian organizations, federal, state, and local agencies, as well as public and private organizations.

The IHS initiated a suicide surveillance data protocol focusing on suicide related behaviors to identify suicide within the IHS Electronic Health Records (EHR) in a standardized and systematic fashion. The suicide surveillance protocol will capture data related to suicide ideation; suicide attempts; and other suicide related behaviors through the use of a universal screening and associated clinical pathways to better understand local facility challenges, identify risk factors and target resources and services appropriately.

Ten percent of those who die by suicide had visited the emergency department within 2 months of death. In FY 2019, the IHS and the National Institute of Mental Health (NIMH) partnered by way of a Memorandum of Understanding (MOU) to address the high rates of suicide impacting the AI/AN communities. Throughout the three year partnership (FY 2019- 2021), IHS and NIH worked together to implement the Ask Suicide Screening Questions (ASQ) and its accompanying toolkit for universal screening within one IHS Emergency Department (ED). The ASQ is a suicide screening resource developed by NIMH for medical settings to help nurses or physicians successfully identify individuals at risk for suicide. In FY 2019, IHS conducted a site visit and staff training on the ASQ, and partnered with IHS OIT to fully integrate the validated suicide risk screening instrument into the IHS electronic health records system for field implementation. An evaluation of the ED pilot site demonstrated 70 percent of all patients who used the ED were screened for suicide risk. The evaluation will be completed and published in FY 2023.

In FY 2021, IHS began training staff in recognizing and responding to suicide through the implementation of a culturally customized suicide prevention gatekeeper program, Question

[3] US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2020. Available from CDC WONDER Online Database, released in 2021. http://wonder.cdc.gov/ucd-icd10.html.
[4] Ibid.
[5] US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Deaths: Leading Causes for 2019.
[6] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health. Available from https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases.
[7] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health. Available from https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases.
[8] Ibid.

Persuade and Refer (QPR). The training was contracted through Sister Sky Inc. and was slated to train 15,418 IHS Staff across 12 IHS areas. As of 2023, Sister Sky Inc. has trained 9,554 staff and provided train the trainer training to 123 IHS staff. In addition, Sister Sky Inc. has developed best practices including a monthly outreach newsletter to provide updates on training availability, train the trainer dates, share information on progress and evidence based practices, and monthly technical assistance calls for training support to discuss technical and administration topics, and dealing with difficult situations related to suicide during trainings.

In FY 2022, IHS collaborated with the US Department of Health and Human Services, Centers for Disease Control and Prevention on a Morbidity and Mortality Weekly Report[9] highlighting disparities in circumstances that contribute to suicide among AI/AN persons. The report's key findings showed that nearly 75 percent of AI/AN suicides were among people ages 44 years and younger, compared to 46.5 percent among non-AI/AN suicides. The greatest proportion of suicides among AI/AN (46.9 percent) were among people ages 25-44 years; the greatest proportion of suicides among non-AI/AN (35 percent) were among people ages 45-64 years.

Among other findings, AI/AN persons were more likely to experience relationship problems and circumstances associated with alcohol and/or substance misuse (including reported alcohol use hours before death), compared with non-AI/AN. Nearly 55 percent of AI/AN persons experienced relationship problems/losses, compared with 42.2 percent among non-AI/AN. AI/AN persons compared to non-AI/AN persons were more likely to experience intimate partner and family relationship problems, interpersonal violence victimization and perpetration, suicide of a friend/family member, and arguments/conflicts preceding death. AI/AN persons compared to non-AI/AN persons also had greater odds of alcohol and/or substance use problems, having experienced a recent or pending crisis related to these conditions, and greater odds of alcohol use prior to suicide. AI/AN persons were less likely to have known mental health conditions (41.5 percent versus 49.2 percent for non-AI/AN persons), any mental health/substance abuse treatment (29.5 percent versus 35.1 percent), and other common risk factors, such as: reduced odds of physical health, job, and financial problems. AI/AN persons had greater odds than non-AN/AN of dying in a natural area (such as a field) or supervised facility (such as a prison). Among both AI/AN and non-AI/AN persons, about 30 percent experienced a past or anticipated crisis within 2 weeks of death. AI/AN decedents were more likely than non-AI/AN decedents to test positive for 1 or more substances, including alcohol and amphetamines. Conversely, AI/AN decedents were less likely to test positive for opioids, benzodiazepines, cocaine, antidepressants, antipsychotics, and barbiturates.

<u>Zero Suicide Initiative:</u> In FY 2017, IHS received $3.6 million to fund 8 pilot IHS and Tribal sites to participate in its first cohort of the Zero Suicide Initiative. The Zero Suicide philosophy is a key concept of the National Strategy for Suicide Prevention (NSSP) and is a priority of the National Action Alliance for Suicide Prevention (Action Alliance). Zero Suicide focuses on developing a system-wide approach to improving care for individuals at risk of suicide who are currently utilizing health and behavioral health systems. Health care systems are uniquely poised to identify those struggling with thoughts of suicide considering 50 percent of those who die by suicide had contact with a primary care provider within 1 month of suicide. Furthermore, 80 percent of those who die by suicide had contact with a primary care provider within 1 year of suicide.

[9] Communication Plan: Suicides Among American Indian/Alaska Native Persons — National Violent Death Reporting System, 2015–2020 https://www.cdc.gov/mmwr/volumes/71/wr/mm7137a1.htm

In FY 2017- FY 2020, IHS funded eight facilities in total, five Tribal and three federal facilities, at $400,000, to implement the Zero Suicide Initiative (ZSI) model within their healthcare system. Each ZSI project plan includes utilizing evidence-based treatments in suicide care, initiating safety plans with patients at risk for suicide, implementing intensive follow-up upon missed or cancelled appointments, universal suicide screening of all at-risk patients, increasing restriction of lethal means, implementing intensive case management, and initiating follow up with patients within 24 hours of transition of care. In year two, all project sites have successfully established a new Zero Suicide policy and have developed suicide risk screening procedures, clinical pathways, and data collection plans to enhance surveillance and analysis capabilities. Similar to other grant programs, the COVID-19 pandemic placed an unforeseen hardship on all facilities implementing ZSI in their Emergency Departments.

In FY 2021, ZSI projects trained over 1,475 staff in evidence-based suicide risk and assessment practices and over 10,000 patients received a positive suicide risk screening. Additionally, through ZSI, all sites established a Suicide Team to develop a Zero Suicide Work Plan.

In FY 2022, IHS funded a new five-year cohort of ZSI projects and is establishing a ZSI Coordinating Center that will provide technical assistance to address the unique needs of Tribes and Tribal organizations implementing the ZSI model. The second ZSI cohort focuses on promoting collaboration with the local, regional and federal health partners. In addition, ZSI funds will support six federal facilities at 166,000 annually to reduce the prevalence of suicide among the AI/AN population within IHS hospitals through improved care coordination and expanding behavioral health care services. These efforts support several HHS Strategic Plan goals and objectives, *including Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families.;* and, *Objective 3.4: Increase safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence.*

Trauma-Informed Care: Trauma Informed Care supports the HHS Strategic Plan, as in the example of *Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families.* In 2019, IHS partnered with the University of New Mexico (UNM) to develop a comprehensive online training curriculum related to trauma and trauma-informed care. Topics included an overview for all staff, and specific training tailored to behavioral health staff, healthcare provider staff, non-provider staff, and supervisors. In FY 2022, 305 attendees completed on-demand trainings. IHS has worked to implement the principles of trauma informed care to ensure its system understands the prevalence and impact of trauma, facilitates healing, avoids re-traumatization, and focuses on strength and resilience. In FY 2022, a total of 14,475, or 96 percent of IHS staff completed the “Overview of Trauma Informed Care and Historical Trauma Guidance” in the HHS LMS.

Lessons learned from the 2016 Improving Patient Care and the Johns Hopkins University Pediatric Integrated Care Collaborative (PICC) pilot project were used by IHS to incorporate into the new trauma informed care policy in the Indian Health Manual released in FY 2020. In FY 2022, IHS will support the new trauma informed care policy by developing a mandatory on-demand, online training for clinical and non-clinical staff. This training will provide guidance to IHS facilities in delivering trauma-informed care services along with promoting self-care to prevent secondary traumatic stress, which can lead to compassion fatigue and burnout.

Behavioral Health Integration Initiative (BH2I): The statistics facing AI/AN peoples for suicide, alcohol-related deaths, domestic and sexual violence, and homicide require the Indian health system to develop a system of comprehensive screening and effective intervention to reduce morbidity and early mortality. IHS supports changing the paradigm of mental health and substance abuse disorder services from being episodic, fragmented, specialty, or disease focused to incorporating it into the patient-centered medical home.

BH2I prioritizes integration across the health care system by developing care teams, strengthening infrastructure, and enhancing clinical processes to include increased depression screenings in primary care clinics. In FY 2022, supporting the HHS Strategic Plan, *Objective 1.4: Drive the integration of behavioral health into the healthcare system to strengthen and expand access to mental health and substance use disorder treatment and recovery services for individuals and families,* IHS awarded 14 new BH2I grantees, totaling $5.5 million, which will be on a five-year funding cycle through FY 2026. Additionally, IHS will contract with a technical assistance provider to assist grantees with the implementation of integrated care efforts.

Technical assistance (TA) provided to each grantee focused on integrated care with expert psychiatrists, primary care physicians, and social workers. In addition, cross-site evaluation among the BH2I projects identified enhanced integration assessment tools, evidence-based practices applicable to an integrated behavioral and primary care environment, best practices for priority objectives including an emphasis on co-located physical space, implementing measurement-based care using a practice management system for clinical measures and validated tools. BH2I projects reported structural successes including integration policies and procedures such as same day access to behavioral health providers within primary care and emergency room settings. Sites also reported increased screening rates for depression, anxiety, trauma and early childhood development disabilities and reduction in wait times to see a mental health counselor and psychiatrist with some sites focused on sustainability strategies.

In FY 2023, in addition to the BH2I grant program, IHS will also support four federal facilities that currently participate in the Improving Pain and Addiction Care in IHS Emergency Departments (PACED) pilot project at $120,000 annually. Funds will support sites as they integrate behavioral health care to develop model clinical care pathways following patient overdose resuscitation within EDs.

Reflective of the Agency's priority to raise the mental health of the AI/AN population IHS Division of Behavioral Health initiatives have focused on increased implementation of depression screening in primary care clinics. In FY 2020, IHS reported 41.1 percent of AI/AN adults over the age of 18 screened for depression using a standardized screening assessment for depression. In FY 2020, this same measure was reported for youth ages 12-17 and data indicated 32.5 percent of eligible youth were screened for depression. For FY 2020, targets were based on prior year results and results indicate the targets were not met for both measures. The FY 2022 targets are set in consideration of the most recent results.

According to CDC, racial and ethnic minority groups have experienced disparities in mental health and substance misuse related to access to care, psychological stress, and social determinants of health. In FY 2021, IHS partnered with the Northwest Portland Indian Health Board to launch a free 24/7 Crisis Text Line for AI/ANs, which includes texting the keywords "Native" and "Indigenous" to 741-741. The Crisis Text Line connects individuals to a live, trained Crisis Counselor allowing for an increase in access to care and support during the COVID-19 pandemic.

TeleBehavioral Health and Workforce Development: The IHS TeleBehavioral Health Center of Excellence (TBHCE) was established in 2009, utilizing funds from the Methamphetamine and Suicide Prevention Initiative, to assess the feasibility of providing behavioral health services via televideo. Due to the rural nature of many IHS and Tribal facilities, I/T/U patients face many issues surrounding access to care, particularly specialty care. Providers working in these remote areas often face barriers to maintaining the required continuing education (CE) credits required for licensure and remaining up to date on current clinical guidelines. The TBHCE assists IHS, Tribal, and urban Indian organizations providers and facilities in overcoming these challenges by providing a range of telebehavioral health services and virtual training. There are 23 sites receiving direct care services through the TBHCE. These services include, adult counseling, child counseling, family counseling, trauma/Post Traumatic Stress Disorder (PTSD) counseling, child psychiatry, adult psychiatry, and addiction psychiatry. In FY 2022, the TBHCE provided 67,422 encounters and 5,658 hours of telebehavioral health services.

Additionally, the TBCHE hosted webinars designed to meet the specific training needs of IHS, Tribal, and Urban Indian (I/T/U) health care providers. More specifically, IHS utilizes tele-education (otherwise known as distance learning) to deliver national continuing education (CE) programming to I/T/U healthcare providers. In FY 2022, TBHCE provided 61 webinars that included 4,719 attendees. In FY 2022, TBHCE provided 40 on demand (self-paced) trainings that included 2,280 attendees. On demand trainings focused on various topics including compassion fatigue, cultural competency, and trauma informed care. In FY 2023, TBHCE will continue to provide virtual live and on demand behavioral health trainings for I/T/U providers.

Finally, IHS developed and maintains the online IHS Essential Training on Pain and Addiction. In FY 2022, the ETPA training will transition to a new host platform.

**OUTPUTS / OUTCOMES**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| 65 Proportion of American Indian and Alaska Native adults 18 and over who are screened for depression. (Outcome) | FY 2022: 37 % Target: 42.9 % (Target Not Met but Improved) | 36.4 % | 36.4% | Maintain |
| 85 Depression Screening ages 12-17. (Outcome) | FY 2022: 32.1 % Target: 33.9 % (Target Not Met but Improved) | 29.5 % | 29.5% | Maintain |
| MH-1 Increase Tele-behavioral health encounters nationally among American Indians and Alaska Natives (Output) | FY 2022: 67,422 Target: 48,000 (Target Exceeded) | 55,200 | 71,000 | +15,800 |

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| MH-2 Suicide Screen and Assessment (Outcome) | Discontinued | Discontinued | Discontinued | N/A |

## GRANTS AWARDS

The proposed FY 2024 budget increases will be used, in part, for grants for IHS facilities, Tribes, Tribal organizations, and urban Indian organizations to develop innovative programs to address behavioral health services and deliver those services within and outside of the traditional health care system. The actual number of non-competitive grants are included below:

| *(whole dollars)* | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget |
|---|---|---|---|
| Number of Awards | 20 | 20 | 20 |
| Average Award | $450,000 | $450,000 | $450,000 |
| Range of Awards | $400,000 - $500,000 | $400,000 - $500,000 | $400,000 - $500,000 |

## AREA ALLOCATION

**Mental Health**

(dollars in thousands)

| DISCRETIONARY SERVICES | FY 2022 Final | | | FY 2023 Enacted /1 | | | FY 2024 Estimated /1 | | | FY '24 +/- FY '23 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Federal | Tribal | Total | Federal | Tribal | Total | Federal | Tribal | Total | Total |
| Alaska | $82 | $16,075 | $16,157 | $86 | $16,880 | $16,966 | $111 | $21,767 | $21,878 | $4,912 |
| Albuquerque | 1,957 | 3,597 | 5,554 | 2,055 | 3,777 | 5,832 | 2,649 | 4,871 | 7,520 | $1,688 |
| Bemidji | 361 | 2,725 | 3,086 | 379 | 2,861 | 3,241 | 489 | 3,690 | 4,179 | $938 |
| Billings | 2,884 | 1,741 | 4,625 | 3,028 | 1,829 | 4,857 | 3,905 | 2,358 | 6,263 | $1,406 |
| California | 125 | 2,879 | 3,004 | 131 | 3,023 | 3,154 | 169 | 3,899 | 4,068 | $913 |
| Great Plains | 7,898 | 3,472 | 11,370 | 8,294 | 3,645 | 11,939 | 10,695 | 4,701 | 15,396 | $3,457 |
| Nashville | 360 | 3,151 | 3,511 | 378 | 3,309 | 3,687 | 487 | 4,267 | 4,754 | $1,067 |
| Navajo | 10,006 | 9,060 | 19,066 | 10,507 | 9,513 | 20,020 | 13,549 | 12,268 | 25,817 | $5,797 |
| Oklahoma | 3,469 | 17,311 | 20,779 | 3,642 | 18,177 | 21,820 | 4,697 | 23,440 | 28,137 | $6,318 |
| Phoenix | 3,717 | 7,760 | 11,477 | 3,903 | 8,148 | 12,052 | 5,033 | 10,508 | 15,541 | $3,489 |
| Portland | 552 | 5,049 | 5,601 | 579 | 5,302 | 5,881 | 747 | 6,837 | 7,584 | $1,703 |
| Tucson | 13 | 2,025 | 2,038 | 13 | 2,126 | 2,140 | 17 | 2,742 | 2,760 | $620 |
| Headquarters | 14,841 | | 14,841 | 15,584 | 0 | 15,584 | 20,097 | | 20,097 | $4,512 |
| **Total, Mental** | **$46,264** | **$74,846** | **$121,109** | **$48,580** | **$78,592** | **$127,171** | **$62,645** | **$101,347** | **$163,992** | **$36,820** |

1/ Note: 2023 and 2024 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 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget /1 | FY 2024 +/- FY 2023 |
| PL | $258,024 | $266,440 | $308,701 | +$42,261 |
| FTE* | 223 | 222 | 235 | +13 |

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**.........................................................................................Permanent

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

## PROGRAM DESCRIPTION

Alcohol, substance abuse, and addiction 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 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. These collaborative activities strive to integrate substance abuse treatment into primary care. For instance, the Substance Abuse and Suicide Prevention Program (SASP) provides prevention and intervention resources developed and delivered by local community partners to address the dual crises of substance abuse and suicide in AI/AN communities.

AI/AN populations suffer disproportionately from substance use disorders (SUD) compared with other racial groups in the United States (U.S.). Research has consistently found that AI/AN persons experience higher rates of substance use compared with the U.S. general population. Findings from the 2019 National Survey on Drug Use and Health (NSDUH) reported the rate of AI/ANs aged 12 and over with an alcohol use disorder (6.4 percent) is higher than that of the total population (5.3 percent).[1] In July 2022, the CDC's National Center for Health Statistics reported that from 2019 to 2020, overall drug overdose death rates (per 100,000 people) increased 39 percent% for non-Hispanic (NH) AI/AN persons compared to White persons (22 percent).[2] During that time, deaths rose more than 500 percent among AI/ANs. Due to misclassification of race and ethnicity on death certificates, the actual number of deaths for AI/ANs may be underestimated by up to 35 percent.[3]

[1]https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect5pe2019.htm#tab5-4a
[2] https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7129e2-h.pdf
[3] https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6619.pdf

Additionally, in a recent study by the National Institute on Drug Abuse (NIDA), deaths involving methamphetamines more than quadrupled among non-Hispanic AI/AN from 2011-2018 (from 4.5 to 20.9 per 100,000 people) overall.[4]

## BUDGET REQUEST

The FY 2024 budget submission for Alcohol and Substance Abuse is $309 million, which is $42 million above the FY 2023 Enacted level.

FY 2023 Base Funding of $266 million – This funding will maintain the program's progress in addressing alcohol and substance abuse needs by improving access to behavioral health services through tele-behavioral health efforts and providing a comprehensive array of preventive, educational, and treatment services.

FY 2024 Funding Increase of $42 million includes:

- Direct Health Care Services Increase: +$17 million to expand access to alcohol and substance abuse care services. These resources will support efforts to reduce health disparities and improve the overall health status for American Indians and Alaska Natives by increasing the availability of health care services in Indian Country. This increase would allow for an estimated 4,910 additional outpatient visits and 111 inpatient days.

- Opioids Grants: +$9 million to expand the IHS Opioid Grant program to a total of $20 million. These additional resources will support opioid use disorder prevention, treatment, recovery, and aftercare services. Increased funds will prioritize projects targeted at recovery and aftercare practices and efforts by supporting community-based peer recovery training programs. Funds will support access to peer-recovery specialists, including access to training platforms with virtual learning and collaborative support, shared resources, and information. Funds will also provide evaluation and technical assistance for ongoing activities responding to the opioid crisis.

- Current Services and Staffing of Newly Constructed Facilities: +$16 million. Information can be found on pages CJ-33 and CJ-35 respectively.

## FUNDING HISTORY

| Fiscal Year | Amount |
|---|---|
| 2020 | $245,618,000 |
| 2021 | $251,360,000 |
| 2022 Final | $258,024,000 |
| 2023 Enacted | $266,440,000 |
| 2024 President's Budget | $308,701,000 |

## TRIBAL SHARES

Alcohol and Substance Abuse funds are subject to Tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services,

[4] https://jamanetwork-com.ezproxyhhs.nihlibrary.nih.gov/journals/jamapsychiatry/fullarticle/2774859

and activities, unless otherwise specified in the annual appropriations bill. A portion of the overall Alcohol and Substance Abuse budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

## PROGRAM ACCOMPLISHMENTS

As alcohol and substance abuse prevention and treatment have transitioned from IHS direct care services to local community control via tribal contracting and compacting, IHS' role has shifted to providing support to enable communities to plan, develop, and implement culturally informed programs. Organized to develop programs and program leadership, the major IHS ASAP activities and focus areas are:

Integrated Substance Abuse Treatment in Primary Care: IHS continues to support the integration of substance abuse treatment into primary care and acute care services. Integrating treatment into ambulatory health care offers immediate and same-day opportunities for health care providers to identify patients with SUDs, provide them with medical advice, help them communicate the health risks and consequences, obtain substance abuse consultations, and refer patients with more severe substance use-related problems to treatment.[5] One integration activity is the implementation of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) instrument. SBIRT is an early intervention and treatment service for people with SUD and those at risk of developing these disorders. IHS has broadly promoted SBIRT as an integral part of a sustainable, primary care-based activity that aims to support and integrate behavioral health into overall care. SBIRT is eligible for reimbursement from the Centers for Medicare and Medicaid Services (CMS). IHS has incorporated SBIRT as a Government Performance and Results Act (GPRA) national measure to be tracked and reported. Since FY 2018, the official GPRA measures have been calculated through the Integrated Data Collection System Data Mart (IDCS DM) utilizing National Data Warehouse (NDW) data. IHS facilities and participating tribal facilities are required to submit data into the NDW throughout the year. In FY 2021, the SBIRT was utilized in 15.8 percent of the patient visits for those ages 9 through 75. The target for this measure was 14.3 percent, therefore IHS efforts exceeded the expected percent of patients to be screened using the SBIRT. At the onset of the COVID-19 pandemic, IHS increased efforts to expand telehealth capacity across Indian Health Service/Tribal/Urban Indian Organizations (I/T/Us) to continue coordination of treatment and services to patients. Additionally, IHS continues to monitor the SBIRT administered through telehealth methods. IHS provides annual national training on SBIRT use, including guidelines for improved clinical documentation in the electronic health record. In FY 2022, IHS increased efforts that broadly promote the SBIRT tool to achieve targets at the regional and local levels, including a more focused education campaign on the importance of early detection and intervention using SBIRT among IHS operated programs. In addition, IHS is actively working to expand local SBIRT use, including a focus on substance use in women of childbearing age, to assist in early identification and referral for treatment and reduce illicit perinatal substance exposure for infants.

Increasing access to Medication Assisted Treatment (MAT): IHS is committed to assuring access to MAT for patients with opioid use disorder (OUD). The IHS strategy focuses on creating community and clinical resources and technical assistance to share best and promising practices. IHS continues to host the *Pain & Opioid Use Disorder* webinar and continuing education series. FY2021 MAT sessions included *Buprenorphine Micro-inductions and MAT in the Emergency Department Setting*. In tandem, IHS is expanding integrated team-based care models. In April

[5] U.S. Office of National Drug Control Policy. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.

2021, the IHS *Advancing Pharmacist Roles in Substance Use Disorder Treatment and Recovery Teams learning model* launched. Participants engage in a learning collaborative to increase knowledge surrounding patient screening, assessments, evidence-based practices for the management of OUDs, and trauma-informed care principles. A total of 307 continuing education credits have been issued in the first six months of the program. This project is also exploring methods to expand tele-MAT services using hub-and-spoke information distribution models.

IHS is working to expand access to MAT in acute care settings. In FY 2022, the IHS Pain and Addiction Care in the Emergency Department (PACED) pilot program intervention funded five projects in direct-service emergency departments. The objective of this intervention is to improve access to Medications for Opioid Use Disorder (MOUD) or improve pain management outcomes in acute care settings. Secondary objectives are to leverage the opioid surveillance dashboard to inform stewardship activities, to create a learning collaborative to share promising practices, and to assist sites with obtaining relevant accreditation. In FY 2022, the IHS emergency departments (EDs) received training from the American College of Emergency Physicians (ACEP) to identify and develop new systems of care and best practices to improve addiction and pain treatment outcomes in the ED by improving patient screening and increasing access to MOUD; improving clinical care pathways following patient overdose resuscitation; enhancing non-opioid pain management strategies as part of opioid stewardship within IHS EDs; and, support local champions to focus on achieving PACED accreditation, which is intended for hospitals that seek to improve pain management and addiction care for patients in EDs and recognize the need for prompt, safe, and effective pain management.

IHS has partnered with the Northwest Portland Area Indian Health Board and the Clinician Consultation Center to facilitate I/T/U clinician access to free Substance Use Disorder tele-consultation services. These services are intended to assist clinicians with patient treatment planning, facilitate didactic learning, and provide support for health systems that desire to create local protocols.

IHS continues to host training sessions for clinicians to receive the Drug Addiction Treatment Act (DATA) 2000 waiver to prescribe buprenorphine, and in FY 2018 added buprenorphine-containing medication and injectable naltrexone to the IHS National Core Formulary. The IHS continues to evaluate new long-acting MAT therapies for inclusion on the National Core Formulary and creates formulary briefs and technical assistance to incorporate these new treatments into practice. In June 2019, the IHS released the Special General Memorandum *Assuring Access to MAT for OUD* that requires federal IHS facilities to create an action plan to identify local MAT resources and coordinate patient access to these services when indicated to assure equitable access to MAT services.[6] In addition, IHS created workforce development strategies that include SUD training for healthcare workers and technical assistance materials that support sites with integrated SUD approaches to care.

To address challenges that limit access to recovery services in remote and rural IHS locations and villages, the IHS released an *Internet Eligible Controlled Substance Prescriber Designation* (IECSP) policy in the Indian Health Manual (Chapter 38) to assure access to MAT using telemedicine models for remotely located Tribal members.[7] In January 2020, an IHS telehealth toolkit for MAT services was created and shared on the ihs.gov/opioids website. These resources assist prescribers and sites with creating tele-MAT services and implementing provisions within the IECSP policy. Additionally, a webinar was hosted in February 2020 to describe available

[6] https://www.ihs.gov/ihm/sgm/2019/assuring-access-to-medication-assisted-treatment-for-opioid-use-disorder/

[7] https://www.ihs.gov/ihm/pc/part-3/chapter-38-internet-eligible-controlled-substance-provider-designation/

MAT resources and policies. In March 2019, the IHS released the *Recommendations to the Indian Health Service on American Indian/Alaska Native Pregnant Women and Women of Childbearing Age with Opioid Use Disorder* developed in collaboration with the American College of Obstetricians and Gynecologists' (ACOG) Committee on AI/AN Women's Health.[8] This resource will help providers improve maternal participation in early prenatal care and support, improve screening for SUD, and increase access to MAT for pregnant women and women of child-bearing age. The goal of these clinical recommendations is to foster relationships and improve awareness surrounding trauma-informed approaches to maternal opioid use that may lead to recovery, hope, and healing. Additionally, the IHS and the American Academy of Pediatrics Committee on Native American Child Health (CONACH) recently released the *Recommendations to the Indian Health Service on Neonatal Opioid Withdrawal Syndrome* that includes clinical recommendations on the prevention and management of neonatal opioid withdrawal syndrome.[9] These recommendations provide standards of care for screening, diagnosing, support, and treatment of pregnant mothers and infants affected by prenatal opioid exposure

IHS has also created a robust workforce development strategy to include didactic training. In FY 2022, the IHS continued its *Pain Management and Opioid Use Disorder Continuing Medical Education* webinar series. The IHS has hosted learning sessions in this series that include buprenorphine prescribing in pregnancy, dental acute pain management recommendations, as well as, an auricular acupuncture-training program. For example, *Implementing an Integrated MAT Model-A Review of Resources, Assessment and Treatment of Pain and Co-occurring OUD In Individual with Serious Mental Illness, and Treatment of OUD in the ED, Should it be a Choice?* The IHS has expanded access to harm reduction interventions that include increased access to the opioid overdose reversal medication, naloxone. In 2015, the IHS signed a memorandum of agreement with the Bureau of Indian Affairs (BIA). The agreement allows IHS to provide BIA Law Enforcement Officers (LEO) with training and naloxone rescue kits for responding to incidents of opioid overdose. In 2017, IHS turned the naloxone training program over to the BIA after certifying 48 BIA LEOs as naloxone trainers. IHS continues to support this program by re-supplying naloxone rescue kits to BIA LEO first responders as needed. In 2019, IHS conducted first-responder train-the-trainer sessions on naloxone and harm reduction strategies for community health workers from IHS and Tribal sites from across the country. IHS also supports naloxone co-prescribing and has created sample collaborative practice agreements to engage pharmacists in naloxone distribution efforts and has hosted an IHS *Grand Rounds* on naloxone co-prescribing to increase provider awareness of this life-saving procedure. A *First Responder Toolkit* that includes a training video, a law enforcement testimonial video, customizable forms, and a train-the trainer curriculum was created to support naloxone deployment in Tribal communities. The IHS formally expanded access to naloxone in March 2018 through a policy titled *Prescribing and Dispensing of Naloxone to First Responders*, which requires IHS federal pharmacies to provide naloxone to all Tribal law enforcement agencies and other trained first responders. These efforts have resulted in a 143 percent increase in naloxone procurement across IHS facilities that utilize the Prime Vendor.

IHS has further adapted the toolkit and strategy to equip community first responders and paraprofessionals with training on opioid overdose response and naloxone. These expanded collaborations with local law enforcement and community first responders resulted in an initial pilot community-health naloxone train-the-trainer program to include naloxone distribution. In December 2021, IHS revised the IHS Naloxone webpage to share technical assistance and

[8] https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/acogguidelines2018.pdf

[9] https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/aapnowsrecommendationstoihs.pdf

resources to support access to naloxone and opioid overdose prevention strategies. IHS collaborated with the Northwest Portland Area Indian Health Board to record a virtual naloxone train-the-trainer program as free technical assistance to Tribes to support access to naloxone in a virtual/contactless approach.

In addition to the naloxone distribution, IHS expanded harm reduction strategies to include an evaluation of Safe Syringe Services. In FY 2020, IHS released a Safe Syringe Services toolkit that includes sample patient education pamphlets, a review of available resources, and information related to creating program financial sustainability. These expanded harm reduction services will support IHS Hepatitis C Elimination and HIV/AIDS efforts. In FY 2022, the IHS hosted technical assistance and resources to expand access to fentanyl test strips.

Proper Pain Management, Opioid Stewardship and Training:
The IHS has created and released a comprehensive Opioid Stewardship workbook to assist sites with creating best practices surrounding safe opioid prescribing and increasing access to integrative pain treatments. The workbook emphasizes utilizing opioid surveillance strategies to evaluate population health outcomes, target opioid interventions, enhance clinical decision support, and create professional practice evaluation strategies. The IHS opioid stewardship program evaluation considers metrics that evaluate trends in Morphine Milligram Equivalents versus a restricted focus on total opioid prescription fills. The IHS developed a total of fifteen opioid prescribing metric definitions for inclusion in the IHS Opioid Prescribing dashboard. The dashboard underwent a limited release in September 2021 and an Opioid Stewardship and Dashboard working group was created to develop dashboard super-users within each IHS region to support implementation, including clinician end-user training and applying population health/opioid stewardship principles and clinical decision support tools. These super-users will also suggest additional metrics to optimize dashboard utility at the local level. In July 2021, the IHS Academic Detailing Service pilot project was established in the Bemidji Area. Two IHS sites were selected to create tailored peer-to-peer interventions to support opioid stewardship activities, increase access to treatment services, and promote quality of care. Sample action plans and evaluation strategies are being developed to be shared with other IHS regions and programs.

The IHS has also increased access to non-pharmacologic pain management approaches. The IHS has collaborated with the Defense Veterans Center for Integrated Pain Management to expand access to focused auricular acupuncture through the creation of sample credentialing and privileging processes, protocols, documentation standards, and sustainability recommendations. Access to additional integrative pain management strategies such as dry needling, deep tissue mobilization, and electrical stimulation have increased.

IHS has created agency policy and clinical practice recommendations to improve patient outcomes and reduce unnecessary opioid exposure. In June 2014, IHS implemented Indian Health Manual Chapter 30 policy titled *Chronic Non-Cancer Pain Management* to promote appropriate pain management with revision in 2018 to align with CDC *Guideline for Prescribing Opioids for Chronic Pain.* This policy will be revised in FY 2021 to include enhanced recommendations related to de-prescribing and medical cannabis. The impact of Prescription Drug Monitoring Programs (PDMPs) on safe opioid prescribing is well documented. IHS implemented Chapter 32, *State Prescription Drug Monitoring Programs,* requiring providers to check state PDMP data bases prior to prescribing opioids and requiring IHS federal pharmacies to report opioid prescribing data to these state PDMPs. Ongoing improvements to automate reporting electronic integration and audit reporting were funded in FY 2021 with implementation in FY 2022.

In May 2016, IHS implemented a policy on mandatory opioid training requiring all federally controlled substance prescribers to complete the *IHS Essential Training on Pain and Addiction* with required refresher training every 3 years. This training is now available on demand with continuing medical education credits. The IHS released its refresher training course in January 2018 including four sessions of its mandatory five-hour training course for providers on proper opioid prescribing. The refresher course was updated in FY 2021. In FY 2021, 276 new clinicians completed this course. In FY 2022, 627 new clinicians completed this course. The mandate also includes an additional refresher training after three years. In FY 2022, 401 clinicians completed the *Essential Training on Pain and Addiction Refresher* course. In FY 2020, course content was updated based on prescriber evaluations. These revisions include expanded modules on managing pain in special populations (e.g., older adults, pregnancy, SUD) as well as content on effective de-prescribing strategies. In FY 2021, IHS engaged in planning discussions with the Veterans Health Administration to promote synergy between safe opioid prescriber training curriculums. A revised training course is anticipated in July 2022.

In August 2021, the IHS released enhanced clinical decision support tools for the Resource and Patient Management System (RPMS) to assist providers in meeting documentation standards outlined in IHM, Part 3 - Chapter 30. The EHR Reminders and dialog note templates facilitate accurate and timely documentation to support best practices and implementation of pain management policy requirements.

Improved Communication Related to Opioid Strategies:
Enhanced communication during the opioid crisis response is vital to program development, policy implementation, and ongoing evaluation. The IHS created and released an Opioid Information Sheet that will serve as a public-facing logic model to share opioid-related measures, agency goals, and available resources for both clinicians and Tribal stakeholders.

IHS supports efforts to develop a unified user experience that includes an expanded website presence with best and promising practices and a communication plan to increase public awareness of agency opioid efforts. This website houses resources, clinical guidelines, and best practices for IHS providers. Additional communication outputs include maintenance of a listserv, quarterly newsletter, and special edition newsletters.

In December 2021, the IHS developed and released a sample recovery rack card as a health promotion and patient education pamphlet for positive messaging around resilience, treatment, and recovery. The resource is downloadable on the IHS website and customizable for local use.

In October 2021, the IHS developed and released technical assistance to address site challenges with procurement of long-acting formulations of buprenorphine. Long-acting buprenorphine was added to the IHS National Core Formulary in August 2021.

In FY 2020, the IHS expanded websites to include a new technical assistance page that will share best and promising practices related to clinical documentation, sample documentation templates and how-to guides, and links to clinician supports. Future content consolidation will include funding opportunities and promising clinical practices. Also in FY 2020, IHS provided *Pain Skills* intensive trainings in the Phoenix and Tucson Area and the Navajo Area. These trainings focus on assessment and treatment of myofascial pain, including non-pharmacological interventions. Additionally, they include the half-and-half DATA Waiver training for buprenorphine MAT. A total of 35 clinicians attended these trainings. In FY 2022, IHS provided two webinars that addressed pain management, opioids, and opioid misuse with a total of 133 attendees.

- Ketamine in the Acute Care Setting
- Synthetic Opioid Overdose

IHS has created agency policy and clinical practice recommendations to improve patient outcomes and reduce unnecessary opioid exposure. In June 2014, IHS implemented IHM Chapter 30 policy titled *Chronic Non-Cancer Pain Management* to promote appropriate pain management. IHS released new clinical guidelines to assist dentists with selecting the safest pain control options. The *Recommendations for Management of Acute Dental Pain* will limit opioid prescribing to patients who cannot safely use alternative pain medication. The guidelines also include a decision tree for pre-operative and post-operative pain management, as well as recommended dosing of systemic analgesics based on anticipated operative pain.

Substance Use Disorder and Chronic Pain Case Consultation Services: To provide ongoing clinical support for providers, IHS, in partnership with the University of New Mexico Pain Center, provided a *Substance Use Disorder and Chronic Pain ECHO*. ECHO is a case-based learning model in which consultation is offered through virtual clinics to healthcare providers by an expert team to share knowledge and elevate the level of specialty care available to patients. In FY 2021, a total of 20 ECHO sessions were offered with 748 attendees.

Youth Regional Treatment Centers (YRTCs): YRTCs are facilities which provide medically managed care and other essential treatment and recovery services to AI/AN youth experiencing SUDs. Congress authorized the establishment of YRTCs in each of the 12 IHS Areas, with two (northern and southern) specifically authorized for the California Area. The YRTCs provide quality holistic behavioral health care for AI/AN adolescents that integrate traditional healing, spiritual values and cultural identification. In FY 2022, 83 percent of the federal YRTCs in operation 18 months or longer have achieved accreditation status, which was significantly impacted by the COVID-19 pandemic. The YRTCs continue to shift delivery of services to enhance safety measures to prevent the spread of COVID-19. The YRTCs continue to provide treatment in socially distanced settings at their sites. In October 2022, the IHS, in collaboration with the 104 federally-recognized Tribes of California, held a grand opening of the Sacred Oaks Healing Center in Davis, CA.

Indian Children's Program (formerly, Fetal Alcohol Spectrum Disorders (FASD): Training and technical assistance on FASD is provided through the IHS TeleBehavioral Health Center of Excellence (TBHCE) Indian Children Program (ICP). The focus of the ICP is training clinicians on developmental and neurobiological issues that can affect AI/AN children. In FY 2022, ICP provided 10 webinars on neurodevelopmental disorders with a total of 648 attendees. The ICP provided three webinars on supporting families of children with neurodevelopmental disorders with a total of 78 attendees. The ICP also provides additional clinician supports. For example, clinicians can take advantage of the Pediatric Neurodevelopmental & Behavioral Health Consultation Clinic. This virtual consultation is designed to help clinicians successfully diagnose, manage, and treat AI/AN youth with FASD, ASD, and other neurodevelopmental issues.

Information Systems Supporting Behavioral Health Care: The Resource and Patient Management System (RPMS) includes functionality designed to meet the unique business processes of behavioral health providers and support behavioral health-related initiatives. Standardized instruments and clinical decision support tools are available to support routine and effective screening for alcohol and substance use, depression, domestic violence and smoking status. Additionally, surveillance tools are available to capture suicide data at the point of care. Aggregate national RPMS behavioral health data is maintained to support local, national and

other program reporting requirements as well as quality performance measurements for numerous screening and prevention initiatives including screening for alcohol and substance use, depression, domestic violence, smoking, and suicide data collection.

Partnerships: IHS is collaborating with other agencies working in the field of SUDs such as the Department of Interior (DOI) Bureau of Indian Affairs (BIA) and Bureau of Indian Education (BIE), Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Veterans Affairs (VA), Health Resources and Services Administration, Office of National Drug Control and Policy (ONDCP), and Centers for Diseases Control and Prevention (CDC), National Institutes of Health (NIH), Department of Justice (DOJ), and Center for Medicare and Medicaid Services (CMS) to ensure that the best available information, trainings, protocols, evaluations, performance measures, data needs, and management skills are incorporated and shared with all agencies and organizations working on substance use disorders.

The DOI, through the BIA, BIE, and IHS have a Memorandum of Agreement (MOA) on *Indian Alcohol and Substance Abuse Prevention*, which was amended in 2011 as a result of the permanent reauthorization of the Indian Health Care Improvement Act. Through this MOA, BIA, BIE, and IHS coordinate and implement plans in cooperation with Tribes to assist Tribal governments in their efforts to address behavioral health issues. The MOA includes coordination of data collection, resources, and programs of IHS, BIA, and BIE.

The Tribal Law and Order Act (TLOA) requires interagency coordination and collaboration among HHS (IHS and SAMHSA), DOI (BIA/BIE), DOJ (Office of Justice Programs/Office of Tribal Justice), and the Office of the Attorney General. The 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, the Interior and the Attorney General to: (1) determine the scope of the alcohol and substance abuse problems faced by Tribes; (2) identify and delineate the resources each entity can bring to bear on the problem; (3) set standards for applying those resources to the problems; and (4) coordinate existing agency programs.

In April 2019, IHS expanded collaboration with the Defense Veterans Center for Integrated Pain Management to explore feasibility of creating an IHS auricular acupuncture program utilizing the Veterans Health Administration Battlefield Acupuncture protocol. IHS has created a pilot program that includes credentialing and privileging processes, clinical practice protocols, documentation standards, patient education materials, and a sustainability plan. The initial training session was hosted in November 2019 and 23 IHS clinicians were certified in this modality. Auricular acupuncture is an evidence-based integrated treatment option and full implementation would require an *IHS Scope of Practice* for nurses and pharmacists to deliver this treatment modality. Ninety-six community-health workers completed training as naloxone trainers for their Tribal communities in one week. The train the trainer sessions were migrated to virtual platforms during the COVID pandemic.

ASA Grant and Federal Award Programs

The IHS Division of Behavioral Health administers community-based grants and cooperative agreements that promote the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to substance abuse from a community-driven context. In particular, the IHS Community Opioid Intervention Pilot Program and the Substance Abuse and Suicide Prevention Program will support several of the

HHS Strategic Plan goals and objectives, including *Objective 2.3: Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death*; and, *Objective 3.4: Increase safeguards to empower families and communities to prevent and respond to neglect, abuse, and violence, while supporting those who have experienced trauma or violence*.

*IHS Community Opioid Intervention Pilot Program (COIPP):* In FY 2021, IHS awarded $16 million to 35 Tribal, Tribal organizations, and Urban Indian Organizations for a three-year cohort to support the development of innovative, locally-designed, culturally-appropriate prevention, treatment, recovery, and aftercare services for those impacted by the opioid epidemic in AI/AN communities. In FY 2022 and into FY 2023, the awarded projects focused on increasing public awareness and education about the impact of opioids on individuals, families and communities. Additionally, IHS established a contract to provide evaluation and technical assistance to guide the pilot project in designing and establishing a COIPP national evaluation. The cross-site evaluation integrates culturally appropriate care as grantees create comprehensive support teams to strengthen and empower families addressing the opioid crisis. Finally, the COIPP grantees continue to prioritize efforts to reduce unmet needs and opioid overdose deaths through education, partnerships, and increased access to treatment for persons with OUD. The IHS COIPP is a three year pilot program and aligns with HHS' Overdose Strategy to respond to the national overdose crisis.

*Substance Abuse and Suicide Prevention Program (SASP):* The SASP is a nationally-coordinated $31.97 million program providing funds for culturally appropriate substance abuse and suicide prevention programming in AI/AN communities. In FY 2022 the IHS awarded two separate five-year grant programs under SASP. The first, Substance Abuse Prevention, Treatment, and Aftercare (SAPTA), awarded $13.698 million to 36 Tribal, Tribal organizations, and Urban Indian Organizations. The second, Suicide Prevention, Intervention, and Postvention (SPIP), awarded $13.772 million to 36 Tribal, Tribal organizations, and Urban Indian Organizations.

The program funds 174 projects. In August 2019, IHS initiated Tribal Consultation and an Urban Confer regarding behavioral health initiatives and the National Tribal Advisory Committee on Behavioral Health recommendations regarding the distribution of funding for the SASP program. In total, 22 comments and recommendations were received and reviewed by IHS. On March 2, 2020, the IHS Director issued a decision to continue distribution of the SASP program funds using a competitive grant mechanism.

The goals of the SASP program include:

1. Increase IHS, Tribal, and Urban (I/T/U) capacity to operate successful substance abuse prevention, treatment, and aftercare and suicide prevention, intervention, and postvention services through implementing community and organizational needs assessment and strategic plans.
2. Develop and foster data sharing systems among I/T/U behavioral health service providers to demonstrate efficacy and impact.
3. Identify and address suicide ideations, attempts, and contagions among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, intervention, and postvention strategies.
4. Identify and address substance use among AI/AN populations through the development and implementation of culturally appropriate and community relevant prevention, treatment, and aftercare strategies.
5. Increase provider and community education on suicide and substance use by offering appropriate trainings.

6. Promote positive AI/AN youth development and family engagement through the implementation of early intervention strategies to reduce risk factors for suicidal behavior and substance use.

SASP projects were awarded funding in at least one of four purpose areas and work to address the corresponding SASP goal listed above. SASP Purpose Areas are:

1. Community Needs Assessment and Strategic Planning
2. Suicide Prevention, Intervention, and Postvention
3. Substance Abuse Prevention, Treatment, and Aftercare
4. Generation Indigenous (Gen-I) Initiative Support

In FY 2023, the IHS awarded a total of $2 million to eight federal IHS facilities to expand SAPTA activities. The awarded IHS facilities will support Tribes in their service catchment area in substance abuse prevention, treatment, and aftercare services. The overall goal of SAPTA is to focus on reducing the prevalence of substance abuse among AIAN populations.

In support of the SASP, IHS established the Universal Alcohol Screening (UAS) as a national measure to increase screening and improve detection and intervention strategies among patients 9 through 75 years of age. In 2020, the COVID-19 pandemic significantly impacted IHS clinical care to patients and continued to impact clinical care throughout FY 2021 and FY 2022, resulting in a percentage lower than the target rates established for FY 2021 and FY 2022. In FY 2021, 31.1 percent of patients were screened and did not meet the national target rate of 39.0 percent. For FYs 2022 and 2023, the national target rates for UAS are set at 39.2 percent and 32.2 percent, respectively.

In the fourth year of the SASP, 100 percent of projects submitted progress reports as a requirement of funding. Positive strides in the delivery of substance use services have been accomplished and reported in preliminary data monitoring for SASP program activities. Successful outcomes during the fourth year of the program include expanded behavioral health services offered through school settings and home visiting with a total of 1,475 patients receiving care. Over 270 providers were trained in behavioral health integration with 163 of those providers located within a primary care setting. Project accomplishments include 67,168 individuals screened for suicidal ideation, 54 percent of the SASP program suicide prevention projects implemented an enhanced process for suicide screening, and over 11,003 community members have been trained in suicide and/or substance use prevention. Fifty three percent of projects hosted a successful prevention education community event, and 59 percent reported their trainings to have expanded staff knowledge (a 12 percent increase from year 2). Twenty nine percent reported implementation and documentation of a system change. In addition, among projects supported, a total of 76,054 individuals received cultural services, a high percentage of projects have continued to offer integrated traditional healing into care, extended service hours, provision of follow-up care, new counseling and case management services. In summary, the SASP program continues to support Tribes, Tribal organizations, urban Indian organizations, and federal facilities offering care.

*Preventing Alcohol-Related Deaths (PARD):* In the 2017 Senate Appropriations Committee Report 114-281, the Committee directed IHS to "allocate $2,000,000 of the increase provided for the alcohol and substance abuse program to fund essential detoxification and related services." Specifically, the number of alcohol related deaths in the community of Gallup, New Mexico was addressed with the report stating, "these deaths underscore the urgent need for substance abuse treatment, residential services and detoxification services" among state, Tribal, and other regional

partners.  In response, the IHS used the increased appropriated funds to address the urgent need in the city of Gallup, New Mexico.  In addition, IHS was aware of the urgent need for alcohol detoxification services in the Great Plains Area after the removal of liquor licenses and alcohol sales in White Clay, Nebraska, leading to the potential for increased mortality if services were unavailable for alcohol detoxification.  As a result, funds were made available to the Oglala Sioux Tribe's Anpetu Luta Otipi to meet the urgent need.  The project period for these grants were from FY 2018 – FY 2022.

During the COVID-19 pandemic, services were temporarily interrupted at the City of Gallup detoxification site, and the Great Plains Anpetu Luta Otipi site. IHS worked with both sites to ensure that each adopted guidelines provided by the local and state health departments, and the CDC for continued operations for detoxification programs. The IHS is performing an evaluation of both sites, and making recommendations according to the extent of the public health crisis emphasizes by the Congressional reports and the findings at the respective sites.  A notice of funding opportunity was published March 1, 2023.  A notice of funding opportunity was published March 1, 2023.  The new funding project is anticipated to start mid-April 2023. The emphasis is on McKinley County, New Mexico, and surrounding counties, which yield 48 percent of all alcohol-related death for AI/AN in the nation. Additional support will develop, foster, and expand clinical capacity for region identified.

*YRTC Aftercare Project:* In December 2017, the IHS awarded $1.6 million to implement a pilot project for aftercare services for AI/AN youth discharged from residential substance abuse treatment, formerly known as the YRTC Aftercare Pilot Project.  The YRTC Aftercare Pilot Project officially ended FY 2022.  During FY 2022, the IHS evaluated the pilot project and published the report, *American Indian and Alaska Native Youth Residential Treatment Aftercare: Evaluation of the Youth Regional Treatment Center Aftercare Pilot Project,* which can be accessed on the IHS YRTC website at www.ihs.gov/yrtc.  Based on findings from the evaluation, The IHS is planning to implement its recommendations to enhance aftercare programming and treatment services for AI/AN youth through protocols and prototyping testing, to verify the fit and effectiveness of improvements in the local continuums of care and regional requirements, as a total precision behavioral health system.  In FY 2023, the IHS awarded the Cherokee Nation's Jack Brown Center, a Tribal-operated YRTC, to operate and refine an aftercare program, based on an amount of $600,000 per year for five years which started November 14, 2022. Additionally, the IHS will support federal-operated YRTC sites in FY 2023, to implement the new objectives of the YRTC Aftercare Project.

## OUTPUTS / OUTCOMES

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| 10 YRTC Improvement/Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more). (Outcome) | FY 2022: 83 % Target: 100 % (Target Not Met) | 100% | 100% | Maintain |
| 80 Universal Alcohol Screening (Outcome) | FY 2022: 33.2 % Target: 39.2 % (Target Not Met but Improved) | 32.2% | 32.2% | Maintain |
| 82 Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Outcome) | FY 2022: 14.3 % Target: 13.5 % (Target Exceeded) | Discontinued | Discontinued | N/A |
| 90 Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Outcome) | FY 2023: Result Expected Jan 31, 2024 Target: Set Baseline (Pending) | Baseline | Baseline | Maintain |

## GRANTS AWARDS

| *(whole dollars)* | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget |
|---|---|---|---|
| Number of Awards | 107 | 112 | 112 |
| Average Award | $350,000 | $350,000 | $350,000 |
| Range of Awards | $300,000 - $400,000 | $300,000 - $400,000 | $300,000 - $400,000 |

## AREA ALLOCATION

**Alcohol and Substance Abuse**

(dollars in thousands)

| DISCRETIONARY SERVICES | FY 2022 Final | | | FY 2023 Enacted /1 | | | FY 2024 Estimated /1 | | | FY '24 +/- FY '23 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Federal | Tribal | Total | Federal | Tribal | Total | Federal | Tribal | Total | Total |
| Alaska | $743 | $36,099 | $36,842 | $767 | $37,277 | $38,044 | $889 | $43,189 | $44,078 | $6,034 |
| Albuquerque | 3,505 | 10,736 | 14,241 | 3,619 | 11,086 | 14,705 | 4,193 | 12,845 | 17,037 | $2,332 |
| Bemidji | 2,231 | 9,448 | 11,678 | 2,303 | 9,756 | 12,059 | 2,669 | 11,303 | 13,972 | $1,913 |
| Billings | 595 | 12,158 | 12,753 | 615 | 12,554 | 13,169 | 712 | 14,545 | 15,257 | $2,089 |
| California | 3,946 | 15,696 | 19,642 | 4,075 | 16,208 | 20,282 | 4,721 | 18,778 | 23,499 | $3,217 |
| Great Plains | 4,472 | 11,952 | 16,424 | 4,617 | 12,342 | 16,959 | 5,350 | 14,300 | 19,649 | $2,690 |
| Nashville | 3,639 | 7,079 | 10,719 | 3,758 | 7,310 | 11,068 | 4,354 | 8,470 | 12,824 | $1,756 |
| Navajo | 2,026 | 20,570 | 22,595 | 2,092 | 21,241 | 23,332 | 2,423 | 24,610 | 27,033 | $3,701 |
| Oklahoma | 5,181 | 13,912 | 19,093 | 5,350 | 14,366 | 19,716 | 6,198 | 16,645 | 22,843 | $3,127 |
| Phoenix | 8,587 | 12,009 | 20,596 | 8,867 | 12,401 | 21,268 | 10,273 | 14,368 | 24,641 | $3,373 |
| Portland | 2,416 | 16,347 | 18,763 | 2,495 | 16,880 | 19,375 | 2,891 | 19,557 | 22,448 | $3,073 |
| Tucson | 63 | 3,516 | 3,579 | 65 | 3,631 | 3,696 | 75 | 4,207 | 4,282 | $586 |
| Headquarters | 51,100 | 0 | 51,100 | 52,767 | 0 | 52,767 | 61,136 | 0 | 61,136 | $8,370 |
| **Total, ASA** | **$88,503** | **$169,521** | **$258,024** | **$91,389** | **$175,051** | **$266,440** | **$105,885** | **$202,816** | **$308,701** | **$42,261** |

1/ Note: 2023 and 2024 are estimates.

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

(Dollars in thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $984,887 | $996,755 | $1,178,097 | +$181,342 |
| FTE* | 86 | 85 | 87 | +2 |

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**.........................................................................................Permanent

**Allocation Method** ............................. Direct Federal, PL 93-638 Tribal Contracts and Compacts, Commercial contracts, and Tribal shares

## PROGRAM DESCRIPTION

The Snyder Act provides the formal legislative authority for the expenditure of funds for the "relief of distress and conservation of health of Indians."[1] In 1934, Congress provided the specific authority to enter into medical services contracts for American Indians and Alaska Natives.[2] These, among other authorities[3] established the basis for the Indian Health Service (IHS) and the Purchased/Referred Care (PRC) Program.[4]

The PRC Program is integral to ensure comprehensive health care services are available and accessible to eligible American Indians and Alaska Natives (AI/AN). The general purpose of the PRC Program is for IHS or Tribal facilities to purchase services from private health care providers in situations where:

1) No IHS or Tribal direct care facility exists,
2) The direct care element is not capable of providing required emergency and/or specialty care,
3) The direct care element has an overflow of medical care workload, and
4) Full expenditure of alternate resources (e.g., Medicare, private insurance) has been met and supplemental funds are necessary to provide comprehensive care to eligible Indian people.

In addition to meeting the eligibility requirements for direct services at an IHS or Tribal facility, PRC eligibility is determined based on residency within the service unit or Tribal PRC delivery Area; authorization of payment for each recommended medical service by a PRC authorizing official; medical necessity of the service and inclusion within the established Area IHS/Tribal medical/dental priorities; and

[1] The Snyder Act, Public Law 67-85, November 2, 1921, 25 U.S.C § 13.
[2] The Johnson O'Malley Act of April 16, 1934, as amended, 25 U.S.C. § 452.
[3] Transfer Act, 42 U.S.C. § 2001; Indian Health Care Improvement Act, as amended, 25 U.S.C § 1601, et seq.
[4] The Consolidated Appropriation Act of 2014, Public Law 113-76, January 18, 2014, adopted a new name for the IHS Contract Health Services (CHS) program to Purchased/Referred Care (PRC). The IHS will administer PRC in accordance with all law applicable to CHS.

full expenditure of all alternate resources (i.e., Medicare, Medicaid, private insurance, state or other health programs, etc.). Alternate resources must pay for services first because the IHS PRC Program is the payer of last resort.[5] Services purchased may include hospital, specialty physician, outpatient, and laboratory, dental, radiological, pharmaceutical, or transportation services. When funds are not sufficient to purchase the volume of PRC services needed by the eligible population residing in the PRC delivery area of the local facility, IHS PRC regulations require IHS or Tribal PRC programs to use a medical priority system to fund the most urgent referrals first.

Medical priority (MP) levels of care are defined as follows:

- MP Level I: Emergent or Acutely Urgent Care Services are defined as threats to life, limb and senses.
- MP Level II: Preventive Care Services are defined as primary health care that is aimed at the prevention of disease or disability.
- MP Level III: Specialty Services are considered ambulatory care which include inpatient and outpatient care services.
- MP Level IV: Chronic Tertiary and Extended Care Services are defined as requiring rehabilitation services, skilled nursing facility care.
- MP Level V: Excluded Services are services and procedures that are considered purely cosmetic in nature, i.e., plastic surgery.

A PRC rate, a capitated rate based on Medicare payment methodology, is used to purchase care, and Medicare participating hospitals are required to accept this rate as payment in full for all hospital-based health care services (Public Law 108-173). This allows IHS to purchase care at a lower cost than if each service were negotiated individually increasing access to quality health care services and provide care to better meet the health care needs of AI/ANs. Physician and non-hospital providers of supplies and services are purchased at the PRC rate. However, if a physician or non-hospital provider does not accept the PRC capitated rate, agreements or contracts can be negotiated with individual providers of supplies or services using the provider's most favored customer rate as a ceiling for negotiation (42 CFR 136 Subpart I). Program funds are administered and managed at IHS Headquarters, at each of the 12 IHS Areas, and at IHS and Tribal facilities across the nation. The regulation has demonstrated that IHS is able to stretch the same amount of money to cover additional necessary health care services and improve access to care.

The PRC Program also administers the Catastrophic Health Emergency Fund (CHEF). Created in 1988, the CHEF was established for the sole purpose of meeting extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses.[6] The CHEF is used to reimburse PRC programs for high cost cases (e.g., burn victims, motor vehicle crashes, high risk obstetrics, cardiology, etc.) after a threshold payment amount is met, the current threshold is $25,000. The CHEF is centrally managed at IHS Headquarters.

The PRC Program contracts with a fiscal intermediary (FI), currently Blue Cross/Blue Shield of New Mexico, to ensure payments are made in accordance with IHS' payment policy, and coordinate benefits with other payers to maximize PRC resources. All IHS-managed PRC programs and some tribally-managed PRC programs use the FI to ensure the use of PRC rates for inpatient services and PRC or negotiated rates for physician and non-hospital providers of supplies and services.

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

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

[6] 25 U.S.C. § 1621a

Note: On February 28, 2019, IHS updated the *Indian Health Manual,* Part 2, Services to Indians and Others, Chapter 3, Purchased/Referred Care. In this IHM update IHS adopted the policy that PRC funds may be used for staff administrating the PRC program at administrative levels. This adopts the GAO recommendation for the use of PRC funds for PRC staff where appropriate. This policy change requires Areas to ensure they are funding requests through Priority Level II before these PRC administrative expenses can be charged.

**BUDGET REQUEST**

The FY 2024 budget request for Purchased/Referred Care is $1.2 billion, which is $181 million above the FY 2023 Enacted level.

FY 2023 Base Funding of $997 million will support over 36,000 inpatient admissions, over 1.1 million outpatient visits, and over 42,000 patient transports.

FY 2024 funding increase of $181 million includes:

- Direct Health Care Services Increase: +$87 million - to address the unmet need for direct health care services identified by the FY 2018 Indian Health Care Improvement Fund Work Group. These funds will support the following estimated increased services:

    - 3,138 Inpatient admissions
    - 92,248 Outpatient visits
    - 3,262 Patient travel trips

- Arizona State-wide PRC Delivery Area ($22 million): The Indian Health Care Improvement Act directs the IHS to establish a state-wide Purchased/Referred Care Delivery Area (PRCDA) in Arizona to serve members of Indian tribes that reside in the state, so long as it does not curtail health services provided to Indians residing on reservations located in the state. Currently, there are many American Indians and Alaska Natives that reside within the state of Arizona, but are not members of Tribes with reservations located within the state (predominately members of the Navajo Nation). As a result, these individuals are not able to access PRC services in Arizona.

    - This proposal would provide the funding necessary to create a state-wide PRCDA in Arizona without reducing the availability of services for members of Tribes that are located within the state.

    - The IHS previously conducted a feasibility study, which showed that there would be 67,434 newly eligible Tribal members under a state-wide PRCDA. The IHS multiplies the average PRC spending per currently eligible Tribal member ($326) by the newly eligible Tribal members to develop the $22 million estimate.

- North and South Dakota State-wide PRC Delivery Area ($12 million): The Indian Health Care Improvement Act directs the IHS to establish a state-wide Purchased/Referred Care Delivery Area (PRCDA) in North Dakota and South Dakota to serve members of Indian tribes that reside in those states, so long as it does not curtail health services provided to Indians residing on reservations located in those states. Currently, there are many American Indians and Alaska Natives who reside within the states of North Dakota and South Dakota, but are not members of Tribes with reservations located within the state. As a result, these individuals are not able to access PRC services in North Dakota and South Dakota.

- This proposal would provide the funding necessary to create a state-wide PRCDA in North Dakota and South Dakota without reducing the availability of services for members of Tribes that are located within the state.

- The IHS will be conducting a feasibility study, but is estimating there will be 24,000 newly eligible Tribal members in the two states under a state-wide PRCDAs. The IHS multiplies the average PRC spending per currently eligible Tribal member ($500) by the newly eligible Tribal members to develop the $12 million estimate.

- New Tribes (+$5 million): These funds will support the delivery of health care services for the United Keetoowah Band of Cherokee Indians of Oklahoma (funding allocation to be determined). These resources would also support other newly federally recognized Tribes in FY 2024.

- Current Services (+$55 million): Information can be found on page CJ-33.

**FUNDING HISTORY**

| Fiscal Year | PRC | CHEF | Total |
|---|---|---|---|
| 2020 | $915,015,000 | $53,000,000 | $965,015,000 |
| 2021 | $922,856,000 | $53,000,000 | $975,856,000 |
| 2022 Final | $931,887,000 | $53,000,000 | $984,887,000 |
| 2023 Enacted | $942,755,000 | $54,000,000 | $996,755,000 |
| 2024 President's Budget | $1,124,097,000 | $54,000,000 | $1,178,097,000 |

**TRIBAL SHARES**

Purchased and Referred Care funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. The CHEF management is federally inherent and no part of CHEF or its administration can be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act. CHEF fund cannot be allocated, apportioned, or delegated on an Area Office, Service Unit or other similar basis (25 U.S.C. 1621(a)(c)).

**PROGRAM ACCOMPLISHMENTS**

Purchased/Referred Care (PRC) Rates – The PRC rates for all hospital-based services implemented in 2007 and the PRC rates for physicians and non-hospital providers of supplies and services implemented in 2016 have increased access to care by allowing I/T/Us to purchase additional services with these Medicare methodology capitated rates, referred to as PRC rates. PRC rates were originally referred to as Medicare-like rates (MLR) for hospital based services but are now identified as PRC rates. PRC rates are based on the Medicare payment methodology for all hospital based services, physician and non-hospital providers of supplies and services. The PRC rates rule (42 CFR 136 Subpart I) for physicians and non-hospital providers of supplies and services applies to tribally-operated PRC programs only to the extent the programs agree to "opt-in" via its Indian Self Determination and Education Assistance Act contract or compact. The rule has flexibility that allows PRC programs to negotiate rates that are higher than the PRC rate based on Medicare methodology, but equal to or less than the rates accepted by the provider or supplier's most favored customer rate; in the absence of Medicare payment methodology for a service, the IHS payment amount is calculated at 65 percent of billed charges from the provider or supplier.

Medical Priorities – Recent PRC program increase in purchasing power through the PRC rates described above have allowed most of the IHS and Tribally-managed PRC programs to approve referrals in priority categories other than Medical Priority I (life or limb), including some preventive care services, thus increasing access to patient care services. In FY 2022, 90 percent of IHS-operated PRC programs were able to purchase services beyond Medical Priority II – Preventive Care Services. Prior funding increases and Medicaid expansion have enabled programs to purchase preventive care beyond emergency care services, such as mammograms or colonoscopies.

The IHS PRC Workgroup helped IHS develop a more accurate form for annually reporting denied and deferred PRC services. In FY 2022, PRC programs denied and deferred an estimated $551,858,726 for an estimated 119,938 services for eligible AI/ANs. Because Tribally-managed programs are not required to report denials data, it is difficult to provide a verifiable and complete measure of the total unmet need for the entire I/T/U system. Therefore, the denied services estimate is based on actual data from federal programs and estimated Tribal data.

Catastrophic Health Emergency Fund (CHEF) – In FY 2022, all high cost cases submitted for reimbursement from the CHEF have been reimbursed. It is estimated that more cases may qualify for CHEF reimbursement but were not reported by local IHS and Tribally-managed PRC programs. Catastrophic case requests are reimbursed from the CHEF until funds are depleted. The implementation of PRC rates for inpatient and non-hospital providers of supplies and services as well as the increase of I/T/U beneficiaries enrolled in Medicaid, Medicare and Private Insurance has enabled the CHEF to reimburse PRC programs for high cost catastrophic events and illnesses that occur through the end of the fiscal year.

COVID-19

The COVID-19 pandemic has disproportionately affected American Indian/Alaska Native (AI/AN) populations across the country. Data indicates AI/ANs have infection rates over 3.5 times higher than non-Hispanic whites, are over four times more likely to be hospitalized as a result of COVID-19, and have higher rates of mortality at younger ages than non-Hispanic whites. The IHS continues to work closely with our Tribal partners, Urban Indian Organizations, state, and local public health officials to coordinate a comprehensive public health response to the ongoing COVID-19 pandemic. During FY 2020 and early FY 2021, the Indian health care system has modified health care delivery and adapted programming to address COVID-19, including long haul COVID-19. Since the beginning of the Public Health Emergency through February 6, 2023, the PRC Fiscal Intermediary has processed 43,297 COVID related claims in the amount of $67 million.

**OUTPUTS / OUTCOMES**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| PRC-2 Track IHS PRC referrals (Outcome) | FY 2022: 66.0 days<br>Target:<br>60.0 days<br>(Target Not Met but Improved) | 60.0 days | 60.0 days | Maintain |
| PRC-3 Track PRC self-referrals (Outcome) | FY 2022: 61.0 days<br>Target:<br>45.0 days<br>(Target Not Met but Improved) | 45.0 days | 45.0 days | Maintain |

**GRANT AWARDS**. This program does not fund grant awards.

## AREA ALLOCATION

**Purchased/Referred Care**

(dollars in thousands)

| DISCRETIONARY | FY 2022 Enacted /1 | | | FY 2023 Enacted /1 | | | FY 2024 Estimated /1 | | | FY '24 +/- FY '23 |
|---|---|---|---|---|---|---|---|---|---|---|
| SERVICES | Federal | Tribal | Total | Federal | Tribal | Total | Federal | Tribal | Total | Total |
| Alaska | $0 | $102,511 | $102,511 | $0 | $103,746 | $103,746 | $0 | $122,621 | $122,621 | $18,875 |
| Albuquerque | 27,153 | 19,105 | 46,258 | 27,480 | 19,335 | 46,815 | 32,479 | 22,853 | 55,332 | $8,517 |
| Bemidji | 13,996 | 55,510 | 69,506 | 14,164 | 56,179 | 70,344 | 16,741 | 66,400 | 83,141 | $12,798 |
| Billings | 44,120 | 21,687 | 65,807 | 44,652 | 21,948 | 66,600 | 52,775 | 25,942 | 78,717 | $12,117 |
| California | 733 | 56,615 | 57,349 | 742 | 57,298 | 58,040 | 877 | 67,722 | 68,599 | $10,559 |
| Great Plains | 67,973 | 24,004 | 91,977 | 68,792 | 24,293 | 93,085 | 81,308 | 28,713 | 110,020 | $16,935 |
| Nashville | 6,213 | 35,569 | 41,782 | 6,288 | 35,997 | 42,285 | 7,432 | 42,546 | 49,978 | $7,693 |
| Navajo | 58,311 | 46,696 | 105,007 | 59,013 | 47,259 | 106,273 | 69,750 | 55,857 | 125,607 | $19,334 |
| Oklahoma | 46,334 | 76,905 | 123,239 | 46,893 | 77,832 | 124,724 | 55,424 | 91,992 | 147,416 | $22,691 |
| Phoenix | 44,784 | 33,561 | 78,345 | 45,323 | 33,965 | 79,289 | 53,569 | 40,145 | 93,714 | $14,425 |
| Portland | 13,327 | 96,010 | 109,337 | 13,488 | 97,167 | 110,654 | 15,941 | 114,844 | 130,786 | $20,132 |
| Tucson | 282 | 21,774 | 22,056 | 286 | 22,036 | 22,322 | 338 | 26,045 | 26,383 | $4,061 |
| Headquarters | 71,713 | | 71,713 | 72,578 | | 72,578 | 85,782 | | 85,782 | $13,204 |
| **Total, PRC** | **$394,940** | **$589,947** | **$984,887** | **$399,699** | **$597,056** | **$996,755** | **$472,417** | **$705,680** | **$1,178,097** | **$181,342** |

1/ Note: 2023 and 2024 are estimates.

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget /1 | FY 2024 +/- FY 2023 |
| PL | $190,718 | $202,527 | $237,530 | +$35,003 |
| FTE* | 209 | 208 | 252 | +44 |

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

## SUMMARY OF THE BUDGET REQUEST

The FY 2024 Indian Health Service (IHS) Budget request for Preventive Health Services includes a total of $238 million, which is +$35 million above the FY 2023 Enacted level.

This funding increase includes:

- Current Services (+$15 million),
- Staffing of Newly Constructed Facilities (+$1 million), and
- Direct Health Care Services Increase (+$19 million)

The detailed explanation of the request is described in each of the budget narratives that follow:

- **Public Health Nursing** (PHN) to support prevention-focused nursing care interventions for individuals, families, and community groups as well as improving health status by early detection through screening and disease case management. The PHN Program home visiting service provides primary, secondary, and tertiary prevention focused health interventions.

- **Health Education** to support the provision of community health, school health, worksite health promotion, and patient education.

- **Community Health Representatives** (CHRs) to help to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained indigenous community members.

- **Hepatitis B and Haemophilus Immunization Programs (Alaska)** will support the provision of vaccines for preventable diseases, immunization consultation/ education, research, and liver disease treatment and management through direct patient care, surveillance, and education for Tribal facilities throughout Alaska. The Immunization Alaska Program budget supports these priorities through direct patient care, surveillance, and educating Alaska Native patients.

These **Preventive Health** services contribute widely to the performance measures that fall under the auspices of Hospitals & Health Clinics. PHN clinical services directly contribute to community health and wellness through immunizations, case management, and patient education. CHRs are also community-based and contribute to follow up care and lay health education. Health Education activities permeate the Indian health system and are integral to the fulfillment of the performance screening measures. The Immunization Alaska Program plays a key role by

tracking immunization rates through specific immunization registries throughout the State of Alaska, and such efforts contribute to the national immunization rates.

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $101,641 | $110,782 | $132,359 | +$21,577 |
| FTE* | 190 | 189 | 227 | +38 |

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**..........................................................................................Permanent

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

**PROGRAM DESCRIPTION**

The Indian Health Service (IHS) Public Health Nursing (PHN) Program is a community health nursing program that focuses on the goals of promoting health and quality of life, and preventing disease and disability. The PHN Program provides quality, culturally sensitive health promotion and disease prevention nursing care services through primary, secondary and tertiary prevention services to individuals, families, and community groups:

- *Primary prevention interventions* aim to prevent disease and include such services as health education/behavioral counseling for health promotion, risk reduction, and immunizations.
- *Secondary prevention interventions* detect and treat problems in their early stages. Examples include health screening of high-risk populations, screening for diabetes and hypertension, fall risk assessments, and school health assessments.
- *Tertiary prevention interventions* prevent or limit complications and disability in persons with an existing disease. The goal of tertiary prevention is to prevent the progression and complications associated with chronic and acute illness by providing optimal care for the patient. Examples include chronic disease case management, self-management education, medication management, and care coordination.

The PHN Program funds provide critical support for direct health care services in the community which improve Americans' access to health care and expand choices of care and service options. *(Supports HHS Strategic Plan Goal 1:Protect and Strengthen Equitable Access to High Quality and Affordable Health Care, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while recognizing social determinants of health.)* PHNs support population-focused services to promote healthier communities through community based direct nursing services, community development, and health promotion and disease prevention activities. PHNs are licensed, professional nursing staff available to improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they transition from the hospital to home.

The PHN expertise in communicable disease assessment, outreach, investigation, and, surveillance helps to manage and prevent the spread of communicable diseases. PHNs contribute to several agency's primary prevention efforts such as providing community immunization clinics, administering immunizations to homebound AI/AN individuals, and through public health education, inspiring AI/AN people to engage in healthy lifestyles and ultimately live longer lives. PHNs conduct nurse home visiting services via referral for such activities as follows:

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

PHNs perform a community assessment to identify high-risk populations and implement evidenced based interventions to address identified areas of need. This activity targets fragmentation in patient care services and improves care continuums, including patient safety. Interventions are monitored with data collection and evaluated for outcome with an emphasis on producing a good return on investments in terms of service(s) provided.

**BUDGET REQUEST**

The FY 2024 budget request for Public Health Nursing is $132 million, which is $22 million above the FY 2023 Enacted level.

FY 2023 Base Funding of $111 million – This funding will support the public health nursing services provided by IHS and Tribal programs, maintain the programs progress in raising the quality of and access to public health nursing care through continuing recruitment of nursing professionals to meet workforce needs, and to meet or exceed agency targets.

FY 2024 Funding Increase of $22 million includes:

- Direct Health Care Services Increase: +$13 million to expand access to public health nursing services. These resources will support efforts to reduce health disparities and improve the overall health status for American Indians and Alaska Natives by increasing the availability of health care services in Indian Country.

- Current Services and Staffing of Newly Constructed Facilities: +$9 million. Information can be found on pages CJ-33 and CJ-35 respectively.

**FUNDING HISTORY**

| Fiscal Year | Amount |
|---|---:|
| 2020 | $91,984,000 |
| 2021 | $92,736,000 |
| 2022 Final | $101,641,000 |
| 2023 Enacted | $110,782,000 |
| 2024 President's Budget | $132,359,000 |

## TRIBAL SHARES

Public Health Nursing funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall Public Health Nursing budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

## PROGRAM ACCOMPLISHMENTS

As part of the Agency's Public Health Response to the pandemic emergency, in FY 2022, the PHN Program continued to work tirelessly with local community partners and public health officials in AI/AN communities to end the pandemic through vaccine administration and measures to stop the spread of the virus; and, in FY 2023, continued an expanded focus on the growing concern in the public health and health promotion arena. Delay or avoidance of medical care because of COVID-19, including urgent, routine and preventive health care services, could result in missed opportunities for management of chronic conditions, receipt of routine vaccinations, or early detection of new conditions, which might worsen outcomes. To support prevention and control of comorbid conditions, PHNs joined agency activities such as the pediatric immunization improvement project, ongoing childhood obesity prevention and breastfeeding promotion, and sexual transmitted infection treatment and prevention. The PHN program stressed compliance with CDC guidance that was reflected in protocols which are communicated to staff and supervisors, and implemented strategies to reduce transmission of the virus within AI/AN communities by providing patient education to promote behaviors that prevented spread and shared best practices as part of the IHS Vaccine Taskforce sponsored IHS-wide webinars.

In FY 2022, as part of the Pediatric Immunization Improvement Project, the PHN program shared best practices from the Phoenix Indian Medical Center PHN Case management pediatric immunization project which improved immunizations for 3 -27 months at their site, from 56 percent to 83 percent.

In FY 2022, the new PHN Grant, PHN Case Management: Reducing sexually transmitted infections, awarded seven grants and three federal program awards to mitigate the prevalence of sexually transmitted infections (STIs) within Indian Country through a case management model that utilizes the PHN as the case manager. In collaboration with the Office of Quality a PHN quality improvement project was created to provide guidance for team-based patient care for PHN treatment in the field to help support decreasing syphilis morbidity and mortality rates in the AI/AN people. In partnership with health promotion/disease prevention colleagues, the PHN program participated in the IHS Public and Community Health Virtual Summit on September 7-9, 2022 with over 400 participants to support patient and community health and sponsored PHN breakout sessions on STIs prevention efforts. In FY 2023, the PHN program participated in the End the Syndemic Informatics Response series to support the agency wide work to present PHN actions that can be taken to address STIs across the agency particularly with community-based coordination efforts with community health teams and public health nursing.

In FY 2022 and FY 2023, PHN program management efforts continue to support PHN data mart enhancements, improvements and updates for PHN workload activity to host data driven decision-making and promote data reporting. In FY2023, the PHN data mart will be used to support the IHS National E3 Vaccine Strategy to ensure that EVERY patient at EVERY encounter will be offered EVERY recommended vaccine, when appropriate by sharing PHN data

and strategies to improve immunization rates for all ACIP-recommended vaccines in Indian Country. In FY 2024, the PHN program will work to achieve and manage an adaptable strategic and long term plan for public health nursing activities surrounding childhood immunizations and prevention of STIs by enhancing partnerships with tribes and Indian organizations and the sharing of PHN data across the Indian health system to demonstrate and trend improvement.

During FY 2022, due to the pandemic crisis, PHN health promotion and disease prevention activities to improve the overall health prosperity of AI/AN communities resulted in decreased patient encounters for non-COVID related follow up. In FY 2023, child immunizations is an ongoing PHN priority, as well as child well-visits, as important ways to keep children healthy and safe from vaccine-preventable illnesses and other issues. The PHN Program aligns with the Agency's priorities and contributes to patient care coordination activities and access to quality, culturally competent care that aims to promote health and quality of life through a community population focused nurse visiting program which serves the patient and family in the home and in the community. The PHN Program assesses the services provided in meeting the agency's priority Government Performance and Results Act (GPRA) measures and integrates the Department's Strategic Goal to strengthen social well-being, equity, and economic resilience. *(Supports the IHS 2023 Agency work plan of managing adaptable strategic and long term plan.)*

Using a variety of methods to educate the AI/AN population such as individual and group patient education sessions, screening activities and referring high-risk patients, and immunizing individuals to prevent illnesses, the PHN works to improve the overall wellness of Americans. Preventative health care informs populations, promotes healthy lifestyles and provides early treatment for illnesses. The PHN Data Mart report for FY 2022 reflects a decrease in PHN activity in GPRA screening documented activities which include the following encounter numbers:

- Tobacco Screening (4,173)
- Domestic Violence Screening (6,789)
- Depression Screening (7,510)
- Alcohol Screening (9,962)
- Adult Influenza Vaccines (27,087)

In 2022 and FY 2023, the PHN Program continued efforts to meet the IHS's goal to decrease childhood obesity and prevent diabetes by supporting Baby Friendly re-designation by accomplishing the following activities: providing patient education, assessment and referral services for prenatal, postpartum and newborn clients during home visits, and utilizing a standardized PHN electronic health record template to document intervention. Several PHN programs targeted breastfeeding patient education efforts by supporting Certification Breastfeeding Specialist online training for PHN staff. The PHN data mart serves as a tool to provide data on PHN activities in support of this evidence-based prevention service of promoting breastfeeding during the nurse patient encounter. For FY 2022, there were a total of 3,380 PHN patient encounters related to the Baby Friendly Hospital Initiative. These patient encounters included 10,916 documented patient education topics provided by the PHN during prenatal, postpartum and newborn encounters, which included the following topics: breastfeeding, child health for the newborn, immunizations, family planning, tobacco use/prevention, gestational diabetes, formula feeding, and child health. As part of this initiative, IHS is encouraging clinicians in Indian Country to support policies and practices that foster breastfeeding as the exclusive feeding choice for infants during their first six months of life. By doing so, clinicians will reduce current and future medical problems and decrease health care costs.

To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people by increasing access to quality health care services, the

PHN Program continues to support caregivers of individuals suffering from dementia. For FY 2022, there have been 3,707 PHN encounters to patients with dementia, and services provided at these PHN encounters include the following:

- Immunizations (1,701)
- Medications (793)
- Life adaptation (417)
- Safety and fall prevention (220)

In support of the Million Hearts campaign to prevent heart attacks and strokes, PHNs provided 17,098 patient encounters in FY 2022 that encompassed patient education on tobacco cessation at 4,360, hypertension at 14,332, and sodium reduction at 900. Additional education provided during these PHN encounters include tobacco use, immunizations, diabetes, and medications.

PHNs provide services to enhance quality care and support patient safety during transitions of care settings by follow up on hospital discharges in an effort to decrease hospital readmissions. In FY 2022, PHNs documented patient encounters with patients who were discharged from the hospital and provided a total of 6,641 follow-up visits; some of these patients had multiple post discharge follow-up visits. Top patient education topics provided during these encounters include immunizations, community disease prevention, acute respiratory syndrome, lifestyle adaptation and medication.

The Public Health Nursing program concluded the five-year PHN Grant Program, Community Based Model of PHN Case Management Services (Behavioral Health), which awarded $1,500,000 per year to improve behavioral health outcomes. Four of the seven PHN case management programs to continue the established PHN services for high-risk behavioral health patients with local clinic or tribal funding support.

In addition, there were seven grant awards and three program awards to participate in the PHN Grant Program, PHN Case Management: Reducing sexually transmitted infections, to support efforts to mitigate the prevalence of sexually transmitted infections within Indian Country through a case management model that utilizes the PHN as a case manager.

DNS also collaborated with the Division of Quality on the Public Health Nursing QI project - Charter and PDSA (Syphilis and PHN) to provide guidance and team-based patient care for necessary treatment in the field. This is to help support decreasing syphilis morbidity and mortality rates in the American Indian and Alaska Native (AI/AN) people.

In FY 2022 and FY2023, the PHN program continued interventions which targeted prevention of sexually transmitted infection to improve care. This included support of the Navajo area-wide PHN policy including PHN competencies and a quality improvement tool to provide guidance for the PHN staff in the management and treatment activity of syphilis. The PHN program supports patient treatment for syphilis in the primary care clinic; however, this project provides an option for high risk patients to be treated in the field when deemed appropriate by the patient's Primary Care Provider. The Navajo Area PHN program in collaboration with the agency's clinical consultant for infectious diseases created policies, protocols and guidance on administration of medication for the treatment of syphilis in an individual's home or field setting to a patient diagnosed with syphilis or an identified sexual contact to a person diagnosed with syphilis to help support decreasing syphilis morbidity and mortality rates in the AI/AN people. This activity can be monitored with the use of the PHN data mart tool as a performance measurement in support of practicing population based health management. The PHN data mart provides information on PHN activities such as the provision of patient education, surveillance and treatment of STIs. PHNs provided 14,488 patient encounters in FY2022 that encompassed 10,363 patient education

codes documented for STI visits which included communicable disease, medications, contact with exposure, immunizations, alcohol and other drugs, and tobacco use. In FY 2022, the PHN program sponsored a five year grant program with the purpose to mitigate the prevalence of STIs within Indian Country. The emphasis is on raising awareness of STIs as a high-priority health issue among AI/AN communities and to support prevention and control activities of comorbid conditions. This cooperative agreement grant, Public Health Nursing Case Management: Reducing Sexually Transmitted Infections, awarded seven (7) grants in September 2022.

The FY 2022 target for the PHN Program measure was 411,325 encounters. The final FY 2022 result of 385,356 patient encounters did not meet the target by 25,969 encounters, a 6 percent margin. Historically, data exporting processes have impacted the overall PHN performance outcome as several tribal programs have migrated away from the IHS Patient Management System (RPMS) resulting in less visits being exported to the agency's National Data Warehouse database; however, in FY 2021 and FY 2022, the pandemic crisis impacted the PHN workload with testing, patient monitoring and vaccine administration activities. The end result was an increase in the number of PHN activities being reported in regards to services provided to address the pandemic crisis. A shift in service away from hosting massive immunization and vaccination clinics and the overall pandemic activity resulted in a decrease in FY 2022 PHN patient encounters. The FY 2024 target is flat compared to FY 2023 as the performance spike in FY 2020 and FY 2021 is a result of the increased PHN activity related to the COVID-19 pandemic and current plan is to analyze FY 2022, FY 2023 and FY 2024 trend data to predict future performance target(s).

In FY 2024, use of the PHN data mart will continue to be used to reflect the PHN activity in meeting Agency goals and to manage an adaptable strategic and long term plan for health promotion and disease prevention PHN activities for childhood immunizations and STI prevention. These reports provide an avenue to monitor the PHN program's support of the health care delivery services in the community and provides available data to inform I/T/U decision-making *(IHS FY 2023 Agency wide plan to enhance partnership with tribes and Indian organizations and to enhance the sharing of data across the Indian health system*).

**OUTPUTS / OUTCOMES**

| **Measure** | **Year and Most Recent Result / Target for Recent Result / (Summary of Result)** | **FY 2023 Target** | **FY 2024 Target** | **FY 2024 Target +/-FY 2023 Target** |
|---|---|---|---|---|
| 23 Public Health Nursing (PHN): Total number of IHS public health activities captured by the PHN data system; emphasis on primary, secondary and tertiary prevention activities to individuals, families and | FY 2022: 385,356 Target: 411,325 (Target Not Met) | 415,438 | 415,438 | Maintain |

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| community groups. (Outcome) | | | | |

## GRANTS AWARDS

| *(whole dollars)* | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget |
|---|---|---|---|
| Number of Awards | 7 | 7 | 7 |
| Average Award | $150,000 | $150,000 | $150,000 |
| Range of Awards | $150,000 | $150,000 | $150,000 |

## AREA ALLOCATION

**Public Health Nursing**

(dollars in thousands)

| DISCRETIONARY SERVICES | FY 2022 Final | | | FY 2023 Enacted /1 | | | FY 2024 Estimated /1 | | | FY '24 +/- FY '23 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Federal | Tribal | Total | Federal | Tribal | Total | Federal | Tribal | Total | Total |
| Alaska | $153 | 13,812 | $13,965 | $167 | $15,054 | $15,221 | $199 | $17,986 | $18,186 | $2,965 |
| Albuquerque | 2,133 | 2,089 | 4,222 | 2,325 | 2,277 | 4,602 | 2,777 | 2,721 | 5,498 | $896 |
| Bemidji | 37 | 2,932 | 2,970 | 41 | 3,196 | 3,237 | 49 | 3,818 | 3,867 | $630 |
| Billings | 1,984 | 3,361 | 5,345 | 2,162 | 3,663 | 5,825 | 2,583 | 4,377 | 6,960 | $1,135 |
| California | 15 | 1,400 | 1,415 | 17 | 1,525 | 1,542 | 20 | 1,823 | 1,843 | $300 |
| Great Plains | 5,585 | 6,117 | 11,702 | 6,088 | 6,667 | 12,755 | 7,273 | 7,966 | 15,239 | $2,484 |
| Nashville | 486 | 2,129 | 2,615 | 530 | 2,320 | 2,850 | 633 | 2,772 | 3,405 | $555 |
| Navajo | 10,062 | 9,465 | 19,527 | 10,966 | 10,317 | 21,283 | 13,102 | 12,326 | 25,428 | $4,145 |
| Oklahoma | 4,135 | 15,550 | 19,685 | 4,507 | 16,948 | 21,455 | 5,385 | 20,249 | 25,634 | $4,179 |
| Phoenix | 4,715 | 6,406 | 11,121 | 5,139 | 6,982 | 12,121 | 6,140 | 8,342 | 14,482 | $2,361 |
| Portland | 724 | 3,157 | 3,880 | 789 | 3,441 | 4,229 | 942 | 4,111 | 5,053 | $824 |
| Tucson | 19 | 1,377 | 1,396 | 21 | 1,500 | 1,521 | 25 | 1,793 | 1,818 | $296 |
| Headquarters | 3,798 | | 3,798 | 4,139 | | 4,139 | 4,945 | | 4,945 | $806 |
| **Total, PHN** | **$33,846** | **$67,795** | **$101,641** | **$36,890** | **$73,892** | **$110,782** | **$44,075** | **$88,284** | **$132,359** | **$21,577** |

1/ Note: 2023 and 2024 are estimates.

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $23,250 | $24,350 | $28,106 | +$3,756 |
| FTE* | 14 | 14 | 16 | +2 |

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**..........................................................................................Permanent

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

**PROGRAM DESCRIPTION**

The Indian Health Service (IHS) Health Education Program has been in existence since 1955 to educate American Indian/Alaska Native (AI/AN) patients, school age children and communities about their health. The program focuses on the importance of educating patients in a manner that empowers them to make positive choices in their lifestyles and how they utilize health services. Accreditation requirements at IHS and tribal facilities specifically require the provision and documentation of patient education as evidence of the delivery of quality care.

In FY 2022, there was a decrease of 8 percent or 256,059 patient visits from the previous year. In FY 2022 there was 2,747,938 patient education visit, which decreased FY 2021 patient education visits. The decrease in visits was impacted by COVID-19. However, FY 2022 patient education visit exceeded target results.

The Health Education funds provide critical support for direct health care services focused on strengthening the collaborative partnerships among direct care providers, patients, communities, and internal and external stakeholders. Funds are utilized to ensure IHS, Tribal, and Urban Indian health care programs have comprehensive, culturally appropriate services, available and accessible personnel, promotes excellence and quality through implemented quality improvement strategies, and strengthens the IHS program management and operations to address health disparities and raise the health status of AI/AN populations to the highest level possible.

**BUDGET REQUEST**

The FY 2024 budget submission for Health Education of $28 million is $4 million above the FY 2023 Enacted level.

<u>FY 2024 Funding Increase of $4 million includes</u>:

- Direct Health Care Services Increase: +$223,000 to expand access to health education services. These resources will support efforts to reduce health disparities and improve the overall health status for American Indians and Alaska Natives by increasing the availability of health care services in Indian Country.

- Current Services and Staffing of Newly Constructed Facilities: +$4 million. Information can be found on pages CJ-33 and CJ-35 respectively.

**FUNDING HISTORY**

| Fiscal Year | Amount |
|---|---|
| 2020 | $20,925,000 |
| 2021 | $21,034,000 |
| 2022 Final | $23,250,000 |
| 2023 Enacted | $24,350,000 |
| 2024 President's Budget | $28,106,000 |

**TRIBAL SHARES**

Health Education funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating out the associated programs, functions, services, and activities. A portion of the overall Health Education budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

**PROGRAM ACCOMPLISHMENTS**

In response to the COVID-19 pandemic, the health education program provided patient education to mitigate risk of transmission, assisted with vaccination and contact tracing, and delivered water/food supplies in the community. (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.2 Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices, and vaccines)*.

In addition, the Health Education Program targeted the following activities in FY 2022, which aligns with the *HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death.*

- In FY 2022,collaborated with the HP/DP program to implement the Cancer Prevention and Screening virtual seminar with more than 100 attendees (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death)*.
- In FY 2022, collaborated with the HP/DP program to provide Mental Health First Aid virtual training to 8 participants receiving their certification (*HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health*) and supported 4 health educators to received

Mental Health First Aid certification to increase awareness of suicide in the communities *(HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death).*

- In FY 2022, collaborated with the HP/DP program to implement colorectal screening pilot projects in three sites *(HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health).*
- In FY 2022, purchased tobacco/vaping displays to three (3) IHS Area Health Education programs to increase community awareness of negative effects of using commercial tobacco (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death*).
- In FY 2022, maintained efforts to advance health literacy and plain language by presenting on Keeping It Plain and Simple webinars to more than 146 participants (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death).*
- In FY 2022, collaborated with the HP/DP Program to host the Community and Public Health summit with 420 registrants (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death).*
- In FY 2022, collaborated with the HP/DP program to host quarterly obesity, cancer, and tobacco prevention webinars with more than 800 participants (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death).*
- In FY 2022, collaborated with the HP/DP program to coordinate a two-day *Project SUN* (culturally appropriate youth tobacco cessation) training with 18 participants; coordinated a two-day *Second Wind* (culturally appropriate adult tobacco cessation) training with 18 participants; and coordinated 2-hours *Let's Talk: Leading through Community Conversations* training with over 70 participants (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death).*
- In FY 2022, collaborated with the Community Health Representative (CHR) program with the National Health Coaching pilot program to train health educators, CHRs, and other disciplines to improve communication and to support patients/clients in their personal and community healthcare journeys (*HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health*).
- In FY 2022, promoted the IHS Introduction to Health Literacy training video posted at the HHS Learning Management System and established the annual Health Literacy Award to recognize teams and individuals to advance health literacy (*HHS Strategic Plan FY 2022-2026 Goal 2, Safeguard and Improve National and Global Health Conditions*

*and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death).*

- In FY 2022, collaborated with Tribes, health boards, schools, and local state health programs to increase outreach prevention activities focusing on immunization, diabetes, sexually transmitted disease, cancer, suicide, alcohol tobacco, and other drugs (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death)*.
- In FY 2023, collaborated with the HP/DP program to coordinate *Catch My Breath* (evidence-based vape prevention) train-the trainers certification program with 38 participants (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death).* Future plan is to train school and youth organization staff to implement vape prevention program to deter youth from using vape products.
- In FY 2024, continue collaborating with various programs and partners to address obesity, sexually transmitted disease, physical activity, alcohol, tobacco and other drugs, cancer, and diabetes. (*HHS Strategic Plan FY 2022-2026, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes, Objective 2.3 Enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death).*
- In FY 2024, continue to collaborate with various programs to promote health literacy activities that include training, webinars, and sharing of best/promising practices (*HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health*).
- In FY 2024, plan to hire a full-time Health Education Consultant. This position has been vacant for several years due to funding limitations.

The Health Education Program maintains data tracking of key program objectives. Tracked data includes educational encounters, the number of patients who received patient education services, provider credentials of who delivered the patient education, site location where patient education was provided, health information provided, amount of time spent providing patient health education, patient understanding, and behavior goals.

**OUTPUTS / OUTCOMES**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| HE-1 Number of visits with Health/Patient Education (Output) | FY 2022: 2,747,938 visits<br>Target:<br>2,575,271 visits<br>(Target Exceeded) | 2,688,583 visits | 2,823,012 visits | +134,429 visits |

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

# AREA ALLOCATION

**Health Education**

(dollars in thousands)

| DISCRETIONARY SERVICES | FY 2022 Final | | | FY 2023 Enacted /1 | | | FY 2024 Estimated /1 | | | FY '24 +/- FY '23 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Federal | Tribal | Total | Federal | Tribal | Total | Federal | Tribal | Total | Total |
| Alaska | $37 | $3,386 | $3,423 | $40 | $3,512 | $3,552 | $45 | $4,094 | $4,138 | $715 |
| Albuquerque | 317 | 1,145 | 1,462 | $347 | 1,187 | 1,534 | 383 | 1,384 | 1,767 | $305 |
| Bemidji | 65 | 742 | 807 | $71 | 769 | 840 | 79 | 897 | 975 | $169 |
| Billings | 257 | 1,251 | 1,507 | $280 | 1,297 | 1,577 | 310 | 1,512 | 1,822 | $315 |
| California | 34 | 397 | 431 | $37 | 412 | 449 | 41 | 480 | 521 | $90 |
| Great Plains | 369 | 2,088 | 2,457 | $403 | 2,165 | 2,568 | 446 | 2,524 | 2,970 | $513 |
| Nashville | 182 | 799 | 981 | $198 | 829 | 1,027 | 220 | 966 | 1,186 | $205 |
| Navajo | 41 | 3,720 | 3,760 | $44 | 3,858 | 3,902 | 49 | 4,497 | 4,546 | $785 |
| Oklahoma | 831 | 2,730 | 3,561 | $908 | 2,831 | 3,739 | 1,004 | 3,300 | 4,305 | $744 |
| Phoenix | 976 | 1,355 | 2,331 | $1,067 | 1,405 | 2,473 | 1,180 | 1,638 | 2,818 | $487 |
| Portland | 112 | 1,093 | 1,204 | $122 | 1,133 | 1,255 | 135 | 1,321 | 1,456 | $252 |
| Tucson | 4 | 291 | 295 | $5 | 301 | 306 | 5 | 351 | 357 | $62 |
| Headquarters | 1,031 | | 1,031 | $1,127 | | 1,127 | 1,246 | | 1,246 | $215 |
| **Total, Hlth Ed** | **$4,254** | **$18,996** | **$23,250** | **$4,650** | **$19,700** | **$24,350** | **$5,143** | **$22,963** | **$28,106** | **$4,856** |

1/ Note: 2023 and 2024 are estimates.

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $63,679 | $65,212 | $74,556 | +$9,344 |
| FTE* | 5 | 5 | 9 | +4 |

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**..........................................................................................Permanent

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

**PROGRAM DESCRIPTION**

The Indian Health Service (IHS) Community Health Representative (CHR) Program is an IHS funded, tribally contracted program of well-trained and medically-guided community-based health workers. The CHR Program was established by the Congress in 1968 in response to the expressed needs of American Indian and Alaska Native (AI/AN) governments, organizations, and the IHS, for a health care program which would provide an outreach component to meet specific tribal health care needs.

The primary purpose of the CHR program is unique, distinct, and in line with broader Community Health Worker (CHW) workforce roles and competencies to include: (1) Relationship and trust-building – to identify specific needs of clients, (2) Communication – especially continuity and clarity, between provider and patient; and traditional knowledge and language, and (3) Focus on Social Determinants of Health – conditions in which people are born, grow, work, live, and age, including social connectedness, traditional knowledge, spirituality, relationship to the environment, and a shared history.

CHRs are trained in the skills of health care provision, disease control and prevention and help to eliminate health disparities by removing barriers to care in their communities. CHRs are the frontline workforce focusing on improving Social Determinants of Health (SDOH) for underserved populations to decrease health inequities across the country using a community-based approach. CHR activities impact SDOH with access to care and coverage, social/cultural cohesion, transportation, food access, environmental quality, social justice, housing and educational training opportunities (*HHS Strategic Plan FY 2022-2026 Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health*).

The CHR Program has made important contributions to Indian health in its efforts to provide community-oriented primary health care services serving as a way to bolster primary and preventive health (*HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*). CHRs are trusted members of the community and serve as a link between the Indian health system, including associated health programs, and AI/AN patients and communities. Importantly, this community-based delivery of care is provided in coordination with tribal health departments and programs.

**BUDGET REQUEST**

The FY 2024 budget request for Community Health Representatives of $75 million is $9 million above the FY 2023 Enacted level.

FY 2024 Funding Increase of $9 million includes:

- Direct Health Care Services Increase: +$5 million to expand access to community health representatives services. These resources will support efforts to reduce health disparities and improve the overall health status for American Indians and Alaska Natives by increasing the availability of health care services in Indian Country.

- Current Services and Staffing of Newly Constructed Facilities: +$4 million. Information can be found on pages CJ-33 and CJ-35 respectively.

## FUNDING HISTORY

| Fiscal Year | Amount |
|---|---:|
| 2020 | $62,892,000 |
| 2021 | $62,892,000 |
| 2022 Final | $63,679,000 |
| 2023 Enacted | $65,212,000 |
| 2024 President's Budget | $74,556,000 |

**TRIBAL SHARES**

Community Health Representatives funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall Community Health Representative's budget line is reserved for inherently federal functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

**PROGRAM ACCOMPLISHMENTS**

In FY 2022, CHR performance measures consist of three categories tracked per fiscal year: a) CHR-1, Number of patient contacts; b) CHR-2, CHR patient contacts for chronic disease services; and c) CHR-3, Number of CHRs trained.

Two reporting categories did not meet targets, and one exceeded the target. NOTE: in the two categories not meeting targets, CHR-1 measure increased by 11.7 percent from FY 2021 to FY 2022 indicating improvement towards target set at a 33 percent increase of 653,181. CHR-2 measure increased by 7.5 percent from FY 2021 to FY 2022, indicating improvement towards target set at a 56 percent increase of 254,418.

Tribes who provided data reported during FY 2022 for CHR-1 performance measure was 488,306 CHR patient contacts. This is a decrease of 164,875 patient contacts below the target measure of 653,181. Tribes who provided data reported during FY 2022 for CHR-2 performance measure was 162,666 CHR reported patient contacts for visits made to patients with chronic diseases. This is a decrease of 91,752 patient contacts below the target measure of 254,418. IHS trained 534 CHRs through an online training platform on Basic/Advanced CHR series courses. This equates to an increase of 158 CHRs trained above the target measure for a 29 percent increase. Beginning in FY 2022 CHR-3 performance measure will increase 10 percent each in FY 2023 and FY 2024 for number of CHRs trained. CHRs are required to complete the CHR web-based modules within one year of employment. Advanced training increases CHRs health knowledge on a variety of public health related topics designed to improve outreach capacity to meet Tribal health system and IHS national goals. CHRs must have completed three years of continuous service as a CHR to be eligible to take the advanced modules. Specialized training expands the CHRs knowledge base. Examples of specialized training include but are not limited to, Motivational Interviewing, Case Management, Maternal Child Health, Mental Health, Health Promotion and Disease Prevention, and CHR RPMS PCC training.

During FY 2022, the Indian health care system modified health care delivery and adapted programming to address COVID-19. The CHR Program adapted accordingly to provide critical technical assistance and guidance for COVID-19 infection control, prevention, and health education outreach to communities. This budget narrative includes examples of how services and programming was adapted to address COVID-19, along with providing standardized programming.

The CHR Program focuses on four (4) goal areas to support the IHS mission and the development of a CHR workforce across Indian Country. The goal areas are:

A. Leadership & Advocacy
B. Workforce Strengthening
C. Integration & Data Systems
D. Sustainability

**GOAL A: LEADERSHIP & ADVOCACY**

- Enhance leadership support for CHRs across the I/T/U system.
- Increase understanding of the importance of CHRs in supporting public and community health and well-being.
- Improve awareness of the value of CHRs across the I/T/U system.

**ACCOMPLISHMENTS**

During FY 2022 the following were accomplished: a) the IHS participated in the HHS-ASPE-CHW Workgroup to collaborate across agencies to provide clarity around CHWs, and identify potential areas of support and where opportunities may exist. This is a 7 federal agency workgroup (*HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*); and b) the IHS participated in the HHS-SDOH Workgroup and Affinity Group (*HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*).

During CY 2023 the following were accomplished: a) continued participation in HHS-ASPE-CHW workgroup working on blog and one-pager outlining CHW workforce and sustainability

efforts, and b) created ten (10) CHR Impact Stories for continued CHR competency, roles and service delivery.

What the program is expected to achieve in FY 2024: a) In progress, set for completion of a 5-year CHR Strategic Plan (2023-2027), and b) host 5-10 webinars to increase awareness of CHR services.

**GOAL B: WORKFORCE STRENGTHENING**

- Improve access to training and education opportunities for CHRs.
- Consider opportunities for CHR career growth and development.
- Refine policy recommendations and guidance for CHRs to clarify roles and responsibilities.

**ACCOMPLISHMENTS**

During FY 2022 the following were accomplished: a) the IHS implemented the first of two national training cohorts under the National Health Coach Pilot Project (NHCPP). The pilot project (over 4 years) will train CHR/paraprofessionals and clinical educators in the coach approach using client-centered services for improving overall health and well-being. The NHCPP includes four project areas: (1) CHR workforce development; (2) Inter-professional training; (3) National Board Health and Wellness (NBHWC) Certification; (4) Social Determinants of Health & Diversity Equity and Inclusion training. There were 484 applicants for 100 training slots, two cohorts of 50 each (*HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*); b) the IHS CHR Program provided Family Spirit training to 15 CHR workshop attendees. The training provides maternal and child health information and skills training to CHR community educators on 63 lessons taught between pregnancy and the child's 3rd birthday for Tribal families. The Family Spirit Program addresses intergenerational behavioral health problems, applies local cultural assets, and overcomes deficits in the professional healthcare workforce in low-resourced communities. It is used in over 100 tribal communities across 16 states (*HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*); c) the CHR Program in partnership with Northwest Portland Area Indian Health Board (NPAIHB) implemented an Indian Country ECHO for CHRs. The Community Health Representative Series Presentations included Hepatitis C Virus, Substance Use Disorder, HIV, LGBTQ-2S, Sexually Transmitted Infections, and COVID-19 Vaccines. This special webinar series was designed for non-clinical staff in key behavioral or community health positions. Total number of attendees to date is 1,109 and was funded through the CARES Act (*HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*); and d) CHR Online Education Module training was implemented to provide CHR online education on Basic and Refresher training. This will provide online core skills training for individuals and teams to bridge the gap between healthcare system and community (*HHS Strategic Plan FY 2022-2026 Goal 1, Objective 1.5 Bolster the health workforce to insure delivery of quality services and care*).

During CY 2023 the following were accomplished: a) to date, 534 CHRs have received 'Basic-level' CHR training using the CHR E-Learning platform,;b) NHCPP cohort 2 health coach training consisting of 54 participates launched February – August 2023; c) continued partnership with NPAIHB implementing an Indian Country ECHO for CHRs; d) completion of CHR advanced module 'Leading at the Community Level;' and e) provided Alzheimer's/Dementia training to CHRs in partnership with Oklahoma Dementia Care Network, 150 CHRs trained.

What the program is expected to achieve in FY 2024: a) increase the number of 'Basic-level' trained CHRs by 10 percent annually per year; b) increase the number of 'Advanced-level' trained CHRs by 10 percent annually per year; c) continue quarterly Indian Country ECHO for CHRs; and d) develop advanced module #2 CHR and Health Coaching.

**INTEGRATION & DATA SYSTEMS**

- Increase integration of CHRs into the I/T/U system.
- Improve utilization and integration of CHRs in healthcare teams and across Tribal communities.
- Formalize integration of CHRs into external health care systems as both frontline community-based support workers and liaisons between patients and health care workers, including clinical providers.
- Increase awareness and the importance of data to document the value of CHRs.

**ACCOMPLISHMENTS**

During FY 2022 the following were accomplished: a) established support contract for CHR RPMS training and technical assistance via office hours; b) supported community and public health efforts with 2022 IHS Public and Community Health Summit incorporating four (4) CHR and community health program presentations; and c) serving as IHS-SDOH lead for affinity/priority Community and Peer Support workgroup.

During CY 2023 the following were accomplished: a) provided CHR RPMS training to three (3) IHS Area sites totaling 90 CHRs trained; b) identified new service utilizing health coaching for IHS to include three (3) EHR Category III codes; c) utilization of CHR data mart for program evaluation; and d) identification of CHR program as a best practice for closed loop referral process utilizing RPMS and EHR.

What the program is expected to achieve in FY 2024: a) increase the number of CHRs trained using CHR RPMS by 10 percent annually per year; b) assess utilization of CHR programs and services, and identify their evidence-based best practices; c) increase subscribers to the CHR listserv; d) provide four (4) CHR RPMS/PCC area workshops annually; e) assist at least two (2) facilities in establishing a CHR pilot program in one of the following areas: Alzheimer's/Dementia, HIV/STI, SDOH, MCH, or Cancer training; and f) leverage professional organizations and partners to promote and/or develop community/clinical linkages in supporting local CHR programs.

**SUSTAINABILITY**

- Identify and support opportunities to enhance CHR program sustainability.
- Ensure for staff growth and retention.

**ACCOMPLISHMENTS**

During FY 2022 the following were accomplished: a) conducted collaboration meetings on CHW/CHR sustainability protocols and guidelines.

During CY 2023 the following were accomplished: a) established two (2) partnerships with state-wide CHW Associations supporting both voluntary CHW certification, and mandatory CHW

certification to include CHRs; and b) participation in HHS-ASPE CHW Sustainability workgroup to promote CHW reimbursement through Medicaid.

What the program is expected to achieve in FY 2024: a) increase the number of Tribal CHR programs utilizing CHW reimbursement; b) educate CHR Tribal leadership on Medicaid covered services for CHWs; c) continue and increase number of partnerships with state-wide CHW Associations; and d) continue cross agency participation in HHS-ASPE CHW workgroup on sustainability protocols and referral guidelines.

The Community Health Representative (CHR) program is over 95 percent directly operated by Tribes or Tribal organizations. As a result, evidence of performance and outcomes is often anecdotal. Lack of national data demonstrating the impact of CHRs in the communities they serve, and the critical role they place to facilitate access to health care services for American Indians and Alaska Natives has raised questions from stakeholders about the overall efficacy of the program.

The CHRs play an invaluable part in the Indian health system by providing culturally competent outreach and facilitation services to members of the communities they serve – usually their own Tribal members. The CHRs have proven to be a critical asset in AI/AN communities' response to COVID-19 by providing much needed long-term contact tracing, case management follow-ups, home visits, patient and community education on vaccine and public health measures, and transportation for tribal community members.

The CHRs serve as a vital link between the patient and the medical home by providing culturally appropriate care and supporting community health.

**OUTPUTS / OUTCOMES**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| CHR-1 Number of patient contacts (Output) | FY 2022: 488,306 patient contacts Target: 653,181 patient contacts (Target Not Met) | 455,417 patient contacts | 478,188 patient contacts | +22,771 patient contacts |
| CHR-2 CHR patient contacts for Chronic Disease Services (Output) | FY 2022: 162,666 patient contacts Target: 254,418 patient contacts (Target Not Met) | 157,551 patient contacts | 165,429 patient contacts | +7,878 patient contacts |
| CHR-3 Number of CHRs Trained (Output) | FY 2022: 534 CHRs Target: 376 CHRs (Target Exceeded) | 376 CHRs | 414 CHRs | +38 CHRs |

## AREA ALLOCATION

**Community Health Representatives**

(dollars in thousands)

| DISCRETIONARY SERVICES | FY 2022 Estimated | | | FY 2023 Estimated | | | FY 2024 Estimated | | | FY '24 +/- FY '23 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Federal | Tribal | Total | Federal | Tribal | Total | Federal | Tribal | Total | Total |
| Alaska | $48 | $4,692 | $4,739 | $53 | $4,790 | $4,842 | $60 | $5,476 | $5,536 | $694 |
| Albuquerque | 38 | 3,689 | 3,726 | 42 | 3,766 | 3,808 | 48 | 4,306 | 4,353 | $546 |
| Bemidji | 52 | 5,070 | 5,122 | 57 | 5,176 | 5,233 | 65 | 5,918 | 5,983 | $750 |
| Billings | 48 | 4,692 | 4,740 | 53 | 4,790 | 4,843 | 60 | 5,476 | 5,537 | $694 |
| California | 22 | 2,110 | 2,132 | 24 | 2,154 | 2,178 | 27 | 2,463 | 2,490 | $312 |
| Great Plains | 245 | 7,312 | 7,557 | 271 | 7,465 | 7,736 | 310 | 8,534 | 8,844 | $1,108 |
| Nashville | 260 | 3,349 | 3,610 | 288 | 3,419 | 3,707 | 330 | 3,909 | 4,239 | $531 |
| Navajo | 74 | 7,257 | 7,331 | 82 | 7,408 | 7,490 | 94 | 8,470 | 8,564 | $1,073 |
| Oklahoma | 97 | 9,562 | 9,660 | 108 | 9,762 | 9,870 | 123 | 11,161 | 11,284 | $1,414 |
| Phoenix | 67 | 6,585 | 6,652 | 74 | 6,722 | 6,796 | 85 | 7,685 | 7,770 | $974 |
| Portland | 51 | 4,933 | 4,983 | 56 | 5,036 | 5,092 | 64 | 5,757 | 5,821 | $730 |
| Tucson | 21 | 2,072 | 2,093 | 23 | 2,116 | 2,139 | 27 | 2,419 | 2,445 | $306 |
| Headquarters | 1,334 | | 1,334 | 1,477 | | 1,477 | 1,689 | | 1,689 | $212 |
| **Total, CHR** | **$2,356** | **$61,323** | **$63,679** | **$2,608** | **$62,604** | **$65,212** | **$2,982** | **$71,574** | **$74,556** | **$9,344** |

1/ Note: 2023 and 2024 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 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget /1 | FY 2024 +/- FY 2023 |
| PL | $2,148 | $2,183 | $2,509 | $326 |
| FTE* | 0 | 0 | 0 | -- |

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**..........................................................................................Permanent

**Allocation Method** .........................................................Self-Governance Compact, Tribal Shares

**PROGRAM DESCRIPTION**

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

Haemophilus Immunization (Hib) Program – The Hib Program started in 1989 with a targeted Haemophilus Influenzae type b prevention project in the Yukon Kuskokwim Delta and now focuses on maintaining high vaccine coverage in a continued effort to prevent communicable disease by providing resources, training, and coordination to Tribal facilities throughout Alaska. Alaska's geography necessitates innovation in program delivery and use of technology as many Tribal facilities are located in remote areas off any continuous road system. The Program maintains immunization practice procedures in partnership with Alaska's statewide Community Health Aide Program to ensure Health Aides working in both urban and remote Tribal facilities have the resources needed to provide high quality vaccination services where Alaska Native families live and play (*HHS Strategic Plan, Goal 1, Objective 1.3 Expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while recognizing social determinants of health; HHS Strategic Plan Goal 2: Safeguard and Improve National and Global Health Conditions and Outcomes*). Through strong collaboration with local Tribal health partners and regional immunization coordinators, the State of Alaska Immunization Program and the IHS Area Immunization Program, the Hib Program offers clinical expertise in advancing vaccine reporting and data management capacity in an environment of evolving and expanding electronic health record systems (*HHS Strategic Plan, Goal 4, Objective 4.4 Improve data collection, use, and evaluation to increase evidence-based knowledge that leads to better health outcomes, reduced health disparities, and improved social well-being, equity, and economic resilience*). In collaboration with statewide partners, the Hib Program advocates for continued access to affordable vaccine through public vaccine funding programs (*HHS Strategic Plan Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Health*

*Care*). The Program works with Tribal public relations to address parental immunization hesitancy and highlight the importance of vaccines, utilizing locally developed culturally appropriate marketing materials and social media campaigns. In alignment with the HHS Strategic Plan Goal 4: Restore Trust and Accelerate Advancements in Science and Research for All, the Hib Program continues to focus on optimizing available information technology to advance capacity in maintaining high vaccine coverage rates, through refining electronic health record processes and expanding capacity for training, social marketing and consultation throughout Alaska statewide.

The Hepatitis B Program and the Hib Program of the Alaska Native Tribal Health Consortium, in collaboration with Alaska Tribal Health Care System partners, provides clinical expertise and consultation, trainings, research, evaluation and surveillance with the goal to reduce the occurrence of infectious disease and improve access to healthcare in the Alaska Native population. The programs support immunization, patient screening, development of electronic health record reminders and systems, providing an infrastructure to maintain high vaccine coverage, and high clinical management coverage of hepatitis B and C in Alaska Natives. The program also manages patients with autoimmune hepatitis (AIH), primary biliary cirrhosis (PBC), and nonalcoholic fatty liver disease (NAFLD). In patients with NAFLD that have nonalcoholic steatohepatitis (NASH) we have recently begun periodic screening and are included in these outcome measures. The Program promotes semi-annual screening of chronic hepatitis patients for both liver cancer and liver function (enzyme testing). The programs' activities support the IHS priorities on quality and partnerships.

Working with partners within the Alaska Tribal Health System to meet the HHS Strategic Plan, the programs provide both direct and telehealth patient care and health provider education to not only increase access to quality care, but also expand the options available (*HHS Strategic Plan, Goal 4, Restore Trust and Accelerate Advancements in Science and Research for All*, and the *HHS Strategic Plan, Goal 1 Protect and Strengthen Equitable Access to High Quality and Affordable Health Care*). Both programs are actively engaged in preventing and treating communicable and chronic diseases (*HHS Strategic Plan Goal 2 Safeguard and Improve National and Global Health Conditions and Outcomes*).

**BUDGET REQUEST**

The FY 2024 budget request for Alaska Immunization is $3 million, which is $326,000 above the FY 2023 Enacted level.

<u>FY 2024 Funding Increase of $326,000</u> includes:

- <u>Direct Health Care Services Increase</u>: +$202,000 will provide coordination of vaccine coverage reporting for Tribal facilities, training of Tribal immunization coordinators, and clinic staff in vaccine recommendations and documentation, consultation in the migration to alternate EHRs, and regular notification to hepatitis patients of the need to complete liver function screenings so that program clinicians can identify serious liver disease or liver cancer when it is at an early and treatable stage.

- <u>Current Services</u>: +$124,000. Information can be found on page CJ-33.

Hepatitis B Program – The program will conduct outpatient clinics five days a week at the Alaska Native Medical Center, travel to regional health centers to conduct outpatient clinics, and will continue its web-based application for video-conferencing that is accessible to the statewide

Alaska Tribal Health System (ATHS) audience to provide relevant clinical information to assist in the care and management of hepatitis and liver disease patients. Continue AK HCV ECHO (Extension for Community Healthcare Outcomes) virtual field clinics where primary care physicians collaborate with program staff for the treatment of hepatitis C cases. Annual field clinics will be conducted across Alaska to provide direct patient care, clinical updates to ATHS staff, and to recruit and conduct follow-up on participants enrolled in the program's research studies. Hepatitis A and Hepatitis B vaccine coverage for Alaska Natives will be measured. In addition, the total number of Alaska Native patients targeted and screened will be measured for hepatitis B, hepatitis C, and other liver disease that affects Alaska Natives.

Haemophilus Immunization (Hib) Program – The budget request will allow staff to provide continued expertise and support to regional Tribal programs on-site and for many partner locations, including rural and isolated locations. 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. Activities include the maintenance of statewide Alaska Native vaccine coverage rate reporting to IHS Headquarters during current phase of evolving electronic health record systems and establishing capacity for vaccine coverage reporting where necessary. Expanding quality of services through provision of technical support for electronic clinical decision support systems (i.e. vaccine forecaster), coverage reporting and patient reminder systems. In addition, efficiency of consultations and trainings offered to Tribal facilities will improve through technology optimization such as utilization of widely available videoconferencing systems and local Distance Learning Network. Community outreach and patient education activities will continue to include limited print of media materials while also expanding to digital and electronic formats.

## FUNDING HISTORY

| Fiscal Year | Amount |
|---|---|
| 2020 | $2,127,000 |
| 2021 | $2,127,000 |
| 2022 Final | $2,148,000 |
| 2023 Enacted | $2,183,000 |
| 2024 President's Budget | $2,509,000 |

### TRIBAL SHARES

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

### PROGRAM ACCOMPLISHMENTS

The Immunization Alaska Program comprised of both the Hepatitis B and Hib Programs has several performance measures to monitor progress in achieving the goal of high vaccine coverage for Alaska Native people as described below.

**Hepatitis B Program**

The Hepatitis B program continues to prevent and monitor hepatitis B infection among a large population of Alaska Natives with or susceptible to the disease. The program evaluates hepatitis A and hepatitis B vaccination coverage of Alaska Natives, and the total number of Alaska Native patients targeted for screening and the total number of patients screened for hepatitis B and

hepatitis C as well as other causes of liver disease that disproportionately affect the Alaska Native population. Due to the opioids crisis, new hepatitis C virus (HCV) infections have increased 69 percent from 2015-2018 compared to the 2011-2014 time period. In response to this crisis, the Program is actively engaged in a statewide HCV elimination project. This involves recruiting patients for treatment through our local outpatient clinic, field clinics and video clinics (*HHS Strategic Plan FY, Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes)* as well as performing provider in-person and webinar education seminars on treating hepatitis C to build. The Program website provides online treatment documents and a treatment algorithm for Alaska Tribal healthcare providers. Also, Program staff conduct monthly Alaska HCV Extension for Community Healthcare Outcomes (ECHO) collaboratives providing remote assistance for hepatitis C case review and treatment recommendations. Since 2014, over 1,200 American Indian/Alaska Native persons have been treated for HCV through the Alaska Tribal Health System *(HHS Strategic Plan Goal 2 Safeguard and Improve National and Global Health Conditions and Outcomes)*. The Program has two non-invasive elastography devices allows for the safe, non-invasive monitoring of liver disease progression without having to perform an invasive liver biopsy. One is a portable machine that is transported to field clinics thus reducing the need for patients to travel to Anchorage or alternative site for their care *(HHS Strategic Plan Goal 1 Protect and Strengthen Equitable Access to High Quality and Affordable Health Care)*.

With the onset of COVID-19 pandemic, the Program is monitoring persons with liver disease who test positive for COVID-19 to track their health outcomes and assess any complications related to their liver disease.

In FY 2022:

- Hepatitis A vaccination coverage did not achieve the target, and hepatitis B vaccination coverage exceeded the target. Hepatitis A vaccination coverage was 83 percent (90 percent target) and hepatitis B vaccination coverage was 93 percent (90 percent target).
- Overall, at least 74 percent of AI/ANs with either chronic hepatitis B (66 percent screened) or hepatitis C (78 percent screened) infection were screened for liver cancer and for liver aminotransferase (enzyme) levels.

**Haemophilus Immunization (Hib) Program**

The Hib program continues to provide resources, training and coordination to Tribes in Alaska to maintain high vaccine coverage among Alaska Native people. Vaccine coverage data is collected for each Tribal region and measured in collaboration with regional Tribal health immunization coordinators (*HHS Strategic Plan, Goal 4, Restore Trust and Accelerate Advancements in Science and Research for All)*. Technical consultation for the varying electronic health record (EHR) systems within each Tribal health organization is provided to support improved vaccine coverage for all Tribes. Statewide Alaska Native vaccine coverage rates (including influenza) are reported to IHS National Immunization Program for infants 3-27 months, 19-35 months, adolescents, adults. Flu vaccine coverage rates for healthcare personnel working at Tribal facilities are also reported to IHS National Immunization Program. Efforts pursuing information technology to advance capacity in maintaining high vaccine coverage rates include: participation as clinical experts on national EHR advisory workgroups regarding immunization-related product development; local advocacy for advancements in Alaska Tribal health electronic health record systems, such as reminder recall systems (i.e. patient reminders) and vaccination service delivery options (i.e. satellite or off-site clinics); providing clinical expertise in the implementation of a clinical decision support system (i.e. vaccine forecaster) in a prominent Alaska Tribal Health electronic health record system; and collaborations with State and Tribal partners in expanding

coverage reporting capacity in available electronic health record systems *(HHS Strategic Plan Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability)*. Improvement in vaccine coverage relies on data capture and quality in electronic health record systems, facilitated by data interfaces, and in conjunction with clinical resources and training.

Routine immunizations have been disrupted by the COVID-19 pandemic. Childhood immunization coverage with 4:3:1:3*:3:1:4 series for Alaska Native children age 19-35 months declined by 5 percent from March 31, 2020 (73 percent) to June 30, 2021 (68 percent) and declined further by 9 percent to September 30, 2022 (59 percent). Leveraging the Healthy People 2030 measures, the Program will add two immunization performance measures to the Program for Alaska Native children age 19-35 months, 4 doses DTaP and 1 MMR.

In response to this drop in non-COVID-19 vaccine coverage among Alaska Native children and in an effort to maintain routine vaccine coverage in all age groups, the Program is actively engaged in optimizing utilization of evidence-based strategies to improve vaccine coverage rates across the lifespan, in collaboration with statewide partners and Tribal public relations. Activities will include technical assistance in optimizing available information technology capacity for efficient accessible childhood, adolescent and adult vaccine coverage reporting within the Alaska Tribal Health Care system.

During FY 2022:

- Immunization Coverage for Alaska Natives age 19-35 months was 59 percent, for the 4:3:1:3*:3:1:4 series (4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Var, 4 PCV).
  - 4 DTaP in this age group was 64 percent, the Healthy People 2030 vaccination objective IID-06 to increase the coverage level of 4 doses of DTaP vaccine in children by age two years has a target of 90 percent.
  - 1 MMR in this age group was 83 percent, the Healthy People 2030 vaccination objective IID-03 to maintain the coverage level of 1 dose of MMR in children by age 2 years has a target of 90.8 percent.
- Achieved 83 percent coverage with full series Haemophilus influenza type b (Hib) vaccine in children age 19-35 months, which is higher than the coverage rate of 80.0 percent for US all-races by age 24 months among children born during 2018-2019.
- In FY 2020, achieved 60 percent Tdap vaccine coverage in all patients 19 years and older who had received Tdap within the past 10 years. Unable to measure in 2021 or 2022.
- In FY 2020, achieved 82 percent pneumococcal vaccine coverage in patients 65 years and older who received pneumococcal vaccine in the past ever. Unable to measure in 2021 or 2022.
- Assisted Tribal facilities using new EHR systems or the IHS EHR immunization package in maintaining or establishing interface connection with the State of Alaska Immunization Information System (SIIS).
- Assisting Alaska Tribal Health electronic health record workgroup with gap analysis and providing associated consultation in implementation and maintenance of new clinical decision support system (i.e. vaccine forecaster).
- Assisted Tribal facilities in utilization of Alaska SIIS patient reminder system.
- Assisted Tribal facilities throughout Alaska to implement new policy and procedures associated with vaccine electronic inventory management, delivery systems and documentation for COVID-19 vaccine.

- Continued engagement in planning for COVID-19 vaccine and supported distribution, in collaboration with Alaska's State and Tribal stakeholders, and working with key participants critical for strategizing and plan implementation.

A summary of immunization[1] results is included below:

| Immunization Measure | Age Group | Alaska Native coverage as of 9/30/2022 | Alaska Native coverage as of 6/30/21 |
|---|---|---|---|
| 4:3:1:3*:3:1:4 | 19-35 months | 59% | 68% |
| 4:3:1:3:3:1 | 19-35 months | 60% | 68% |
| 3 Hib vaccines doses | | 83% | 88% |
| 3 PCV (pneumococcal conjugate vaccine) | 19-35 months | 85% | 89% |
| 4 DTaP | 19-35 months | 64% | 72% |
| 1 MMR | 19-35 months | 83% | 88% |
| 1+ HPV | 13-17 years female | 77% | 82% |
| Pneumococcal vaccine | 65+ years | --- | ~~82%~~ |
| Tdap | 19 years and older | --- | ~~60%~~ |

The Hib program continues to collaborate with Centers for Disease Control and Prevention in networking with IHS, State, and Tribal agencies to provide technical assistance regarding EHRs. Challenges include the diversity of EHRs employed by Tribal organizations that may result in temporary loss or delay of Area-wide reporting of vaccine coverage. Regular reporting of immunization coverage is critical in assuring sufficient monitoring and follow-up with facilities experiencing vaccination administration issues. Technical assistance to sites will continue to be addressed through coordinated efforts by the Hib Program, IHS, State, and Tribes. Vaccine coverage is measured.

**OUTPUTS / OUTCOMES**

| **Measure** | **Year and Most Recent Result / Target for Recent Result / (Summary of Result)[1]** | **FY 2023 Target** | **FY 2024 Target[2]** | **FY 2024 Target +/-FY 2023 Target** |
|---|---|---|---|---|
| AK-1 Chronic Hepatitis B Patients Screened/Targeted (Output) | FY 2022: 603 Screened<br>Target:<br>600 Screened<br>(Target Met) | 600 Screened | 550 Screened | -50 Screened |
| AK-2 Chronic Hepatitis C Patients Screened/Targeted (Output)[3] | FY 2022: 1364 Screened<br>Target:<br>1300 Screened<br>(Target Exceeded) | 1300 Screened | 1300 Screened | Maintain |

[1] IHS vaccination rates compare favorably with overall National vaccination rates. The CDC conducts National Immunizations Surveys which allows self-reporting of vaccines. https://www.cdc.gov/vaccines/vaxview/index.html

[2] Hepatitis Program (Known Cases Screened) Sum of known hepatitis B cases FY 2022: 914. Decline is hepatitis B cases due to an aging cohort and their deaths; discovery of new cases is rare given hepatitis B vaccinations.

[3] Hepatitis Program (Known Cases Screened) Sum of known hepatitis C cases FY 2022: 1,788. New cases still occurring through the monthly rate decreased slightly compared to FY2021. Treated cases with advanced fibrosis/cirrhosis being followed indefinitely.

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result)[1] | FY 2023 Target | FY 2024 Target[2] | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| AK-3 Other Liver Disease Patients Screened (Output) [4] | FY 2022: 398 Screened<br>Target:<br>200 Screened<br>(Target Exceeded) | 300 Screened | 300 Screened | Maintain |
| AK-4 Hepatitis A vaccination (Output) [5] | FY 2022: 83 %<br>Target:<br>90 %<br>(Target Not Met) | 90 % | 90 % | Maintain |
| AK-5 Hepatitis B vaccinations (Output) [6] | FY 2022: 93 %<br>Target:<br>90 %<br>(Target Exceeded) | 90 % | 90 % | Maintain |

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

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

## AREA ALLOCATION

**Immunization Alaska**

(dollars in thousands)

| DISCRETIONARY SERVICES | FY 2022 Final | | | FY 2023 Enacted /1 | | | FY 2023 Estimated /1 | | | FY '24 +/- FY '23 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Federal | Tribal | Total | Federal | Tribal | Total | Federal | Tribal | Total | Total |
| Alaska | $0 | $2,148 | $2,148 | $0 | $2,183 | $2,183 | $0 | $2,509 | $2,509 | $326 |
| **Total, Imm AK** | **$0** | **$2,148** | **$2,148** | **$0** | **$2,183** | **$2,183** | **$0** | **$2,509** | **$2,509** | **$326** |

1/ Note: 2023 and 2024 are estimates.

[4] Hepatitis Program (Known Cases Screened) Sum of known other liver disease cases FY 2022: 441. Other liver disease includes AIH and PBC (310 cases), plus the addition of NAFLD with NASH (131 cases).

[5] Hepatitis A/B Immunization rates for Alaska Native children who achieve Hepatitis A 1-dose completion and Hepatitis B 3-dose completion aged 19-35 months are compiled and reported throughout the Alaska Native Tribal Health System on a quarterly basis.

[6] The rates reported herein represent the most recent reporting period. Established target immunization rate for each vaccine is 90%.

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

(Dollars in Thousands)

| | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget | FY 2024 2024 +/- FY 2023 |
|---|---|---|---|---|
| PL | $73,424 | $90,419 | $115,156 | +$24,737 |
| FTE* | 8 | 8 | 9 | +1 |

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**..........................................................................................Permanent

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

**PROGRAM DESCRIPTION**

The Indian Health Service (IHS) Office of Urban Indian Health Programs (OUIHP) was established in 1976 to make health care services more accessible to Urban American Indian/Alaska Native (AI/AN) people. The IHS OUIHP 2023-2027 Strategic Plan guides, supports, and improves access to high quality, culturally appropriate health care services for Urban AI/AN people.

The IHS enters into limited, competitive contracts and grants with 41 501(c)(3) non-profit organizations to provide health care and referral services for Urban AI/AN people in 22 states and 11 IHS Areas. Awarding of these contracts and grants to UIOs also addresses *HHS Strategic Plan Goal 2, Safeguard and Improve National and Global Health Conditions and Outcomes*. UIOs define their scope of work and services based upon the service population, health status, and unmet needs of the Urban AI/AN community they serve. Each Urban Indian Organization is governed by a Board of Directors that must include at least 51 percent of Urban AI/AN people.

UIOs provide unique access to quality health care and culturally appropriate services for Urban AI/AN people. The 41 UIOs are an integral part of the Indian health care system and serve as resources to both tribal and Urban AI/AN communities. Urban AI/AN people are often invisible in the urban setting and face unique challenges when accessing health care. A large proportion of Urban AI/AN people live in or near poverty and face multiple barriers such as the lack of quality and culturally relevant health care services in cities. UIOs are an important support to Urban AI/AN people seeking to maintain their tribal values and cultures and serve as a safety net for Urban AI/AN patients. Social determinants of health play a key role in health and wellness, and UIOs address a wide range of factors contributing to improved health outcomes. For example, Urban AI/AN people in need of substance use disorder treatment commonly exhibit co-occurring disorders, and UIOs integrate behavioral health into primary care to offer health services within a culturally appropriate framework. UIOs provide health care services that address *HHS Strategic Plan Goal 1, Protecting and Strengthening Equitable Access to High Quality and Affordable Healthcare.*

## BUDGET REQUEST

The FY 2024 budget submission for Urban Health is $115 million, which is $25 million above the FY 2023 Enacted level.

FY 2023 Base Funding of $90 million – The base funding provides for the following activities.

- Improving Urban AI/AN access to health care to improve health outcomes in urban centers.
- Strengthening programs that serve Urban AI/AN people throughout the United States.
- Enhancing Urban Indian Organization third party revenue, implementing payment reforms such as the transition to a new prospective payment system, and increasing quality improvement efforts.
- Increasing the number of accredited Urban Indian Organization programs and patient centered medical homes for Urban AI/AN individuals.
- Implementing and utilizing advanced health information technology.
- Expanding access to quality, culturally competent care for Urban AI/AN people through collaboration with other federal agencies.
- Implementing IHCIA authorities specific to UIOs.

FY 2024 Funding Increase of $25 million includes:

- Direct Health Care Services Increase: +$21 million to expand access to urban Indian program care services. These resources will support efforts to reduce health disparities and improve the overall health status for AI/AN people by increasing the availability of health care services in Indian Country.

- Current Services: +$4 million. Information can be found on page CJ-33.

## FUNDING HISTORY

| Fiscal Year | Amount |
| --- | --- |
| 2020 | $57,684,000 |
| 2021 | $62,684,000 |
| 2022 | $73,424,000 |
| 2023 | $90,419,000 |
| 2024 OMBJ Level | $115,156,000 |

## PROGRAM ACCOMPLISHMENTS

In Calendar Year 2021, UIOs provided 696,722 health care visits for 70,216 Urban AI/AN people who do not have access to the resources offered through IHS or tribally operated health care facilities because they do not live on or near a reservation. UIOs are described as follows:

- Full Ambulatory Care: Programs providing direct medical care to the population served for 40 or more hours per week.
- Limited Ambulatory Care: Programs providing direct medical care to the population served for less than 40 hours per week.
- Outreach and Referral: Programs providing case management of behavioral health counseling and education services, health promotion/disease prevention education, and immunization counseling but not direct medical care services.

- Residential and Outpatient Substance Abuse Treatment: Programs providing residential and outpatient substance abuse treatment, recovery, and prevention services.

Included in the above 41 UIOs funded through contracts and grants, are the following:

- Oklahoma City Indian Clinic and Indian Health Care Resource Center of Tulsa: These two urban sites, initially demonstration projects, are now permanent programs within the IHS's direct care program and must continue to qualify as an Urban Indian Organization under the IHCIA definition, 25 U.S.C. § 1660b.
  - Former National Institute on Alcohol Abuse and Alcoholism Programs: As of FY 2020, the Urban Indian Health Program includes five UIOs that previously received grants originally awarded by the National Institute on Alcohol Abuse and Alcoholism (former-NIAAA program) and later administered by the IHS Alcohol and Substance Abuse Program (ASAP). The OUIHP confirmed each of these former-NIAAA programs is an Urban Indian Organization as defined by the IHCIA and fully implemented the administrative transfer from ASAP to OUIHP, as authorized by IHCIA at 25 U.S.C. § 1660c – Urban NIAAA transferred programs. In FY 2020, Congress approved the transfer of this funding from the ASAP budget to the Urban Indian Health budget line. In FY 2023, the final portion of the former-NIAAA funding will be reprogrammed from ASAP to Urban Indian Health. These Urban Indian Organization contract awards address *IHS Goal 1, to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people.* These contract awards also align with *HHS Strategic Plan Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare*. The five UIOs provide high quality, culturally relevant prevention, early intervention, outpatient and residential substance abuse treatment services, and recovery support to meet the needs of Urban AI/AN communities they serve.

The other major Urban Indian Health focus areas and activities are:

- 4-in-1 Grant Program: In FY 2022, the OUIHP awarded 4-in-1 grants to 32 UIOs. The grantees are awarded for a five-year funding cycle from April 1, 2022 - March 31, 2027. These grants provide funding to UIOs to support four health program areas: health promotion and disease prevention services; immunization services; alcohol and substance abuse related services; and mental health services. Grantees are required to participate in a national evaluation of the 4-in-1 grant program. The national evaluation includes reporting on the cultural interventions integrated into the 4-in-1 program activities, and practice-based and evidence based approaches that are implemented to meet the needs of the Urban Indian service population. These grants *protect and strengthen equitable access to high quality and affordable health care, which meets HHS Strategic Plan Goal 1 and enhance promotion of healthy behaviors to reduce occurrence and disparities in preventable injury, illness, and death, which meets HHS Strategic Plan Goal 2, Objective 2.3.*

- Urban Indian Education and Research Organization Cooperative Agreement: In FY 2022, the OUIHP awarded one national Indian organization to provide national-level education and research services for UIOs and OUIHP through a cooperative agreement. The grantee was awarded a five-year funding cycle from June 1, 2022 – May 31, 2027. The cooperative agreement includes five project areas: (1) public policy; (2) research and data; (3) training and technical assistance; (4) education, public relations, and marketing; and (5) payment system reform/monitoring regulations. This cooperative agreement also addresses the unmet needs of 4-in-1 grantees under the training and technical assistance focus area.

- Albuquerque Indian Dental Clinic: Provides dental services through the Albuquerque Area IHS Dental Program. The provision of dental services also addresses *HHS Strategic Plan Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare.*

UIOs are evaluated in accordance with the IHCIA requirements. The program is administered by the OUIHP at IHS Headquarters. The OUIHP integrates Enterprise Risk Management by annually reviewing Urban Indian Organization progress with set goals and objectives. The IHS Urban Indian Organization On-Site Review Manual is used by the IHS Areas to conduct annual onsite reviews of IHS-funded UIOs to monitor compliance with Federal Acquisition Regulation contractual requirements established through legislation. The results are submitted to OUIHP for review and follow-up to ensure corrective action plans are successfully completed prior to continuation of funding. Requirements in the manual are based on best-practice standards for delivering safe and high quality health care and are similar to standards used by accrediting organizations.

Many UIOs are seeking or maintaining accreditation from several accreditation organizations such as the Joint Commission, Accreditation Association for Ambulatory Healthcare (AAAHC), and Commission on Accreditation of Rehabilitation Facilities. In FY 2022, through an IHS contract with AAAHC, accreditation services were provided to 25 out of the 41 UIOs to meet *HHS Strategic Plan Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare*.

UIOs fulfill IHS data reporting requirements including the IHS Government Performance and Results Act (GPRA) report and the Diabetes Non-Clinical Audit report. UIOs currently participate in the IHS Improving Patient Care Initiative and are now in the Quality and Innovation Learning Network implementing what they have learned across a wider variety of clinical and administrative options.

From October 1, 2020, to September 30, 2021, the Urban Indian Organization FY 2021 GPRA cycle accomplishments included:

- 97 percent of the UIOs reported on 26 of the 26 performance measures (although not all have facility-specific data available due to inclusion in an IHS Service Unit);
- 59 percent of the UIOs reported through the Integrated Data Collection System Data Mart (IDCS DM);
- 13 (38 percent) have GPRA data specific to their health program available in IDCS DM;
- 7 UIOs reported through the Clinical Reporting System (2 of these programs reported both through IDCS DM and through CRS); and
- 13 UIOs reported manually using 100 percent review of appropriate data source (as opposed to sampling a smaller percentage of records).

The IHS will proceed with plans to have all UIOs export data to the IHS National Data Warehouse (NDW). This includes working with UIOs utilizing commercial off the shelf systems to export data to the NDW. The OUIHP will continue to work with the IHS National Patient Information Reporting System staff to improve the export and accuracy of data for UIOs. The OUIHP, with the assistance of the IHS Office of Information Technology, will continue to provide training and technical assistance to UIOs on accurate and uniform data collection, so as to achieve standardization throughout the system. This work aligns with *HHS Strategic Plan Goal 5, Advance Strategic Management to Build Trust, Transparency, and Accountability*.

On December 27, 2020, the Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260) (hereinafter "the Act") was signed into law. The Act provided the IHS with a total FY 2021 appropriation of $6.4 billion. The Joint Explanatory Statement for Division G for the Act designated $1,000,000 to conduct an infrastructure study for facilities run by UIOs. The infrastructure study provides the first step towards creating a comprehensive action plan to focus on improving equity and reduce barriers to programs and services. In FY 2021, the IHS initiated urban confer to seek input on developing and implementing the infrastructure study from UIOs. In FY 2022, the IHS awarded a contract to The Innova Group to conduct the infrastructure study to identify future facility needs of UIOs. The infrastructure comprehensive action plan will address *HHS Strategic Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare.*

In FY 2021, the OUIHP leveraged the IHS Office of Public Health Support's Indefinite Delivery Indefinite Quantity contract to develop a new 5-year IHS OUIHP strategic plan. On December 3, 2021, the IHS initiated urban confer to seek input and recommendations on the development of a new strategic plan to improve access to high quality, culturally competent health services for Urban Indians. In FY 2022, an evaluation of the previous five-year OUIHP strategic plan was completed and a new five-year OUIHP strategic plan was established. The 2023-2027 OUIHP strategic plan's priorities, goals, objectives, and performance measures were developed in partnership with UIOs, partners, and external stakeholders. The new OUIHP strategic plan addresses *HHS Strategic Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare*.

On January 5, 2021, Congress amended 25 U.S.C. § 5321(d) to extend the Federal Tort Claims Act (FTCA) coverage to UIOs and their employees to the same extent and in the same manner as to Indian Self-Determination and Education Assistance Act (ISDEAA) contractors and compactors. The OUIHP team implemented this new legislation for IHS. In February 2022, the OUIHP developed and provided an updated UIO FTCA Frequently Asked Questions document and made it available on the IHS Office of Quality, Risk Management webpage.

On June 15, 2021, the OUIHP and IHS Office of Quality Risk Management held the first training to provide an overview of FTCA coverage for UIOs. On August 16, 2022, a second training to provide an update on FTCA coverages and reporting processes for UIOs. The extension of the FTCA coverage to UIOs and their employees addresses *HHS Strategic Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare.*

In FY 2022, the OUIHP approved Urban Emergency Funds totaling $200,000. The OUIHP approved two Urban Emergency Funds for the Indian Health Center of Santa Clara Valley, one for $35,506 and the other for $97,008. In both instances, funds aided in addressing water damage to their clinic, which resulted in damage to their behavioral health conference room/office space, the loss of tow pediatric dental exam rooms and some clinic support areas. The Bakersfield American Indian Health Project received $64,486 to enhance security of their facility and parking lot due to issues of theft and vandalism which affected the safety of patients and staff as well as costly repairs to transportation services. Offering Urban Emergency Funds to UIOs in a time of need addresses *HHS Strategic Goal 1, Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare.*

**OUTPUTS / OUTCOMES**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| UIHP-7 Number of AI/ANs served at Urban Indian clinics. (Outcome) | FY 2021: 70,216 Target: 70,000 (Target Met) | 73,726 | 77,412 | +3,686 |
| UIHP-8 Percentage of AI/AN patients with diagnosed diabetes served by urban health programs that achieve good blood sugar control (Outcome) | Discontinue | Discontinued | Discontinued | N/A |
| UIHP-9 Proportion of children, ages 2-5 years, with a BMI at or above the 95th percentile (Outcome) | Discontinue | Discontinued | Discontinued | N/A |
| UIHP-10 Increase the number of diabetic AI/ANs that achieve blood pressure control (Outcome) | Discontinue | Discontinued | Discontinued | N/A |
| UIHP-11 Reduce the proportion of American Indians/Alaska Natives with diagnosed diabetes who have poor glycemic control (A1c >9%). (Outcome) | Discontinue | Discontinued | Discontinued | N/A |

**GRANTS AWARDS** - Funding for UIOs for FY 2024 includes both grants and contracts awarded to the programs.

| *(whole dollars)* | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget |
|---|---|---|---|
| Number of Awards | 33 | 35 | 35 |
| Average Award | $291,166 | $287,367 | $287,367 |
| Range of Awards | $164,373 - $1,350,000 | $164,373 - $1,350,000 | $164,373 - $1,350,000 |

# AREA ALLOCATION

**Urban Health**

(dollars in thousands)

| DISCRETIONARY SERVICES | FY 2022 Enacted /1 | | | FY 2023 Enacted /1 | | | FY 2023 Estimated /1 | | | FY '24 +/- FY '23 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Federal | Urban | Total | Federal | Urban | Total | Federal | Urban | Total | Total |
| Alaska | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $ |
| Albuquerque | 0 | 4,374 | 4,374 | 0 | 5,387 | 5,387 | 0 | 6,861 | 6,861 | $1,474 |
| Bemidji | 0 | 6,615 | 6,615 | 0 | 8,146 | 8,146 | 0 | 10,374 | 10,374 | $2,229 |
| Billings | 0 | 3,690 | 3,690 | 0 | 4,545 | 4,545 | 0 | 5,788 | 5,788 | $1,243 |
| California | 0 | 10,108 | 10,108 | 0 | 12,447 | 12,447 | 0 | 15,853 | 15,853 | $3,405 |
| Great Plains | 0 | 2,472 | 2,472 | 0 | 3,045 | 3,045 | 0 | 3,878 | 3,878 | $833 |
| Nashville | 0 | 1,473 | 1,473 | 0 | 1,814 | 1,814 | 0 | 2,311 | 2,311 | $496 |
| Navajo | 0 | 1,188 | 1,188 | 0 | 1,463 | 1,463 | 0 | 1,863 | 1,863 | $400 |
| Oklahoma | 0 | 3,418 | 3,418 | 0 | 4,209 | 4,209 | 0 | 5,360 | 5,360 | $1,151 |
| Phoenix | 0 | 4,064 | 4,064 | 0 | 5,005 | 5,005 | 0 | 6,375 | 6,375 | $1,369 |
| Portland | 0 | 8,958 | 8,958 | 0 | 11,031 | 11,031 | 0 | 14,049 | 14,049 | $3,018 |
| Tucson | 0 | 839 | 839 | 0 | 1,033 | 1,033 | 0 | 1,315 | 1,315 | $283 |
| Headquarters | 0 | 26,225 | 26,225 | 0 | 32,295 | 32,295 | 0 | 41,131 | 41,131 | $8,835 |
| **Total, Urban** | **$0** | **$73,424** | **$73,424** | **$0** | **$90,419** | **$90,419** | **$0** | **$115,156** | **$115,156** | **$24,737** |

1/ Note: 2023 and 2024 are estimates.

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $73,039 | $80,568 | $94,324 | +$13,756 |
| FTE* | 13 | 13 | 13 | -- |

*FTE numbers reflect only Federal staff and do not include increases for tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**..........................................................................................Permanent

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

**PROGRAM DESCRIPTION**

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

Loan Repayment Program (Section 108): The LRP is an invaluable tool for recruiting and retaining healthcare professionals by offering them the opportunity to reduce their student loan debts through service to Indian health programs with critical staffing needs. Applicants agree to serve two years at an Indian health program in exchange for up to $20,000 per year in loan repayment funding and up to an additional $5,000 per year to offset tax liability. Loan repayment recipients can extend their initial two-year contract on an annual basis until their original approved educational loan debt is paid.

Applicants who apply for but do not receive funding, are identified as either "matched unfunded" or "unmatched unfunded". The "matched unfunded" applicants are health professionals employed in an Indian health program. The "unmatched unfunded" applicants are health professionals that either decline a job offer because they did not receive loan repayment funding or those unable to find a suitable assignment meeting their personal or professional needs.

Scholarship Program (Sections 103 and 104) – Section 103 scholarships include the preparatory and pre-graduate scholarship programs that prepare students for health professions training programs. Graduate students and junior- and senior-level undergraduate students are given priority for funding for programs under Section 103, unless the section specifies otherwise. Section 104 includes the Health Professions Scholarship program, which provides financial support consisting of tuition, fees and a monthly stipend for AI/AN students from federally

recognized Tribes enrolled in health profession or allied health profession programs. Students accepting funding for programs under Section 104 incur a service obligation and payback requirement. In FY 2022, there were 560 new online scholarship applications submitted to the IHS Scholarship program. After evaluating the application for completeness and eligibility, a total of 192 of these new scholarship applications accepted the scholarship. The IHS Scholarship program also reviewed applications from previously awarded scholars that were continuing their education.

Extern Program (Section 105) - Section 105 of the IHCIA, is designed to give IHS scholars and other health professions students the opportunity to gain clinical experience with IHS and Tribal health professionals in their chosen discipline. This program is open to IHS scholars and non-scholars. Students are employed up to 120 days annually, with most students working during the summer months.

**BUDGET REQUEST**

The FY 2024 budget submission for Indian Health Professions of $94 million is $14 million above the FY 2023 Enacted level.

FY 2023 Base Funding of $81 million – The base funding enables AI/ANs to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs; serve 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; and assist Indian health programs to recruit and retain qualified health professionals.

FY 2024 Funding Increase of $14 million includes:

- Indian Health Professions Increase: +$13 million to support a variety of activities to improve recruitment and retention, including compensation and hiring initiatives, bolstering the personnel security program, and streamlining human resources information systems. Examples of key activities supported by these funds are:
  - Additional Scholarship and Loan Repayment Awards (+$4 million). These funds will support additional scholarship and loan repayment awards to improve recruitment and retention by bolstering two programs in high demand.
  - Compensation and Hiring Initiatives (+$3 million). Activities include the review and development of Title 38 Special Salary Rates for allied health professionals, and system enhancements to implement work schedules for health care providers that are currently available at VA and the private sector.
  - Personnel Security Program (+$3 million). This program is responsible for the proper vetting of incoming personnel, as well as continuous monitoring of personnel, to ensure eligibility to obtain and maintain a position of trust within the federal government.
    - IHS' vetting process is also extended to support the Indian Child Protection and Family Violence Prevention Act – Public Law 101-630, which is an additional check for all personnel occupying a position or performing work that involves regular contact with, or control over Indian children.

- The IHS personnel security program directly supports the recruitment and retention of IHS personnel.

- Human Resources Information Systems (+$2 million). Funds will streamline recruitment and retention activities, such as automating compensation and onboarding activities to expedite the hiring process.

- Housing Subsidies for Health Care Professionals (+$1 million). The FY 2018 appropriation provided a new authority for the IHS to provide housing subsidies for health care professionals as a recruitment tool for IHS and Tribal Health Programs. The IHS did not receive funding to implement this new authority until the recruitment and retention funding increase in FY 2020. The IHS is in the process of implementing a pilot for this program to measure its success. Additional resources would make this a more robust pilot, with results that are more appropriate for generalizing across the Indian health system, while filling critical vacancies.

- Current Services: +$756,000. Information can be found on page CJ-33.

**FUNDING HISTORY**

| Fiscal Year | Amount |
|---|---|
| 2020 | $65,314,000 |
| 2021 | $67,314,000 |
| 2022 Final | $73,039,000 |
| 2023 Enacted | $80,568,000 |
| 2024 President's Budget | $94,324,000 |

**PROGRAM ACCOMPLISHMENTS**

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

- Recruiting well-qualified health care professionals through various sources: IHS Scholarship Recipients, US Public Health Service Commissioned Corps, Uniformed Services University of the Health Sciences (USUHS), various social media networking sites, virtual career fair events and in person physician specialty conferences.
- Conducting IHS Scholarship Program webinar-based general information session webinars for potential applicants.
- Conducting Loan Repayment Program webinars for new recipients to provide information about the requirements of their service obligation. Updated the LRP website with current eligible professions and updated site scores.
- Enabling AI/ANs to enter health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs.
- Serving as a catalyst in developing AI/AN communities by providing educational opportunities for AI/ANs to become health care professionals and return to their local communities to provide health care.
- Developing and maintaining American Indian psychology career recruitment programs as a means of encouraging AI/ANs to enter the mental health field.
- Assisting AI/AN health programs to recruit and retain qualified health professionals.
- Collaborating with the National Health Service Corps Loan Repayment Program that received an additional funding for loan repayment awards to clinicians working at IHS

facilities, Tribally-operated 638 health programs, and Urban Indian programs to combat the nation's opioid crisis.
- Consulting annually with IHS Area Directors, Tribal health directors, and Urban Indian health directors regarding their health professions priorities eligible for Scholarship and Loan Repayment Program funding.
- Developing and managing the IHS Exit Survey Program currently piloting in 2 Areas.
- Developing and managing the IHS Housing Subsidy Program currently piloting in 1 Area.

While the IHP programs have seen successes, IHP continues to strive to improve performance and identify areas of risk. Placement of new scholars within 90 days of completing their training continues to be a challenge. The use of outreach activities such as recruitment and placement webinars, direct emails to scholarship recipients, and the referral of graduates to area and site recruiters have all been used to facilitate the 90 day scholar placement. In FY 2021, 69 percent of scholars had a hire letter within 90 days (target was 78 percent). Failure to meet this goal was primarily due to scholars of certain disciplines being unable to register for their licensing board examinations until after successful completion of their education and finding positions within the 90 day period. The Scholarship program continues to seek new ways to assist IHS scholars to meet this requirement. Assuring scholars and loan repayment recipients meet their service obligation is another critical component of the IHP programs. Annual employment verification through personnel rosters and certification by Tribal employers assist in this process. Improvements to the Scholarship program and LRP databases allow staff to identify when health professionals are expected to complete their service obligation and allow for timely follow-up.

Loan Repayment Program (Section 108): In FY 2022, a total of 1,635 health professionals were receiving IHS loan repayment. This included 541 new two-year contracts, 552 one-year extension contracts, and 542 health professionals starting the second year of their FY 2021 two-year contract.

In FY 2022, there were no "matched unfunded" applicants and 32 "unmatched unfunded" health professionals (including 72 behavioral health providers, 10 dentists, 46 mid-level providers and 92 nurses among others). The inability to fund these 321 health professional applicants is a significant challenge for the recruitment efforts of the agency. A more detailed breakout of loan repayment awards in FY 2022 by discipline is included in a table at the end of the narrative.

Scholarship Program (Sections 103 and 104): In FY 2022, there were 560 new online scholarship applications submitted to the IHS Scholarship program. After evaluating the application for completeness and eligibility, a total of 192 of these new scholarship applications accepted the scholarship. The IHS Scholarship program also reviewed applications from previously awarded scholars that were continuing their education. A total of 160 extension awards were funded for FY 2022. A detailed breakout of scholarships awarded by discipline for FY 2021 is included in a table at the end of the narrative.

Extern Program (Section 105): In summer 2022, the Extern Program funded a total of 3 student externs. The pandemic situation continues to affect many facilities from hiring the student externs. A breakout of extern awards by Area Offices is included in a table at the end of the narrative.

## OUTPUTS / OUTCOMES

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| 42 Scholarships: Proportion of Health Scholarship recipients placed in Indian health settings within 90 days of graduation. (Outcome) | FY 2022: 69 % Target: 50 % (Target Exceeded) | 40 % | 40 % | Maintain |
| IHP-1 Number of scholarship awards under section 103 (Output) | FY 2022: 94 Awards Target: 65 Awards (Target Exceeded) | 40 Awards | 103 Awards | +63 Awards |
| IHP-2 Number of scholarship awards under section 104 (Output) | FY 2022: 258 Awards Target: 250 Awards (Target Exceeded) | 250 Awards | 253 Awards | +3 Awards |
| IHP-3 Number of externs under section 105 (Output) | FY 2022: 3 Externs Target: 100 Externs (Target Not Met) | 35 Externs | 35 Externs | Maintain |
| IHP-4 Number of new 2 year contract awarded loan repayments under section 108 (Output) | FY 2022: 541 contracts Target: 570 contracts (Target Not Met) | 570 contracts | 610 contracts | +40 Contracts |
| IHP-5 Number of continuing 1 year loan repayment contract extensions under section 108 (Output) | FY 2022: 552 Awards Target: 680 Awards (Target Not Met) | 680 Awards | 655 Awards | -25 Awards |
| IHP-6 Total number of new awards funded in previous fiscal year under section 108 (Outcome) | FY 2022: 542 awards Target: 538 awards (Target Exceeded) | 570 awards | 610 awards | +40 Awards |

* FY 2022 “Targets” include estimates based on complete FY 2021 funding cycle data.
** The “Number of Loan Repayments – Total” includes New Awards, Contract Extensions and Continuation Awards.
*** In FY 2022 a total of 223 awardees to date declined their award. The main reason for declinations is that the applicants also applied to the National Health Service Corps LRP and were accepted.

## GRANTS AWARDS

The IHP administers three grant programs which fund colleges and universities to train students for health professions: (1) American Indians into Nursing Program (Section 112), (2) Indians into Medicine Program (Section 114), and (3) American Indians into Psychology Program (Section 217). These programs provide support to students during their health career professional pathway and encourage students to practice in the Indian health system.

| *(whole dollars)* | FY 2022 Operating | FY 2023 President's Budget | FY 2024 OMBJ |
|---|---|---|---|
| **American Indians Into Nursing Program (Section 112) – CFDA No. 93.970** | | | |
| Number of Awards | 5 | 5 | |
| Average Award | $337,341 | $337,341 | $ |
| Range of Awards | $337,341 | $337,341 | $ |
| **Indians Into Medicine Program (Section 114) – CFDA No. 93.970** | | | |
| Number of Awards | 4 | 4 | |
| Average Award | $321,250 | $321,250 | $ |
| Range of Awards | $195,000 - $700,000 | $195,000 - $700,000 | $- $ |
| **American Indians Into Psychology Program (Section 217) – CFDA No. 93.970** | | | |
| Number of Awards | 3 | 3 | 3 |
| Average Award | $240,791 | $240,791 | $240,791 |
| Range of Awards | $240,791 | $240,791 | $240,791 |

**Scholarship Program Awards** –For FY 2022, the IHS Scholarship Program made awards to the following disciplines:

| **Section 103 Pre-professional 30 students** | | | |
|---|---|---|---|
| | | | |
| Pre Nursing | 3 | | |
| **Section 103 Pre-graduate –64 students** | | | |
| Pre-Dentistry | 14 | | |
| Pre-Medicine | 50 | | |
| **Section 104 Health Professions - 258 students** | | | |
| Counseling Psychology | 2 | Pharmacy | 27 |
| Dentistry | 18 | Physical Therapy | 27 |
| Clinical Lab Science | 2 | Env. Health | 1 |
| Chiropractor | 1 | Physician Assistant | 17 |
| Clinical Psychology | 6 | Optometry | 16 |
| Nurse Practitioner | 21 | Physician, Allopathic | 32 |
| Nurse Practitioner | | Physician, Osteopathic | 29 |
| Nurse, Baccalaureate Degree | 42 | Podiatry | 1 |
| Nurse Midwife | 2 | Social Work | 2 |
| Nurse Anesthetist | 3 | | |

**Loan Repayment Program Awards** – In FY 2022, the IHS LRP made awards to the following disciplines:

| Awards by Profession | Total Awards | New Awards | Contract Extensions | Matched Not Awarded |
|---|---|---|---|---|
| Behavioral Health | 59 | 30 | 30 | 0 |
| Dental* | 90 | 41 | 54 | 0 |
| Nurse | 250 | 180 | 74 | 0 |

| Awards by Profession | Total Awards | New Awards | Contract Extensions | Matched Not Awarded |
|---|---|---|---|---|
| Optometrists | 48 | 9 | 45 | 0 |
| Pharmacists | 175 | 73 | 110 | 0 |
| Physician Assistants/ Advanced Practice Nurses | 150 | 63 | 83 | 0 |
| Physicians | 124 | 34 | 93 | 0 |
| Podiatrists | 22 | 7 | 16 | 0 |
| Rehabilitative Services | 105 | 45 | 67 | 1 |
| Other Professions | 71 | 59 | 14 | 2 |
| **TOTAL** | **1093** | **541** | **552** | **3** |

* Includes Dentists and Dental Hygienists.
**Awards are through July award cycle.

| Other Professions | Total Awards | Matched Not Awarded | By Pay System | Awards |
|---|---|---|---|---|
| Acupuncturist | 2 | 0 | Tribal Employee | 654 |
| Chiropractors | 9 | 0 | Civil Service | 290 |
| Dietetics/Nutrition | 30 | 0 | Commissioned Corps | 65 |
| Engineering | 4 | 0 | Urban Health Employees | 13 |
| Medical Laboratory Scientist | 9 | 0 | | |
| Medical Technology | 1 | 0 | | |
| Radiology Technicians | 10 | 0 | | |
| Sanitarian | 4 | 0 | | |
| Respiratory Therapists | 2 | 0 | | |
| **TOTAL** | **71** | **0** | **Total** | **1093** |

**Extern Program Awards –** In summer 2022, the IHS Extern Program had a total of 3 student externs. The current pandemic situation affected many facilities in hiring and supervising student externs for the summer.

| AREA OFFICES | NUMBER OF STUDENT EXTERNS |
|---|---|
| Albuquerque | 1 |
| Billings | 1 |
| Great Plains | 1 |

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $2,466 | $2,986 | $4,487 | +$1,501 |
| FTE* | -- | -- | -- | -- |

*Tribal Management Grant funds are not used to support FTEs.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

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

**FY 2024 Authorization**.........................................................................................Permanent

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

**PROGRAM DESCRIPTION**

The Tribal Management Grant (TMG) program was authorized in 1975 under Sections 103(b)(2) and 103(e) of Public Law (P.L.) 93-638, Indian Self-Determination and Education Assistance Act (ISDEAA), as amended. Under the authority of the ISDEAA, the program was established to assist all federally recognized Indian Tribes and tribally-sanctioned tribal organizations (T/TO) to plan, prepare, or decide to assume all or part of existing Indian Health Service (IHS) programs, functions, services, and activities (PFSA) and to further develop and enhance their health program management capability and capacity.

The IHS established four funding priorities for the TMG program:

- Tribes that receive federal recognition or restoration within the last five years with implementing or developing management and infrastructure systems for their organization
- T/TO that need to improve financial management systems to address audit material weaknesses
- Eligible Direct Service and Title I Federally recognized Indian Tribes or Tribal organizations submitting a competing continuation application or new application
- Eligible Title V Self Governance Federally recognized Indian Tribes or Tribal organizations submitting a competing continuation or new application.

The TMG program offered four project types with three different award amounts and project periods:

(1) Planning - fund up to $50,000 with project periods not to exceed 12 months. A Planning Project allows establishment of goals and performance measures for current health programs or to design their health programs and management systems.

(2) Evaluation - fund up to $50,000 with project periods not to exceed 12 months. An Evaluation Study Project determines the effectiveness and efficiency of a program or if new components are needed to assist the T/TO to improve its health care delivery system.
(3) Feasibility - fund up to $70,000 with project periods not to exceed 12 months. A Feasibility study analyzes programs to determine if T/TO management is practicable.
(4) Health Management Structure (HMS) grants are funded up to $300,000 with project periods not to exceed 36 months. HMS projects include the design and implementation of systems to manage PFSA, such as Electronic Health Records (EHR) systems or billing and accounting systems, management systems, health accreditation, as well as correction of audit material weaknesses.

**BUDGET REQUEST**

The FY 2024 budget submission for Tribal Management Grants of $5 million is $2 million above the FY 2023 Enacted level.

FY 2024 Funding Increase of $2 million includes:

- Tribal Management Grants Increase: +$2 million for new tribal management grants. $2 million would support up to 10 new grants to assist federally recognized Indian Tribes and tribally-sanctioned tribal organizations (T/TO) to plan, prepare, or decide to assume all or part of existing Indian Health Service (IHS) programs, functions, services, and activities (PFSA) and to further develop and enhance their health program management capability and capacity.

- Current Services: +$1,000. Information can be found on page CJ-33.

**FUNDING HISTORY**

| Fiscal Year | Amount |
|---|---:|
| 2020 | $2,465,000 |
| 2021 | $2,465,000 |
| 2022 Final | $2,466,000 |
| 2023 Enacted | $2,986,000 |
| 2024 President's Budget | $4,487,000 |

**TRIBAL SHARES**

Program funds are not subject to tribal shares since they are transferred through a federally-administered grant program.

**PROGRAM ACCOMPLISHMENTS**

- In FY 2020 the number of awards decreased due to the COVID-19 pandemic.

- Provided technical assistance to potential applicants and provided post award technical assistance to recipients –

- Approximately one percent of TMG funding has been used for overall administration of the program; these funds provide TMG program requirements, training, and general technical assistance.

## OUTPUTS / OUTCOMES

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| TMG-1 Planning Grants (Output) | FY 2021: 2 planning grants Target: 0 planning grants (Target Exceeded) | 2 planning grants | 2 planning grants | Maintain |
| TMG-2 Health Management Structure (HMS) grants (Output) | FY 2021: 9 HMS grants Target: 0 HMS grants (Target Exceeded) | 10 HMS grants | 10 HMS grants | Maintain |

## GRANTS AWARDS

| *(whole dollars)* | FY 2022 Operating | FY 2023 President's Budget | FY 2024 OMBJ |
|---|---|---|---|
| Number of Awards | 20 Total Awards: 11 Noncompeting Continuations and 9 New | 20 Total Awards: 10 Noncompeting Continuations and 10 New [1] | 20 Total Awards: 10 Noncompeting Continuations and 10 New [2] |
| Average Award | $105,135 | $105,135 | $105,135 |
| Range of Awards | $50,000 - $150,000 | $50,000 - $150,000 | $50,000 - $150,000 |

[1] FY 2022 is an estimate will update when awarded.
[2] FY 2023 is an estimate will update when awarded.

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $95,046 | $103,805 | $118,475 | +$14,670 |
| FTE* | 254 | 253 | 261 | +8 |

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**.........................................................................................Permanent

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

## PROGRAM DESCRIPTION

The IHS Direct Operations budget supports the provision of Agency-wide leadership, oversight, and executive direction for the comprehensive public and personal health care provided to American Indians and Alaska Natives. Each year, additional tribal shares are taken from the Direct Operations budget by tribes who choose to contract or compact their health care programs. As a result, over the past 5 years the amount of Direct Operations funding retained by IHS for carrying out inherently federal functions and supporting direct service tribes has decreased on average by approximately 2 percent per year. In an individual year, this amount has been as high as 6 percent. This unique aspect of the IHS Budget puts additional pressure on resource needs for core management functions.

## BUDGET REQUEST

The FY 2024 budget submission for Direct Operations of $118 million is $15 million above the FY 2023 Enacted level.

FY 2023 Base Funding of $104 million – Funding provides for the direct operations of IHS's system-wide administrative, management, and oversight priorities at the discretion of the IHS Director that include:

- Continuing vital investments to enhance the IHS's capacity for providing comprehensive oversight and accountability in key administrative areas such as: human resources, property, acquisition, financial management, information technology, and program and personnel performance management.
- Improving responsiveness to external authorities such as Congress, the GAO, and the Office of Inspector General (OIG); and addressing Congressional oversight and reports issued by the GAO and the OIG to make improvements in management of IHS programs, such as the PRC program, quality oversight, and workforce.

- Addressing requirements for national initiatives associated with privacy requirements, facilities, and personnel security.
- Continuing analysis and settlement of tribal contracting and compacting Contract Support Costs (CSC) claims and maintaining policies and procedures to accurately determine CSC needs in the future.

- FY 2024 Funding Increase of $15 million includes:

  - Direct Operations: +$12 million for the IHS direct operations budget. Increases include:

    - Core Management Functions ($12 million). These resources build on the FY 2023 President's Budget request to sustain and bolster core capacity to promote the efficient and effective administration and oversight of national functions like financial management, human resources, grants management, acquisitions, ISDEAA contracting and compacting administration, contract support costs and tribal lease payment administration, performance management, and other administrative supports and systems.

      - These resources would support critical hiring and systems needs at the national level, and within the IHS Area Offices. Current funding and staffing levels have led to delays in reporting, contracting, grant making, and hiring, and may lead to increased program risk. They will also support the IHS in implementing the new requirements of the PROGRESS Act and the Evidence Act.

      - In addition, these funds would support the implementation of recommendations from the Integritas report as well as the OIG, GAO, the Presidential Task Force on Protecting Native American Children in the Indian Health Service System. The IHS is executing a plan to determine milestones for implementation, as well as costs associated with implementing these recommendations.

      - Increasing resources for these core management functions is vital for shoring up foundational capacity to support the IHS mission. Additional staff and resources are needed to maintain national and Area-level focus on fiscally responsible, accountable, and effective administration over inherently federal functions such as budget formulation and execution, policy management, workforce management and personnel security, acquisitions and grants management, Government Performance and Results Act and related performance management, and other key functions.

      - The IHS also faces increasing responsibilities associated with expansion of Indian Self- Determination, through which Tribal Health Programs operate over 60 percent of the IHS's appropriated resources. The IHS must have the necessary resources to provide technical assistance to Tribes and Tribal Organizations, and effectively manage ISDEAA contracts and compacts. Investments in these critical programs can mitigate the potential for missed deadlines with potentially large and recurring financial penalties, facilitate consistency in ISDEAA contract and compact terms to reduce legal risk, and ensure well prepared and accurate reporting and negotiations.

- Current Services: +$3 million. Information can be found on page CJ-33.

## FUNDING HISTORY

| Fiscal Year | Amount |
|---|---|
| 2020 | $71,538,000 |
| 2021 | $82,456,000 |
| 2022 Final | $95,046,000 |
| 2023 Enacted | $103,805,000 |
| 2024 President's Budget | $118,475,000 |

## TRIBAL SHARES

Direct Operations funds are subject to Tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities. A portion of the overall Direct Operations budget line is reserved for inherently federal functions and is therefore retained by the IHS.

## PROGRAM ACCOMPLISHMENTS

The Direct Operations budget is critical for continued progress in assuring an accountable, quality, and high-performing Indian health system. Examples of significant agency activities made possible by Direct Operations funds are provided below.

The IHS is committed to improving the quality and safety of health care services. The Office of Quality (OQ), formally established in FY 2019, has made significant quality and patient safety improvements across the Agency. The OQ provides the structure to promote accountability and oversight with a focus on quality assurance to promote and sustain compliance with Centers for Medicare and Medicaid Services and accreditation organizations; quality improvement through innovation and implementation of quality improvement science; and improve patient safety and reduce all cause harm. Through the national leadership of the OQ in FY 2021, the IHS made substantial strides in addressing priority areas for quality improvement and patient safety including full implementation of the IHS Safety Tracking and Response system for tracking adverse events; coordinating infection control and prevention assessments in collaboration with the Centers for Disease Control and Prevention (CDC); and hiring an Associate Director for Quality Assurance and Patient Safety.

The IHS is committed to making improvements and ultimately to being removed from the Government Accountability Office (GAO) High Risk list. Although the IHS is still on the list, significant progress has been made. The GAO cited 14 open recommendations in the High Risk Reports. Of those 14 recommendations cited in the High Risk Reports, GAO closed 12 recommendations. In August 2020, the IHS requested GAO to close another recommendation regarding Quality Care.

Like other rural healthcare providers, the IHS historically has difficulties recruiting and retaining healthcare providers. To address these challenges, IHS continues to maximize the use of available recruitment and retention tools such as recruitment, retention, and relocation incentives (3Rs); and use of Title 38 pay authorities. Most recently, the IHS increased its competitive stance in the healthcare labor market through the authorization of new Title 38 Special Salary Rate pay tables for IHS nurses. Additionally, the Office of Personnel Management granted IHS the authority to approve up to a 50 percent 3Rs rate as needed to recruit and retain specific Chief Executive Officers overseeing health facilities.

To strengthen human resources management, the IHS issued a Special General Memorandum 21-02, Personnel Security and Suitability Determinations that establishes agency policy on addressing unfavorably background investigations. In FY 2022, the IHS will pilot the USA Performance management system, which is an electronic performance management system developed by the Office of Personnel Management. This system will allow IHS to manage and track all performance plans in one system and will replace the paper performance plans. The use of an electronic system provides a streamlined and standardized performance management process. In FY 2023, USA Performance will roll-out IHS-wide.

In FY 2019, the IHS continued to expand the use of data analysis and visualization tools to enhance reporting and data-driven decisions. Building on the successful completion of the IHS 3rd Party Revenue Dashboard—a Qliksense based application developed to enhance reporting, trend analysis, and monitoring of third-party resources (e.g. Medicare and Medicaid) collected by federally-operated facilities—the IHS completed the "Follow the Money" Dashboard. This dashboard allows non-technical users to review funding status and spending data related to Purchased/Referred Care (PRC) instantly. Both applications democratize data previously held only in the proprietary accounting and reporting systems, Unified Financial Management System and Financial Business Intelligence System. Users are able to access data in a non-technical format that can be quickly sorted and compared by parameters such as type, Area, Service Unit, month, and fiscal year. This capability eliminates delays in accessing data through production financial systems, provides more financial information more widely, and reduces the requirement for a skilled financial analyst to produce labor intensive reports on demand, thereby freeing valuable time for value added analysis.

The IHS is committed to ensuring quality care for all patients and is actively working on deploying innovative strategies with a focus on achieving and sustaining improvements in quality of care, accountability and data-driven decision making, and recruiting and retaining a high performing workforce.

## AREA ALLOCATION

**Direct Operations**

(dollars in thousands)

| DISCRETIONARY | FY 2022 Estimated | | | FY 2023 Enacted /1 | | | FY 2024 Estimated /1 | | | FY 2024 +/- FY 2023 |
|---|---|---|---|---|---|---|---|---|---|---|
| **SERVICES** | Federal | Tribal | Total | Federal | Tribal | Total | Federal | Tribal | Total | Total |
| Alaska | $50 | $11,161 | $11,211 | $55 | $12,189 | $12,244 | $63 | $13,912 | $13,975 | $1,730 |
| Albuquerque | 1,223 | 736 | 1,958 | 1,335 | 803 | 2,139 | 1,524 | 917 | 2,441 | $302 |
| Bemidji | 1,713 | | 1,713 | 1,871 | | 1,871 | 2,135 | | 2,135 | $264 |
| Billings | 2,702 | 78 | 2,780 | 2,951 | 85 | 3,037 | 3,369 | 97 | 3,466 | $429 |
| California | 1,818 | | 1,818 | 1,986 | | 1,986 | 2,266 | | 2,266 | $281 |
| Great Plains | 2,991 | | 2,991 | 3,267 | | 3,267 | 3,729 | | 3,729 | $462 |
| Nashville | 1,259 | 1,867 | 3,126 | 1,375 | 2,039 | 3,414 | 1,569 | 2,327 | 3,896 | $482 |
| Navajo | 3,758 | | 3,758 | 4,104 | | 4,104 | 4,684 | | 4,684 | $580 |
| Oklahoma | 2,228 | 4,221 | 6,449 | 2,433 | 4,610 | 7,044 | 2,777 | 5,262 | 8,039 | $995 |
| Phoenix | 3,261 | 964 | 4,224 | 3,561 | 1,053 | 4,614 | 4,064 | 1,201 | 5,266 | $652 |
| Portland | 2,347 | 1,597 | 3,944 | 2,563 | 1,745 | 4,308 | 2,925 | 1,991 | 4,917 | $609 |
| Tucson | 836 | | 836 | 914 | | 914 | 1,043 | | 1,043 | $129 |
| Headquarters | 50,235 | | 50,235 | 54,864 | | 54,864 | 62,618 | | 62,618 | $7,754 |
| **Total, Direct Ops** | **$74,421** | **$20,624** | **$95,046** | **$81,279** | **$22,526** | **$103,805** | **$92,766** | **$25,709** | **$118,475** | **$14,670** |

1/ Note: 2023 and 2024 are estimates.

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $5,850 | $6,174 | $6.226 | +$52 |
| FTE* | 12 | 11 | 11 | -- |

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**Authorizing Legislation** .......................... Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA), as amended 25 U.S.C. § 5381 et seq., 42 C.F.R. Part 137

**FY 2024 Authorization**..........................................................................................Permanent

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

## PROGRAM DESCRIPTION

The OTSG serves as the primary liaison and advocate for Tribes and Tribal organization participating in the Tribal Self-Governance Program (TSGP) as authorized under Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA) (25 U.S.C. §5381 et. seq.) Through the TSGP, Tribes have the option to assume IHS program funds and manage them to best fit the needs of their Tribal communities. Tribes participating in the TSGP negotiate with the IHS and take on full funding, control, and accountability for those programs, services, functions, and activities (PSFAs), or portions thereof, that the Tribe chooses to assume.

The Self-Governance budget supports several OTSG activities and functions:

- Develops and oversees the implementation of Tribal self-governance legislation and authorities in the IHS that expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health.
- Participates in nation-to-nation negotiations of ISDEAA Title V Compacts and Funding Agreements and provides oversight of the Agency Lead Negotiators.
- Reviews eligibility requirements for Tribes to participate in the TSGP and receive Self-Governance Planning and Negotiation Cooperative Agreements that help to bolster the health workforce to ensure delivery of quality services and care.
- Provides resources and technical assistance to Tribes and Tribal organizations to expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health for the implementation of Tribal self-governance.
- Provides TSGP training to Tribes, Tribal organizations, and Tribal groups to expand equitable access to comprehensive, community-based, innovative, and culturally-

competent healthcare services while addressing social determinants of health.

- Coordinates national Tribal self-governance meetings, including an annual consultation conference in partnership with the Department of the Interior, to promote the participation by all AI/AN Tribes in the IHS Tribal Self-Governance program and expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health.
- Develops, publishes, and presents information related to the IHS TSGP activities that will expand equitable access to comprehensive, community-based, innovative, and culturally-competent health care services while addressing social determinants of health.
- Coordinates self-governance Tribal Delegation Meetings for IHS Headquarters and Area Senior officials to expand equitable access to comprehensive, community-based, innovative, and culturally-competent healthcare services while addressing social determinants of health.

**BUDGET REQUEST**

The FY 2024 budget submission for Self-Governance of $6 million is $52,000 above the FY 2023 Enacted level.

FY 2023 Base Funding of $6 million: The base funding supports further implementation of the IHS Tribal Self-Governance program, continues funding for Planning and Negotiation Cooperative Agreements to assist Indian Tribes to prepare and enter into the IHS Tribal Self-Governance program, and continues to fund performance projects and Tribal share needs in IHS Areas and Headquarters for any AI/AN Tribes that have decided to participate in the IHS Tribal Self-Governance program**.**

FY 2024 Funding Increase of +$52,000 includes Current Services (see page CJ-33).

**FUNDING HISTORY**

| Fiscal Year | Amount |
|---|---|
| 2020 | $5,806,000 |
| 2021 | $5,806,000 |
| 2022 Final | $5,850,000 |
| 2023 Enacted | $6,174,000 |
| 2024 President's Budget | $6,226,000 |

**TRIBAL SHARES**

Program funds are not subject to tribal shares. However certain portion of the program funds support initial program transfers to Tribes when they assume the responsibility for carrying out the associated programs, functions, services, and activities. A portion of the overall program budget line is reserved for federally inherent functions and is therefore retained by the IHS to perform the basic operational services of the Agency.

**PROGRAM ACCOMPLISHMENTS**

The IHS TSGP has grown dramatically since the execution of the initial 14 compacts and funding agreements in 1994. In Fiscal Year (FY) 2022, IHS transferred approximately $2.7 billion of the

total IHS budget appropriation to Tribes and Tribal organizations to support 109 ISDEAA self-governance compacts and 135 funding agreements.[1]

The Self-Governance budget brings health care quality expertise to the IHS, and Tribes, by:

- Providing support for projects that assist Tribally operated health programs that build, strengthen, and sustain collaborative relationships. For example, the IHS collaborated with Tribes and Tribal Organizations to coordinate the FY 2022 Annual Self-Governance Tribal Conference which brings together Self-Governance Tribes, the Department of Interior, and other federal agencies to discuss key topics with Self-Governance Tribes to share and learn best practices, and to promote the participation of all American Indian and Alaska Native Tribes in IHS Tribal Self-Governance activities. In FY 2022, the IHS also awarded three (3) Tribal Self-Governance Planning Cooperative Agreements to Tribes, which support Tribes and Tribal organizations with the planning and preparation necessary to assume responsibility for providing health care to their Tribal members through the IHS TSGP. These activities will continue to be goals in FY 2023 and FY 2024.

- Collaborating on crosscutting issues and processes including, but not limited to: program management issues; self-determination issues; Tribal shares methodologies; and emergency preparedness, response and security to secure and effectively manage the assets and resources. In FY 2022, the IHS coordinated with Tribes and Tribal Organizations three (1 in person and 2 virtual) Tribal Self-Governance Advisory Committee and Joint Tribal-Federal Technical Workgroup meetings. This Committee advocates for Self-Governance Tribes and Tribal Organizations, suggests policy guidance on the implementation of the TSGP, and advises the IHS Director on issues of concern to all Self-Governance Tribes. Additionally, in FY 2022, the IHS implemented Tribal Consultation, and in FY 2023, the IHS continues to work with the Tribal Consultation Policy Workgroup of Tribal and Federal leaders, to update the IHS Tribal Consultation Policy and establish it as permanent policy in the Indian Health Manual. Activities in FY 2024 will focus on the continue education of the new Tribal Consultation policy.

- Providing technical assistance, disseminating communication, and supporting the disbursement of funds to Self-Governance Tribes to build, strengthen, and sustain collaborative relationships. In FY 2022, the Office of Tribal Self-Governance (OTSG) worked collaboratively to update the OTSG Funds Management System (OTSGFM) by interfacing the Unified Financial Management System (UFMS) obligation process and the financial information entered into the OTSGFM. Through this interface the high number of reporting variances between UFMS and OTSGFM will decrease and the monthly reconciliation between the two systems will be more efficient. In February of FY 2023, the interface between the two systems was implemented and obligations were initiated through the OTSGFM. In FY 2024, the two systems will be interfaced for a

[1] For FY 2024, the IHS estimates an additional five Tribes will be entering into Title V ISDEAA compacts and funding agreements. This estimate corresponds to the number of Self-Governance Negotiation Cooperative Agreements available each fiscal year. Eligibility requirements for these agreements mirror the statutory requirements that Tribes must meet to participate in the IHS Tribal Self-Governance Program (25 U.S.C. §5383; 42 C.F.R. Part 137, Subpart C). For this pool, an average estimate of $5 million per Tribe is used to project estimates for Tribes entering into a Title V ISDEAA compacts and funding agreements, inclusive of both Tribal shares and Contract Support Costs.

full year and the goal is to significantly decrease the reporting variances and easily reconcile the two systems on a monthly basis.

## OUTPUTS / OUTCOMES

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| TOHP-SP Implement recommendations from Tribes annually to improve the Tribal consultation process and IHS operations. (Output) | FY 2022: 9 recommendations Target: 4 recommendations (Target Exceeded) | 5 recommendations | 5 recommendations | Maintain |

## GRANT AWARDS

| *(whole dollars)* | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget |
|---|---|---|---|
| Planning Cooperative Agreements | | | |
| Number of Awards | 3 | 5 | 5 |
| Award Amount | $180000 | $180,000 | $120,000 |
| Negotiation Cooperative Agreements | | | |
| Number of Awards | 0 | 5 | 5 |
| Award Amount | $0 | $84,000 | $48,000 |

## AREA ALLOCATION

**Self-Governance**

(dollars in thousands)

| DISCRETIONARY SERVICES | FY 2022 Final | | | FY 2023 Enacted /1 | | | FY 2024 Estimated /1 | | | FY 2024 +/- FY 2023 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Federal | Tribal | Total | Federal | Tribal | Total | Federal | Tribal | Total | Total |
| Alaska | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Albuquerque | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | $0 |
| Bemidji | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | $0 |
| Billings | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | $0 |
| California | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | $0 |
| Great Plains | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | $0 |
| Nashville | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | $0 |
| Navajo | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | $0 |
| Oklahoma | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | $0 |
| Phoenix | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | $0 |
| Portland | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | $0 |
| Tucson | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | $0 |
| Headquarters | 5,850 | 0 | 5,850 | 6,174 | 0 | 6,174 | 6,174 | 0 | 6,226 | $52 |
| **Total, Self-Gov** | **$5,850** | **0** | **$5,850** | **$6,174** | **0** | **$6,174** | **$6,174** | **0** | **$6,226** | **$52** |

1/ Note: 2023 and 2024 are estimates.

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| Medicare | $253,619 | $252,185 | $262,525 | +$10,340 |
| Medicaid | $1,206,302 | $1,288,152 | $1,340,967 | +$52,815 |
| **M/M Total** | **$1,459,921** | **$1,540,337** | **$1,603,492** | **+$63,155** |
| Private Insurance | $210,497 | $213,209 | $221,950 | +$8,741 |
| VA Reimbursements | $7,202 | $7,548 | $7,858 | +$310 |
| **Total** | **$1,677,620** | **$1,761,094** | **$1,833,300** | **+$72,206** |
| FTE | 6,853 | 6,853 | 6,853 | -- |

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

**PROGRAM DESCRIPTION**

In 1976, the Indian Health Care Improvement Act (IHCIA) authorized the Indian Health Service (IHS) to collect Medicare and Medicaid (M&M) reimbursements for services provided in IHS facilities to patients with M&M eligibility. The IHCIA was later amended to allow IHS to collet Private Insurance (PI) reimbursements for services provided in IHS facilities for patients with PI. In 2010, the IHCIA was amended to authorize the IHS to be reimbursed by the Department of Veterans Affairs (VA) and the Department of Defense for services provided through the IHS to beneficiaries eligible for services from either Department. In 2012, the IHS and the VA signed an agreement under which VA agreed to reimburse IHS for direct care services provided through the IHS to eligible American Indian and Alaska Native (AI/AN) veterans.

In fiscal year (FY) 2023, $1.76 billion is projected from third party insurers, of which $1.5 billion is IHS Federal M&M collections and $213 million is from private insurers. The FY 2024 estimates above are based on the FY 2023 estimated collections. Public and private collections represent a significant portion of the IHS and Tribal health care delivery budgets. Some IHS health care facilities report that 60 percent or more of their yearly budget relies on revenue collected from third party payers.

*Accreditation* - In accordance with IHCIA authorization for collections, the IHS places the highest priority on meeting accreditation and certification standards for its healthcare facilities. Third party revenue is essential to maintaining facility accreditation, certification and standards of health care established by the Centers for Medicare and Medicaid (CMS), organizations such as The Joint Commission and the Accreditation Association for Ambulatory Health Care. Third party collections are used to improve the delivery of and access to health care for AI/AN people.

*Monitoring* – In addition to conference calls with IHS Areas, the IHS employs an online system to monitor the third party reimbursement process for IHS operated facilities. The Third Party Internal Controls Self-Assessment Tool provides necessary information for local managers and Headquarters staff to monitor compliance with applicable policies and procedures during the third party revenue collections process so they can take necessary actions and improve overall program activity. In order to improve monitoring by

Headquarters The Online Tool questions will be updated starting with the FY 2023 report period. The questions were updated by a small workgroup to clarify the questions and to ensure the self-assessment is capturing all the critical steps and compliance with the revenue generation cycle. The IHS has also implemented Third Party Revenue Collections and Third Party Alternate Resource (health insurance coverage) Dashboards to monitor collections and insurance coverage at the National, Area, State and local level. Training of revenue cycle staff to use the dashboards effectively to identify areas for improvement began in FY 2018 and will continue in FY 2023. In FY 2022, IHS has made progress on development and implementation of a standard site review/site assessment/site internal auditing template.

In 2021, the General Accountability Office (GAO) was tasked with reviewing IHS's oversight of third-party collections and its procurements. The Report that was generated, GAO-22-104742, Indian Health Service: Information on Third-Party Collections and Processes to Procure Supplies and Services, examined recent trends in third-party collections and IHS's processes to oversee such collections. The GAO did not have any negative findings or recommendations for IHS to implement.

*Impact of COVID-19* – COVID-19 created unprecedented financial stress on the I/T/U health system. Strict public health driven social-distancing measures, curfews, and stay at home orders intended to prevent the risk of further infection led IHS patients and health care facilities to cancel elective surgeries, and non-essential medical, surgical and dental procedures. Many AI/AN patients also had to postpone care. Revenue was monitored weekly and I/T/U revenues initially declined during FY 2019-FY 2021, however, beginning in FY 2022 IHS has seen a continued increase in collections that exceeded the pre pandemic levels. We will continue to monitor collections in to ensure we continue upward trends.

*Regulation Review and Compliance* - IHS continues to ensure compliance with statutory rules and regulations that impact third party collections directly and indirectly. Rules pertaining to the Medicare and Medicaid programs continue to have a direct impact on revenue generation. IHS reviews new policies and draft regulations prior to publication and provides feedback to CMS. After they are published for public review, IHS is able to discuss the impacts with Tribal government representatives and urban programs. In addition, IHS has formed workgroups to maximize the positive impact for all IHS, Tribal, and Urban Indian health program facilities, such as the IHS National Business Office Committee, which serves as a subcommittee to the IHS National Council of Executive Officers.

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

*Linking Quality to Payment* - Pursuant to health reform efforts, IHS is continuing to develop materials, presentations and stakeholder outreach for our federal, tribal and urban partners on what is needed to participate in the Medicare Payment Reform/Quality Initiative efforts by CMS such as the Quality Payment Program (QPP). This includes data calls and working with Areas to determine IHS stakeholders that have reported or planning to report for future years. The IHS National QPP Working Group members collaborate with CMS, the Medicare and Medicaid Policy Committee (MMPC) and the Tribal Technical Advisory Group (TTAG) to support QPP efforts. Also, the IHS yearly reviews the Electronic Clinical Quality Measures (eCQMs) and selects new measures for 2023 if needed.

*Improving Documentation and Care* -In accordance with 2015 Certified Health Information Technology Standards, IHS launched a collaborative initiative to train staff in the collection of voluntary Sexual Orientation and Gender Identity (SO/GI) data in order to identify essential health services. Collecting this

data in electronic health records is essential to providing high-quality, patient-centered care and facilitating payment. An opportunity for Two-Spirit and LGBTQ people to share information about their SO/GI in a welcoming and patient-centered environment opens the door to a more trusting patient-provider relationship and improved health outcomes for our patients.

*Reimbursement for Services to Veterans* - In December 2012, IHS and the Department of Veterans Affairs (VA) signed the VA/IHS National Reimbursement Agreement that facilitates reimbursement by the VA to the IHS and Tribal facilities for direct health care services provided to eligible AI/AN veterans. In January 2017, IHS renewed its interagency agreement with the VA to facilitate the use of the Veteran's Health Administration (VHA) Consolidated Mail Outpatient Pharmacy (CMOP) System by the IHS. The intent of this agreement is to cost-effectively expand clinical and support capabilities of participating facilities through use of VHA CMOP resources and by combining participating facilities' prescription needs with VHA's. Improved efficiencies were gained through more efficient and effective use of staff, reduction in medication error costs, and reduction in medication error litigation. In June 2018, the IHS and VA signed an amendment to the agreement that extends the period of the reimbursement agreement through June 30, 2022. In 2021, the IHS and VA signed an amended Memorandum of Understanding. IHS and VA agreed to mutually collaborate and coordinate on the evaluation of new options to reimburse all services provided to AI/AN Veterans at IHS and THP facilities, and UIOs, to the fullest extent allowable by law. This was a significant step in continuing to ensure implementation of Section 405 of the IHCIA. The agreement represents a positive partnership to support improved coordination of care and non-duplication of resources between IHS federal facilities and the VA and it paved the way for agreements negotiated between VA and tribal health programs. IHS will continue to work directly with the VA to implement billing and reimbursement practices to ensure IHS receives proper payment for care provided at IHS and Tribal facilities to AI/AN veterans. Recent changes that were added through amendments to the agreement were identifying Telehealth as a direct service and allowing the billing/reimbursement for the COVID- 19 Vaccinations and Antibody Treatment. Monitoring, auditing, and compliance with the agreement will continue to be a focus in FY 2023 and FY 2024. Current activities include but are not limited to exercising the additional Electronic Billing capabilities, working through system changes within the VA to ensure proper payments, proper denials, and assisting Tribes and IHS facilities in stabilizing their billing programs

*Training* - IHS provides continuous training to health care facility staff in areas related to various functions within the revenue cycle, including patient registration, benefits coordination, coding, third party billing, management of accounts receivable and other aspects of the revenue cycle. Programs are expected to ensure sufficient resources and training for staff to capture insurance in the Resource and Patient Management System (RPMS) system and bill accordingly. Area I/T/U staff are highly encouraged to participate in annual CMS trainings, which have been held virtually during the PHE IHS also hosts an annual Partnership Conference to provide the most current information related to finance, information technology, health information management, Purchased/Referred Care, and business office functions; special emphasis is also provided for the specific management needs of Tribes and urban programs. IHS continued virtual training in FY 2022 and began some hybrid in-person training in FY 2023. IHS will resume in person training in FY 2023 and FY 2024.

**PROGRAM ACCOMPLISHMENTS**

- With the Memorandum of Understanding and amended Reimbursement Agreement between the VA and IHS in place, IHS developed and executed an implementation plan to collect VA reimbursements at all IHS federal sites serving eligible Veterans. The VA has approximately 120 agreements with Tribal Health Programs in addition to the agreements at federal sites. In FY 2020 IHS implemented several amendments to the Reimbursement Agreement regarding

telehealth, pharmacy, and PRC reimbursement for COVID-19 related testing and treatment. In FY 2021, the VA and IHS implemented and transitioned to a new VA claims processing system and Fiscal Service Center for claim payment.

The IHS HQ has also entered into cooperative agreements since 2010 with organizations such as the National Indian Health Board and the National Congress of American Indians to coordinate and conduct consumer centered outreach and education, training and technical assistance on a national scale for the 574 Federally-recognized AI/AN Tribes, and Tribal organizations on the changes and authorities of the new legislation for the ACA and the IHCIA. The national organization partners have provided training sessions and webinars for Tribes and tribal members, helped coordinate numerous enrollment events, created toolkits for youth and elders and offered technical assistance to AI/AN and non-AI/AN enrollment assisters. Through the IHS National Indian Health Outreach and Education (NIHOE) Initiative, the IHS continues to partner with national and regional Tribal/Indian organizations to educate consumers and tribal governments on the health care insurance options available, the process for enrollment, financial assistance, the exemption options for American Indians and Alaska Natives, eligibility determinations, the tribal employer mandate, and maximizing revenue. During FY 2022 and FY 2023, IHS partnered under the NIHOE initiative to conduct several live outreach and enrollment trainings and during the COVID-19 pandemic, pivoted to online webinars and training specific to operating during the pandemic. In addition, IHS was able to work with the NIHOE partners to modify the work plans to include activities related to COVID-19 response messaging and the Public Health Emergency unwinding. In FY 2023 and FY 2024, the NIHOE initiative will include messaging on Medicaid Unwinding from the PHE and other PHE transitions.

- In FY 2022, the IHS Office of Resource Access and Partnerships (ORAP) hosted a joint Partnership Conference with over 2,400 attendees from the Business Office, OIT, Health Information Management, Purchased/Referred Care, Finance, and other components of the Revenue Cycle. The conference convened a series of training sessions showcasing advances and improvements of these mission-critical functions. The Business Office sessions focused on increasing efficiencies in the revenue cycle, business practices and productivity, and using reports to identify gaps in the revenue cycle. The Purchased/Referred Care (PRC) sessions included updates to the PRC Chapter of the *Indian Health Manual*, developments in automating Catastrophic Health Emergency Fund functions, and PRC referral best practices. The Health Information Management (HIM) sessions provide information and best practices on coding and auditing, the electronic health record, operational processes, privacy, and records management. Sessions were also available on leadership training, stress management, quality improvement, and wellness activities. Due to the COVID-19 pandemic, the Partnership Conference was held virtually in 2021 and 2022. In FY 2023 and FY 2024 planning will focus on an in-person conference. In FY 2023 and FY 2024, IHS will continue to strengthen its revenue generation policies and management practices, including internal controls, patient registration, patient benefits coordination, provider documentation training, certified procedural coding training, third party billing, electronic claims processing, accounts receivable, and debt management. Priority activities will include enhancement of third party billing and accounts receivable software to improve effectiveness and to ensure system integration with its business processes, compliance with Medicare and Medicaid, and industry standards and changes in operational processes. Improvements for IHS operated facilities will be coordinated with concurrent enhancements in Purchased/Referred Care business practices related to alternate resources. IHS will continue to develop and implement various tools including reports to analyze a facility's service population and identify opportunities to increase revenue.

- The IHS HQ provided a hybrid in-person and virtual Third Party Billing/Accounts Management

training in FY 2022 for IHS revenue staff across the Agency and the training was also available to Tribal and urban program staff. This training focused on Third Party Billing and Accounts Management, and the Resource Patient Management System (RPMS) Process. In addition, IHS hosted an Accounts Reconciliation Workshop in FY22, which included finance and business office staff from every IHS Area. In July of FY 2022, IHS held a national Patient Registration/Benefits Coordination training. In FY 2023 and FY 2024 IHS is planning to resume in person training on Revenue Cycle Topics.

- In FY 2019, the IHS revised and updated the Revenue Operations Manual (ROM). The ROM provides a system-wide reference resource available to all I/T/U facilities across the United States, to assist staff with all functions related to business operation procedures and processes. IHS developed training materials for the revised ROM and conducted webinars in FY 2021 to provide an overview of the revised ROM 2.0. In FY 2022, IHS drafted a new process to request changes to the ROM. In FY2023 and FY2024 the ROM will continue to be used as a valuable tool to the I/T/U business office staff.

- In FY 2022 and FY 2023, IHS continued its strong partnership with Treasury Fiscal Services to further protect, control, and monitor all third party collections. Treasury mandates require that all Federal Agencies move towards an electronic environment for funds transfers and accountability of funds. IHS has met and exceeded Treasury standards in the electronic conversion. In FY 2022, IHS transitioned two new IHS facilities into the Treasury Processes for Third Party Collections. In FY 2022, IHS continued the partnership with Treasury and worked toward improving the electronic environment for receipts and proof of payment. In FY 2023, IHS issued guidance for the Business Office response to the Social Security Number Fraud Prevention Act of 2017. This law will require IHS Federal programs to stop mailing documents containing social security numbers. IHS worked to implement changes in the RPMS system to remove the SSN as much as possible and has advised business office staff on the mailing policy to address when SSNs are required to be mailed.

- In FY 2022, IHS opened two new clinics to serve newly recognized Tribes in Montana and Virginia, the Little Shell Tribal Health Center and the Mid-Atlantic Service Unit. IHS assisted these new clinics with establishing processes required for billing and collecting third party resources.

- In FY 2022, IHS converted the Eagle Butte IHS Hospital and the Ft. Yates Hospital from acute care hospitals into Critical Access Hospitals to enable them to receive cost-based reimbursement. IHS assisted these hospitals with the conversion and with establishing processes required for billing and collecting third party resources.

- In FY 2021, ORAP and the IHS National Business Office Committee drafted a Revenue Cycle Initiative. Training of revenue cycle staff to use the dashboards effectively to identify areas for improvement continued in FY 2022 and FY 2023. Upon full approval and implementation, the Initiative will improve oversight, transparency, and accountability of the revenue cycle process at our federally operated service units through the development of: (1) a central repository of revenue cycle data elements, and (2) tools and training that revenue cycle stakeholders can use to actively monitor and manage their revenue cycle programs. In FY 2022, IHS continued the Initiative focusing on partnering with the IHS Navajo Area, and in FY 2023, the Revenue Cycle Initiative completed the first iteration of the revenue cycle dashboard. In FY 2024, the Revenue Cycle Initiative will remain a priority.

- In FY 2023, IHS has made progress on development and implementation of a standard site review/site assessment/site internal auditing template. This activity supports the

Compliance/Regulatory Priority of the 2023 Agency Work Plan.

- In FY 2021, IHS analyzed documentation of telemedicine services to ensure appropriate and consistent documentation for workload reporting for annual all-inclusive rate negotiations, budgeting purposes, and compliance with billing standards. In FY 2022, worked closely with each IHS Area to identify areas of focus for improving documentation and in FY 2023, IHS will continue to provide guidance and training on telemedicine documentation and in FY 2024, IHS will continue the analysis of FY 2023 data.

- In FY 2022, IHS continued to issue and update COVID-19 specific guidance. Topics have included vaccination billing guidance, VA telehealth billing guidance, and Patient Registration documentation guidance for vaccination events. In FY 2023 IHS has begun drafting guidance and resources related to unwinding from the PHE. IHS developed a Medicaid Unwinding webpage and will continue to develop resources for transitions from the PHE.

- In FY 2022 and FY 2023, in anticipation of the end of the PHE and the unwinding of Medicaid when states will return to normal operations, continue eligibility determinations, and disenroll beneficiaries, IHS issued guidance and provided training to IHS Areas explaining the upcoming unwinding and providing the steps that IHS Areas and staff should undertake to educate staff and Medicaid beneficiaries about the unwinding and what steps they must take to ensure eligibility continuation, minimize disenrollments or obtain alternative health benefits coverage such as through the Marketplace.

- In FY 2022 and continuing in FY 2023, IHS began discussions with the VA regarding amending the IHS-VA Reimbursement Agreement to include reimbursement to IHS for services provided to AI/AN veterans through the Purchased Referred Care (PRC) program. PRC - This activity supports the Financial Priority of the 2023 Agency Work Plan.

- In FY 2023, the IHS National Business Office Committee created a Training and Workforce Development Workgroup to develop a business office workforce planning assessment so that staffing needs can be measured, training and development goals can be established, and workforce options can be used to create an optimally staffed and trained workforce. This activity supports the Human Capital Priority of the 2023 Agency Work Plan

- In FY 2022 and FY 2023, IHS participated in over 300 rounds of clearance of HHS regulations and policy proposals. The impact of the PHE and the numerous changes in law and policy to improve the response to COVID-19 magnified the priority of these reviews. In FY 2024, IHS will continue to review new proposals for impacts on the Indian health system as they are introduced and provide feedback to the proposing agencies. This activity supports the Compliance/Regulatory Priority of the 2023 Agency Work Plan.

- In addition, IHS collaborates with CMS and the Tribes on a number of matters, including implementation of and training regarding recent changes in legislation, eligibility policies, covered services policies, reimbursement policies and payment methodologies, claims processing, denials, training and use of information technology resources at IHS and Tribal sites to increase the enrollment of M&M eligible AI/AN patients. IHS continues to coordinate outreach, education, and training efforts in collaboration with other federal, state and Tribal partners. IHS continues to partner with CMS to provide a number of training sessions nationwide for Tribal, Urban Indian Organization (UIO) and IHS employees, focusing on outreach and improving access to M&M programs. During the PHE, guidance and training has been provided online

specifically updated in accordance with AMA and CMS rules, regulations, and waiver authorities.

**FY 2023 - 2024 Collections Estimates**

The FY 2023 estimate of collections is based on FY 2023 actual collections to date. The FY 2024 amounts are estimated based on the FY 2023 projected collections, multiplied by the medical inflation rate.

***Medicare and Medicaid (M&M)* -- The FY 2024 Budget estimate assumes collections of $1.6 billion, $63 million above FY 2023 collections:**

- ***Medicaid* – The FY 2024 budget estimate assumes collections of $1.34 billion, $52 million above FY 2023 collections.** IHS continues to educate its users on the benefits of Medicaid enrollment. IHS continues to monitor its user population and insurance coverage and is making all possible efforts to maximize Medicaid enrollment in all States and to maintain current collection levels.

- ***Medicare* – The FY 2024 budget estimate assumes collections of $262 million, $10 million above FY 2023 collections.** IHS hospitals and clinics have taken strong steps to increase enrollment of its population in Medicare. In addition, IHS has expanded efforts to improve the quality of care and maintain current collections.

- ***Private Insurance* – The FY 2024 budget estimate assumes collections of $222 million, $8.7 million above FY 2023 collections.** IHS will continue to monitor its user population and increase direct assistance to stabilize and expand insurance coverage whenever possible to maintain and maximize private insurance collections.

- ***VA/IHS National Reimbursement Agreement* – The FY 2024 budget estimate assumes collections of $7.8 million, $310,000 above FY 2023 collections.** The FY 2023 estimate is based on the FY 2023 projected collections. The estimate includes estimated collections received by IHS for Federal health programs. IHS and VA have agreed to continue to monitor actual reimbursements and work together to improve the quality of care for all veterans and maximize payments whenever possible. IHS continues to work with the VA in identifying the actual number of AI/ANs with VA benefits eligibility and, of those, how many receive direct care from IHS. IHS and the VA continue to work in partnership to identify and resolve billing and reimbursement issues and provide sites with on-going support and training. All IHS sites have signed implementation plans and have the ability to bill the VA for Veterans Services.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**INDIAN HEALTH SERVICE**
**FY 2024 Performance Budget Submission to Congress**

## TABLE OF CONTENTS

### Facilities

Page

*Summary of the Request*
Facilities Summary ....................200
Maintenance & Improvement ....................202
Sanitation Facilities Construction ....................207
Health Care Facilities Construction ....................212
Facilities & Environmental Health Support Summary ....................217
Facilities Support ....................217
Environmental Health Support ....................219
Office of Environmental Health & Engineering Support ....................221
Equipment ....................227
Quarters ....................231

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| BA | $940,328 | $958,553 | $1,066,055 | +$107,502 |
| FTE* | 1,185 | 1,114 | 1,468 | +354 |

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

## SUMMARY OF THE FACILITIES BUDGET

The Indian Health Facilities Appropriation includes facility projects, program support, medical equipment, and personnel quarters activities. Project activities include Maintenance and Improvement (M&I), Sanitation Facilities Construction (SFC), and Health Care Facilities Construction (HCFC). The program support activity is Facilities and Environmental Health Support (FEHS). Equipment and Personnel Quarters collections are also separate activities.

The Facilities Appropriation continues funding for health facility support, public health and preventive services where staff are funded through the Facilities Appropriation to work in healthcare facilities and in the AI/AN communities across Indian country.

## BUDGET AUTHORITY

The FY 2024 budget submission for Facilities is $1.1 billion and is $108 million above the FY 2023 Enacted Level. Starting in FY 2024, the budget proposes to reduce or eliminate existing facilities backlogs.

Maintenance & Improvement –The FY 2024 budget submission for Maintenance and Improvement is $188 million, which is $17 million above the FY 2023 Enacted Level. These funds are the primary source for providing maintenance, repair, and improvement of health care facilities. Specific objectives and program priorities to address the condition of facilities include:

- Providing routine maintenance and repairs to upkeep facilities at their current conditions;
- Achieving compliance with buildings and grounds accreditation standards of the Joint Commission or other applicable accreditation bodies;
- Providing improvements to facilities for enhanced patient access and care through larger M&I projects to reduce the Backlog of Essential Maintenance, Alteration and Repair (BEMAR), which is estimated at $1 billion for all IHS and reporting Tribal facilities;
- Ensuring that health care facilities meet building codes and standards;
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., sustainability, energy conservation, seismic, environmental, handicapped accessibility, and security; and
- Demolishing facilities when excess to the needs of the Service and/or a liability to health and safety.

Sanitation Facilities Construction –The FY 2024 budget submission for Sanitation Facilities Construction is $201 million, which is $5 million above the FY 2023 Enacted Level.

These funds provide for water supply, sewage disposal, and solid waste disposal facilities, including:

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

Health Care Facilities Construction – The FY 2024 budget submission for Health Care Facilities Construction is $261 million, which is $3,000 above the FY 2023 Enacted Level.

This funding level for the construction of new and replacement healthcare facilities will allow IHS to continue/complete the following projects:

- Whiteriver Hospital, Whiteriver, AZ
- Pueblo Pintado Health Center, Pueblo Pintado, AZ
- Small Ambulatory
- New and Replacement Staff Quarters
- Green Infrastructure
- Health System Planning Software Program

Facilities and Environmental Health Support (FEHS) – The FY 2024 budget submission for Facilities and Environmental Health Support is $372 million, which is $73 million above the FY 2023 Enacted Level.

This total includes funding for leadership and staffing to manage and implement all aspects of the Facilities Appropriation and shared operating costs at existing, new and replacement health care facilities.

FEHS funds provide for:

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

Equipment –The FY 2024 budget submission for Equipment is $45 million, which is $12 million above the FY 2023 Enacted Level.

These funds provide for:

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

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $169,664 | $170,595 | $187,528 | +$16,933 |
| FTE* | -- | -- | -- | -- |

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

1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**.........................................................................................Permanent

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

## PROGRAM DESCRIPTION

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

Maintaining reliable and efficient buildings is an increasing challenge as existing health care facilities age and additional space is added into the real property inventory. The average age for IHS-owned health care facilities is approximately 42 years, whereas the average age, including recapitalization of private-sector hospital plants, is 11 years.[1] Many IHS and Tribal health care facilities are operating at or beyond capacity, and their designs are not efficient in the context of modern health care delivery. In addition, as existing health care facilities continue to age, the operational and maintenance costs increase. (The 'average age of hospital plant' measures the average age of the facility including capital improvements, replacement of built-in equipment and modernization.)

[1] *Almanac of hospital financial & operating indicators: a comprehensive benchmark of the nation's hospitals (2016 edition) https://aharesourcecenter.wordpress.com/2011/10/20/average-age-of-plant-about-10-years/*

IHS hospital administrators have reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance with the Medicare Hospital Conditions of Participation. Further, the administrators reported that maintaining aging buildings and equipment is a major challenge. Over one third of all IHS hospital deficiencies have been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors.

The physical condition of IHS-owned and many tribally owned healthcare facilities is evaluated through routine observations by facilities personnel and by in-depth condition surveys. These observations and surveys identify facility, fire-life-safety, and program deficiencies, and are used to develop IHS' estimate of the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). The BEMAR is a measure of the condition of health care facilities in the Indian health system and establishes priorities for larger M&I projects. The FY 2022 BEMAR for all IHS and reporting Tribal health care facilities as of October 1, 2022, is $1,227 million. When IHS replaces an older, obsolete hospital or clinic with a new facility, all deficiencies associated with the old facility are removed from the backlog.

The Facilities Program, of which the Facilities and Biomedical staffing and activities, Maintenance and Improvement funding, Medical Equipment funding, and Personnel Quarters/Housing are important elements, directly or indirectly supports:

HHS Strategic Goal 1 - Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare; Objective 1.2 - Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs; and Objective 1.5 - Bolster the health workforce to ensure delivery of quality services and care.

HHS Strategic Goal 2 - Safeguard and Improve National and Global Health Conditions and Outcomes; Objective 2.2 - Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices and vaccines; and Objective 2.4 - Mitigate the impacts of environmental factors, including climate change, on health outcomes.

HHS Strategic Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability; Objective 5.4 - Ensure the security and climate resiliency of HHS facilities, technology, data, and information, while advancing environment-friendly practices.

How the Facilities Program is implementing: In consultation with Tribes and the Federal healthcare sites, IHS is allocating funding to the IHS Area Offices to complete BEMAR projects to make renovations and improvements, replace and modernize medical equipment, and provide staff quarters necessary to support health care delivery in the health care facilities and to modernize the health care facilities to support health care delivery and expand access to quality health care services.

M&I Funds Allocation Method

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

1. *Routine Maintenance Funds* – These funds support activities that are generally classified as those needed for maintenance and minor repair to keep the health care facility in its current condition. Funding allocation is formula based. The Building Research Board of the

National Academy of Sciences has determined that approximately two to four percent of current replacement value of supported buildings is required to maintain (i.e., 'sustain') facilities in their current condition.[2]

2. *M&I Project Funds* – These funds are used for major projects to reduce the Backlog of Essential Maintenance, Alteration and Repair (BEMAR) and make improvements necessary to support health care delivery. This funding will provide improvements to facilities for enhanced patient access and care and facilitate larger M&I projects to reduce the (BEMAR) within a five year period. Funding allocation is formula based.

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

4. *Demolition Funds* – The IHS has a number of Federally owned buildings that are vacant, excess, or obsolete. Demolition funds are used to dispose of these excess assets. These funds may be augmented with Environmental Compliance Funds as available for demolition and disposal to the extent that the proposed action reduces hazards, environmental concerns, or liability to IHS. Based upon recent interpretation of the Administrative Provision related to Demolition of hazardous, obsolete federal buildings, the inventory of this federal inventory continues to grow, as does the potential liability.

**BUDGET REQUEST**

The FY 2024 budget submission for Maintenance & Improvement of $188 million is an increase of $17 million above the FY 2023 Enacted level.

FY 2023 Base Funding of $171 million supports maintenance, repair, and improvements for existing IHS and Tribal facilities.

FY 2024 Funding Increase of $17 million includes:

- Maintenance and Improvement: +$10 million would provide resources to the fund routine maintenance and repair activities and critical Backlog of Essential Maintenance, Alteration and Repair (BEMAR) projects at IHS and Tribal healthcare facilities. Maintenance and Improvement activities and projects are typically less extensive in nature and can be implemented quickly. Addressing these deficiencies is critical to providing high-quality health care; for example, one third of all IHS hospitals' deficiencies are related to facilities with some failing on infection control criteria and others having malfunctioning exit doors. Facility deficiencies/BEMAR and medical equipment are complex and involve many variables such as accreditation standards, healthcare patient satisfaction, changing healthcare delivery standards, building codes, old building equipment/system, and medical devices/equipment plus telemedicine used by healthcare professionals.

The total $188 million funding request for FY 2024 would support:

[2] *Committing to the Cost of Ownership - Maintenance and Repair of Public Buildings,* The National Academies Press (1990), *available at* http://www.nap.edu/catalog.

- Approximately $110 million is the projected amount for routine maintenance and repair to sustain the condition of federal and Tribal healthcare facilities buildings. These funds will support facilities activities that are generally classified as those needed for 'sustainment' of existing facilities and provided to the IHS Area Offices and to Tribes for daily maintenance activities and local projects to maintain the current state of health care facilities. These *Routine Maintenance Funds* may be used for Area and Tribal M&I projects to fund smaller elements of the backlog of work to address the old and antiquated facilities plant infrastructure (e.g., mechanical and electrical BEMAR) and program enhancements.

- Approximately $74 million would be available for major Area and Tribal M&I projects to reduce the BEMAR deficiencies and to improve healthcare facilities to meet changing healthcare delivery needs. The FY 2023 Budget Request continues funding critical projects to address the old and antiquated facilities plant infrastructure (e.g., mechanical and electrical BEMAR), accreditation standards, and program enhancements, all of which is essential to support health delivery.

- Approximately $3 million would be available for environmental compliance projects. The IHS places a high priority on meeting Federal, State, and local legal/regulatory environmental requirements, including allocating funding to address findings and recommendations from environmental audits. The IHS has currently identified approximately $9 million in environmental compliance tasks and included them in the BEMAR database.

- M&I funds, retained by Headquarters at $500,000, also provide resources for the demolition of IHS facilities that are no longer needed. The IHS has approximately 100 Federally owned buildings that are vacant, excess, or obsolete. Many of these buildings are safety and security hazards. IHS plans for orderly demolition of some of these buildings, in concert with transferring others, reducing hazards and liability. Demolition Funds may be used in concert with environmental compliance funds as available for demolition of the Federal buildings to the extent that the proposed action reduces hazards, environmental concerns, or liability to the Indian Health Service. Since FY 2000 when funds were first set aside for the demolition of Federal buildings, associated demolition costs have risen significantly due to inflation, environmental regulations, recycling and landfill diversion requirements, abatement of hazardous material, etc. For example, many IHS locations are very remote which significantly increases the cost to haul the demolition waste off the reservation to approved landfills and recycling facilities.

- Current Services: +$7 million, information can be found on page CJ-33.

## FUNDING HISTORY

| Fiscal Year | Amount |
|---|---|
| 2020 | $168,952,000 |
| 2021 | $168,952,000 |
| 2022 Final | $169,664,000 |
| 2023 Enacted | $170,595,000 |
| 2024 President's Budget | $187,528,000 |

## TRIBAL SHARES

There are no Tribal Shares allocated from Maintenance & Improvement funds. Rather, Tribal shares associated with the Facilities Program may be transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities at a Federal or Tribal healthcare site. Tribes may also contract or compact to perform individual Maintenance & Improvement projects that are awarded to federally owned sites

## OUTPUTS / OUTCOMES

The Outcomes for this program are measured through BEMAR, i.e., progress in addressing maintenance needs and facility deficiencies. Maintaining effective and efficient healthcare buildings improve the ease and access to care, facilitate successful behavioral health services, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment to deliver services.

IHS targets the M&I funding, and supplements these funds with collections where available, towards major projects to reduce the BEMAR and improve the condition of existing Federal and Tribal healthcare sites. A few examples of these projects include: renovating/expanding pharmacy space, improvements to dental clinics to serve more users, remodeling reception/waiting areas, construction of CT suite and new digital radiology rooms, repaving parking lots, emergency department renovations, new heating-ventilation-air conditions systems, sustainability projects to reduce utility costs, etc. Continued investment in the BEMAR which is currently at $1 billion, will enable IHS and the Tribes to maintain accreditation standards and delivery quality health care services.

**GRANT AWARDS –** This program has no grant awards.

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $197,783 | $196,167 | $201,021 | +$4,854 |
| FTE* | 115 | 114 | 114 | -- |

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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, as amended 2010

**FY 2024 Authorization** ...........................................................................................Permanent

**Allocation Method**......................Needs-based priority system for construction project fund allocation and implemented through P.L. 86-121 Memorandum of Agreements, P.L. 93-638 Self-Determination Contracts and Self-Governance Construction Project Agreements.

**PROGRAM DESCRIPTION**

The Indian Health Care Improvement Act (IHCIA) requires the Indian Health Service (IHS) to identify the universe of sanitation facilities needs for existing American Indian and Alaska Native (AI/AN) homes by documenting deficiencies and proposing projects to address their needs. These projects prevent communicable diseases by providing new and existing homes with services such as water wells, onsite wastewater disposal systems, or connections to community water supply and wastewater disposal systems. These projects can also include provision of new or upgraded water supply or waste disposal systems.

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

Projects that provide sanitation facilities to existing homes are selected for funding in priority order each year from the Sanitation Deficiency System (SDS). The SDS is an inventory of the sanitation deficiencies of federally recognized AI/AN eligible homes and communities; the sanitation deficiencies include needed water, sewer, and solid waste facilities for existing AI/AN homes. Project selection is driven by objective evaluation criteria including health impact, existing deficiency level, adequacy of previous service, capital cost, local Tribal priority, operations and maintenance capacity of the receiving entity, availability of contributions from non-IHS sources, and other conditions that are locally determined. The SDS priority position of each unfunded project is reevaluated with the Tribes in each Area annually.

Sanitation Facilities Construction (SFC) projects can be managed by IHS directly or by Tribes that elect to use the Title I or Title V authorization under P.L. 93-638, the Indian Self-Determination and Education Assistance Act. Sanitation facilities projects are carried out cooperatively with the Tribes that will be served, and construction is performed by either the IHS or the Tribes. Projects start with a Tribal project proposal and are funded and implemented through execution of an agreement between a Tribe and IHS. In these agreements, the Tribes also assume ownership responsibilities, including operation and maintenance. The overall SFC goals, reporting requirements, eligibility criteria, project planning, and funding priorities remain the same, regardless of the delivery methods chosen by a Tribe.

The SFC Program leverages its capabilities in partnering with Tribes by also partnering with other Federal agencies in constructing or financing construction of water supply, wastewater and solid waste disposal projects addressing sanitation deficiencies faced by Tribes. One way in which the SFC Program engages in such partnerships is through the Infrastructure Task Force (ITF), a partnership of Federal agencies focused on finding ways to better serve Tribes through cooperative efforts.

**BUDGET REQUEST**

The FY 2024 budget submission for Sanitation Facilities Construction of $201 million is $5 million above the FY 2023 Enacted level

FY 2023 Base Funding of $196 million supports construction of sanitation facilities to serve new and existing American Indian and Alaska Native homes.

FY 2024 funding level of $201 million will include:

- Up to $85 million will be used to serve new and like-new homes, which are non-Department of Housing and Urban Development (HUD) homes (HUD homes are served under HUD authorities and appropriations). Some of these funds may also be used for sanitation facilities for individual homes of the disabled or sick, with a physician referral, indicating an immediate medical need for adequate sanitation facilities in their home.[1] As needed, amounts to serve new and like-new homes will be established by Headquarters after reviewing Area proposals. Priority will be given to projects under the BIA Housing Improvement Program (HIP) to serve new and like-new homes with the exception of "Category A" BIA HIP homes which are considered existing homes and will be served with the funds described in this section. The IHS appropriated funds for sanitation facilities construction are prohibited by law from being used to provide sanitation facilities for new homes funded with grants by the housing programs of HUD. These HUD housing grant programs for new homes should continue to incorporate funding for the sanitation facilities necessary for those homes.

- Up to $55 million[2] will be used to cover cost increases due to inflation on projects funded during the pandemic with pre-pandemic cost estimates serving AI/AN homes and communities.

- Up to $55 million may be distributed to the Areas for prioritized projects identified in the IHS data system as Tier 1 Ready to Fund serving existing homes, based on a formula that considers, among other factors, the cost of facilities to serve existing homes that: (a) have not received

[1] Indian Health Service. Chapter 5 Eligibility for IHS SFC Program Services and IHS-Funded Projects. Criteria for the Sanitation Facility Construction Program June 1999 ver. 1.02, 3/13/03.

[2] Assumed 8% inflation associated with $675.5M in project funding from FY2023 IIJA.

sanitation facilities for the first time, or (b) are served by sanitation facilities that are in need of some form of improvement. Another element of the distribution formula is a weight factor that favors Areas with larger numbers of AI/AN homes without water supply or sewer facilities, or without both. If there are insufficient Tier 1 projects then these funds will be used to support project planning, design, and construction administration to address existing sanitation deficiencies impacting AI/AN homes are fully designed and construction ready in FY 2024. These funds will be used in conjunction with the FY 2023 Infrastructure Investment and Jobs Act.

- Up to $4 million will be reserved at IHS Headquarters for special projects to include up to $2 million for data migration of available water and wastewater system data from tribally owned and operated systems serving AI/AN homes and communities from electronic or paper file formats. This data is currently located in electronic or paper files within the IHS Areas and will be migrated under this initiative into the SFC Program Geographic Information System (GIS) portal. This data is used by the SFC Program to assist in needs identification, planning, and designing facilities to serve tribal homes and communities. An amount up to $2 million will be used to maintain and enhance the SFC Program data and reporting systems. The remaining special project funds will be used to pay for Area requested research studies, training, or other needs related to sanitation facilities construction, but which are not eligible for construction funds.

- Up to $2 million will be reserved at IHS Headquarters for emergency projects as requested by Areas to address water supply and waste disposal emergencies caused by natural disasters or other unanticipated situation that require immediate attention to avoid a health hazard or to protect the Federal investment in sanitation facilities. Any emergency funds unused by the end of the fiscal year may be distributed to address the SDS projects in the Areas.

- Current Services: +$5 million, information can be found on page CJ-33.

## FUNDING HISTORY

| Fiscal Year | Amount |
|---|---:|
| 2020 | $193,577,000 |
| 2021 | $196,577,000 |
| 2022 Final | $197,783,000 |
| 2023 Enacted | $196,167,000 |
| 2024 President's Budget | $201,021,000 |

## PROGRAM ACCOMPLISHMENTS

The SFC Program is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated to provide water and waste disposal facilities for eligible AI/AN homes and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have declined. Research supported by the Centers for Disease Control and Prevention states populations in regions with a lower proportion of homes with water service, reflect significantly higher hospitalization rates for pneumonia, influenza, and respiratory syncytial virus.[3] Researchers associated the increasing illnesses with the restricted access to clean water for hand washing and hygiene. The SFC Program works collaboratively with

[3] Thomas W. Hennessy, Troy Ritter, Robert C. Holman, Dana L. Bruden, Krista L. Yorita, Lisa Bulkow, James E. Cheek, Rosalyn J. Singleton, and Jeff Smith. The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives. American Journal of Public Health: November 2008, Vol. 98, No. 11, pp. 2072-2078.

Tribes to assure all AI/AN homes and communities are provided with safe and adequate water supply and waste disposal facilities as soon as possible.

In FY 2022, IHS funded projects to provide service to 63,916 AI/AN homes. IHS also completed construction on 207 projects with an average project duration of 3.99 years. However, at the end of FY 2022, about 1.6 percent of all AI/AN homes tracked by IHS lacked water supply or wastewater disposal facilities; and, about 113,749 or approximately 30 percent of AI/AN homes tracked by IHS were in need of some form of sanitation facilities improvements. The individuals who live in homes without adequate sanitation facilities are at a higher risk for gastrointestinal disease, respiratory disease and other chronic diseases.[4] Many of these homes without service are very remote and may have limited access to health care which increases the importance of improving environmental conditions.

The total sanitation facility need reported through SDS has increased approximately $1 billion or 30 percent from $3.4 billion to $4.5 billion from FY 2021 to FY 2022. In FY 2022, the IHS was appropriated $850 million (FY 2022 appropriations of $175 million and $675.5 million in IIJA funding) to address sanitation deficiencies and support provision of sanitation facilities to eligible AI/AN homes and communities. The magnitude of the sanitation facility needs increase is due to the underlying challenges of construction cost inflation, construction material availability, material supply chain challenges, and failing infrastructure. The failing infrastructure challenge is due to a combination of the infrastructure's age and inadequate operation and maintenance. Under the IHCIA, the IHS is authorized to provide operation and maintenance assistance for, and emergency repairs to, Tribal sanitation facilities, when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities, however resources have not been appropriated specifically for this purpose.

During FY 2021, 390 construction projects to address water supply and wastewater disposal needs were funded with a construction cost of $220 million using IHS and contributed funds. Once constructed, these sanitation facilities will benefit an estimated 188,000 AI/AN people and help avoid over 379,600 inpatient and outpatient visits related to respiratory, skin and soft tissue, and gastro enteric disease over 30 years. The health care cost savings for these visits alone is estimated to be over $403 million. Every $1 spent on water and sewer infrastructure will save $1.23 in avoided direct healthcare cost. These outcomes support Strategy 14, "Develop and coordinate environmental engineering, environmental health, and health facilities engineering services to provide effective and efficient public health services.

In FY 2024, the SFC Program will continue to focus on improving quality of data reported through the SDS on the sanitation facility needs supporting AI/AN homes and communities. These efforts will ensure the sanitation facilities needs included in SDS are:

- Associated with timely completion of design and construction activities on funded sanitation facilities projects;
- Adequately documented;
- Reflect an update of current needs; and
- Include only sanitation facilities fundable by the SFC program for AI/AN eligible homes and communities and consistent with the prescribed Deficiency Levels referenced in the IHCIA.

It is estimated that the project duration will increase from 4.0 to 4.5 years due to increased project workload and insufficient SFC Program staffing to complete construction document preparation. The

SFC Program is working proactively to increase SFC Program staff through streamlining the recruitment and hiring and engaging the Commissioned Corps of the U.S. Public Health Service. The SFC Program has also taken steps to retain current staff by providing pay incentives to current Civil Service staff. The SFC Program is also actively working with other federal partners to resolve this challenges including the Environmental Protection Agency and the US Army Corps of Engineers.

Consistent with existing practice, funds will only be obligated to projects that have been certified by the SFC Program Areas as "ready to fund"; this means they have a well-defined scope, a detailed cost estimate, a completed preliminary design and that known potential risks to project construction, operation and maintenance have been considered and mitigated.

**OUTPUTS / OUTCOMES**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| 35 Number of new or like-new and existing AI/AN homes provided with sanitation facilities. (Outcome) | FY 2022: 63,916 Target: 44,000 (Target Exceeded) | 54,000 | 54,400[1] | +400 |
| SFC-E Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion. (Outcome) | FY 2022: 4.0 yrs Target: 4 yrs (Target Met) | 4.0 yrs | 4.5 yrs | +0.5 yrs |

[1]Target based on funding from both FY 2024 President's Budget and $675.5 million from the Infrastructure Investment and Jobs Act (IIJA).

**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 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $259,293 | $260,896 | $260,899 | +$3 |
| FTE* | -- | -- | -- | -- |

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

1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**.........................................................................................Permanent

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

**PROGRAM DESCRIPTION**

The Indian Health Service (IHS) Health Care Facilities Construction (HCFC) funds provide optimum availability of functional, modern IHS and tribally operated health care facilities and where required staff quarters. The IHS is authorized to construct health care facilities and staff quarters, support Tribal construction of facilities under the Joint Venture Construction Program (JVCP), provide construction funding for Tribal projects Under the Small Ambulatory Program (SAP), and provide funding to construct new and replacement dental units.

The health care facilities constructed by the IHS ensure access to quality, culturally competent health care for one of the lowest income populations in the United States, American Indians and Alaska Natives (AI/AN). The focus of the IHS health care service programs provided in these facilities is on prevention and delivery of comprehensive primary care in a community setting.

The HCFC program is funded based on an IHS-wide list of priorities for construction projects. During FY 1990, at the direction of Congress, the IHS established the Health Facilities Construction Priority System (HFCPS) methodology. The HFCPS ranks proposals using factors reflecting the total amount of space needed, age and condition of the existing health care facility, if any, degree of isolation of the population to be served in the proposed health care facility, and availability of alternate health care resources. The remaining health care facilities projects on the HFCPS list, including those partially funded, total approximately $3.2 billion as of January 2022. The reauthorization of the Indian Health Care Improvement Act (IHCIA) includes a provision, "any project established under the construction priority system in effect on the date of enactment of the Act of 2009 shall not be affected by any change in the construction priority system taking place after that date…" Total need for the HCFC Program is approximately $15 billion for expanded and active authority facility types according to *The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress*.

The Joint Venture Construction Program (JVCP) authorizes IHS to enter into agreements with Tribes that construct their own health care facilities. The Tribe provides the resources, whether from its own funds, through financing, grants, contributions, or a combination thereof, for the construction of its health care facility. IHS health care facility construction appropriations are not used for construction of facilities in the JVCP but may be used to equip the health care facility. Tribes apply for the JVCP during a competitive process and the approved projects are entered into agreements with IHS. Based on the date of projected completion of construction by the respective Tribe, the IHS agrees to request a funding increase from Congress for additional staffing and operations consistent with a fully executed beneficial occupancy of the health care facility.

The Small Ambulatory Program (SAP) provides funding for small Tribal health care facilities. The SAP is authorized by Section 306 of the Indian Health Care Improvement Act, Public Law 94-437, and projects are competitively selected for funding as funds are appropriated. The SAP program is available for AI/AN Tribes or Tribal organizations to competitively obtain funding for the construction, expansion or modernization of tribally owned small ambulatory health care facilities. The selected projects will not be a part of the IHS HFCPS.

A new facility is designed to meet the demand for health services from a growing population by providing more healthcare providers and exam rooms, dentists and dental chairs, improved imaging systems, and expanded services such as eye care and audiology. Each new facility includes a component to address behavioral health issues. Administration staff is increased to strengthen management, collections and bring health care quality expertise to the replacement facility. Each facility also incorporates additional space for Tribal health programs which complements IHS programs and how the HCFC programs are implementing.

**BUDGET REQUEST**

The FY 2024 budget submission for Health Care Facilities Construction of $261 million is $3,000 above the FY 2023 Enacted level.

The total $261 million requested for FY 2024 would support:

Whiteriver Hospital, Whiteriver, AZ $200 million

These funds will be used for construction of the replacement hospital. It will serve a projected user population of 36,113 providing 67,000 primary care provider visits and 101,200 outpatient visits annually. This project also includes an estimated 144 staff quarters for health care professionals serving at the facility.

Pueblo Pintado Health Center, Pueblo Pintado, AZ $24 million

These funds will be used to complete construction of the health center and 82 staff quarters located in the Pueblo Pintado, AZ. Pueblo Pintado Health Center will consist of 126,454 GSF of space. The Health Center will serve a projected user population of 6,135 generating 24,579 primary care provider visits and 49,084 outpatient visits annually. The facility will provide an expanded outpatient and community health department, and a full array of ancillary and support services.

Small Ambulatory $25 million

These resources would support up to 10 small ambulatory facilities in American Indian and Alaska Native communities. Consistent with prior years, the IHS will request applications from interested Tribes. Funds will support for construction, expansion or modernization of non-IHS

owned, small Tribal ambulatory health care facilities located apart from a hospital.

New and Replacement Staff Quarters $6 million

These funds will fully-fund 400 new or replacement staff quarters. Many of the 2,700 quarters across the IHS health delivery system are more than 40 years old and in need of major renovation or total replacement. Additionally, in a number of locations the amount of housing units is insufficient. The identified unmet need, of housing units in isolated, remote locations is a significant barrier to the recruitment and retention of quality healthcare professionals across Indian Country. The amount distributed to each Area will be based on each Area's internal priority list.

Green Infrastructure: $5 million

The IHS will use these funds to incorporate green infrastructure and the current energy efficiency codes and standards available in its planning, design, and operations of buildings to the maximum extent practicable. This approach will reduce costs, minimize environmental impacts, and use renewable energy.

Health System Planning Software Program $1 million

These funds would be used to update the HSP to:

1. Include new authorities that the IHS is granted or has been granted in the IHCIA,
2. Update the equipment capabilities
3. Integrate HSP with the IHS GIS capabilities.

The Health System Planning (HSP) is used to plan the services, staffing, equipment, and space of heath care facility projects. The HSP software program is used in every project in the IHS system both Tribal and Federal. In addition the program has the ability rapidly assess the unmet need for services in any community where AI/AN reside. Healthcare practices, space and equipment change constantly requiring the software to change also.

Current Services of $3,000 is described on page CJ-33.

**FUNDING HISTORY**

| Fiscal Year | Amount |
|---|---:|
| 2020 | $259,290,000 |
| 2021 | $259,290,000 |
| 2022 Final | $259,293,000 |
| 2023 Enacted | $260,896,000 |
| 2024 President's Budget | $260,899,000 |

**PROGRAM ACCOMPLISHMENTS**

Each healthcare facility project that is completed increases access to much needed health care services. Each completed replacement facility is typically larger to meet the increased demand for health services from a growing population. Tribes typically provide land, at no cost to the Federal Government, for the new or replacement health care facility.

During FY 2022, IHS has funded one project completed by Tribes. The River Peoples Health Center (funded as PIMC Northeast Health Center) in the Salt River Pima-Maricopa Indian Community, AZ. A 197,850 GSF outpatient health center and serve a projected user population of 18,596

During FY 2022, IHS has completed the Dilkon Alternative Rural Health Center and 109 staff quarters located in Dilkon, Arizona.  A 150,000 GSF outpatient health center and serve a projected user population of 17,195.  The new facility will provide an expanded outpatient department, community health department, and a full array of ancillary and support services.

During FY 2022, the Yseleta del Sur Pueblo, completed a Health Center in El Paso, TX under the Joint Venture Construction Program which IHS will fund the staffing and operations for the next 20 years.

The FY 2022 appropriation contributed to the Rapid City Health Center, Rapid City, SD; Alamo Health Center, Alamo, NM; Pueblo Pintado Health Center, Pueblo Pintado, AZ; Phoenix Indian Medical Center, Phoenix, AZ, Whiteriver Hospital, Whiteriver, AZ; Gallup Indian Medical Center, Gallup, NM; and Sells Alternative Rural Hospital, Sells, AZ projects.

The FY 2022 appropriation also contributed $25 million to the IHS SAP, $10 million to the Staff Quarters Program, and $5 million to the Green Infrastructure Program. The selection and agreements to award the funds is beginning in late FY 2022.

The FY 2023 appropriation will contribute to the Phoenix Indian Medical Center, Phoenix, AZ, Whiteriver Hospital, Whiteriver, AZ; Gallup Indian Medical Center, Gallup, NM; Bodaway Gap Health Center, The Gap, AZ; Albuquerque West Health Center, Albuquerque, NM; and Sells Alternative Rural Hospital, Sells, AZ projects.

The FY 2023 appropriation also contributed $30 million to the IHS SAP, $25 million to the Staff Quarters Program and $5 million to the Green Infrastructure Program. The selection and agreements to award the funds is beginning in late FY 2023.

The JVCP has saved the Federal Government over $1 billion dollars in capital expenses since its inception.  The outcome of the JVCP provides the same accomplishments as described above.

The federal construction and the Joint Venture programs bring new and increased health care capacity to AI/AN communities where there is a great need.  These activities increase the access to quality healthcare in these underserved communities.

**OUTPUTS / OUTCOMES**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/- FY 2023 Target[2] |
|---|---|---|---|---|
| 36 Health Care Facility Construction: Number of health care facilities construction projects completed. (Outcome) | FY 2022: 2 projects Target: 1 projects (Target Exceeded) | 1 project | 0 Project | -1 Project |
| HCFC-E Energy consumption in | FY 2022: 2 projects Target: | 1 project | 0 Project | -1 Project |

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/- FY 2023 Target[2] |
|---|---|---|---|---|
| Leadership in Energy and Environmental Design (LEED) certified IHS health care facilities compared to the industry energy consumption standard for comparable facilities. (Outcome) | 1 projects (Target Exceeded) | | | |

1. Projects completed in FY 2022 is River People Health Center (PIMC NE) and the Rapid City Health Center. In FY 2023 the Dilkon Health Center is expected to be completed.
2. In FY 2024, the IHS HCFC program has six (6) projects in planning and three (3) in design. The FY 2024 target is listed as zero (0), as no projects will be completed during the FY.

**GRANT AWARDS –** Program has no grant 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 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $283,124 | $298,297 | $371,530 | +$73,233 |
| FTE* | 1,005 | 1,000 | 1,160 | +160 |

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**..........................................................................................Permanent

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

**SUMMARY OF PROGRAMS**

Facilities and Environmental Health Support Account (FEHS) programs provide and support an extensive array of real property, health care facilities and staff quarters construction, maintenance and operation services, as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. The programs directly and indirectly support all of the IHS facilities performance measures and improved access to quality health services. The programs and staff at the IHS Headquarters, Area Office, and Service Unit levels work collaboratively with Tribes and other agencies to promote and provide access to improvements in public health through surveillance, education, intervention activities, construction of sanitation facilities and health care facilities. These activities are aligned in sub-activities: Facilities Support, Environmental Health Support, and Office of Environmental Health and Engineering Support. In addition to personnel salary and benefits costs, funding under this activity is used for utilities, certain non-medical supplies and personal property, and biomedical equipment repair.

**FACILITIES SUPPORT**

**PROGRAM DESCRIPTION**

Facilities Support Account (FS) provides funding for Area and Service Unit staff for facilities-related management activities, operation and maintenance of real property and building systems, medical equipment technical support, and planning and construction management support for new and replacement health facilities projects.

Facilities operations, maintenance, repair, and improvements address deficiencies/BEMAR and medical equipment, which are complex and involve many variables such as accreditation

standards, healthcare patient satisfaction, changing healthcare delivery standards, building codes, old building equipment/system, and medical devices/equipment plus telemedicine used by healthcare professionals.

The IHS owns approximately 11,000,000 square feet of facilities (totaling 2,193 buildings) and 1,760 acres of federal and trust land. The nature of space varies from sophisticated medical centers to residential units and utility plants. Facilities range in age from less than one year to more than 170 years, with an average age greater than 40 years. A professional and fully-functional workforce is essential to ensure effective and efficient operations. An estimated 600 Federal positions (fulltime equivalents) are funded under this sub-activity. Typical staff functions funded may include:

- Facilities engineers and maintenance staff responsible for ensuring that building systems are operated properly, facilities and grounds are maintained adequately, utilities are managed appropriately, environmental compliance requirements are met, and buildings are safe;
- Specialized clinical engineers and technicians who maintain and service medical equipment;
- Realty staff that manages the real property requirements and quarters; and
- Facilities planning, project management, and construction-monitoring that assist in the planning and construction of projects.

In addition, FS provides partial funding for related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities-related personal property, and biomedical equipment repair and maintenance. Accomplishments include supporting health delivery through the attainment of accreditation and the maintenance of the environment of care of buildings, utility systems, life safety systems, and medical equipment.

Adequate facilities/maintenance staffing both at the Area Offices and service units are paramount to maintain accreditation, for the continuity of health services, and ensuring that major building systems function correctly. Workload for the facilities and biomedical staff has continued to increase to meet the Agency's emphasis on accreditation standards and supporting program enhancements/expansion, which is predominately funded with collections.

In consultation with Tribes and the Federal healthcare sites, IHS is coordinating with and allocating funding to the IHS Area Offices to complete BEMAR projects to make renovations and improvements necessary to support health care delivery in the health care facilities and to modernize the health care facilities and staff quarters to expand access to quality health care services including modern medical equipment.

The Facilities Program, of which the Facilities and Biomedical staffing and activities, Maintenance and Improvement funding, Medical Equipment funding, and Personnel Quarters/Housing are important elements, directly or indirectly supports:

HHS Strategic Goal 1 - Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare; Objective 1.2 - Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs; and Objective 1.5 - Bolster the health workforce to ensure delivery of quality services and care.

HHS Strategic Goal 2 - Safeguard and Improve National and Global Health Conditions and Outcomes; Objective 2.2 - Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available

diagnostics, treatments, therapeutics, medical devices and vaccines; and Objective 2.4 - Mitigate the impacts of environmental factors, including climate change, on health outcomes.

HHS Strategic Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability; Objective 5.4 - Ensure the security and climate resiliency of HHS facilities, technology, data, and information, while advancing environment-friendly practices.

How the Facilities Program is implementing: In consultation with Tribes and the Federal healthcare sites, IHS is allocating funding to the IHS Area Offices to complete BEMAR projects to make renovations and improvements, replace and modernize medical equipment, and provide staff quarters necessary to support health care delivery in the health care facilities and to modernize the health care facilities to support health care delivery and expand access to quality health care services.

## ENVIRONMENTAL HEALTH SUPPORT

## PROGRAM DESCRIPTION

The Environmental Health Support Account (EHSA) provides funding for IHS Area, District, and Service Unit management activities and environmental health staff which include engineers, environmental health officers, engineering aides, injury prevention specialists, and institutional environmental health officers. More than 70 percent of these IHS and Tribal staff live and work in Tribal communities; another 20 percent provide regional services to Tribes or IHS facilities; and less than 10 percent of our staff are administrative managers. AI/ANs face hazards in their environments that affect their health status, including communities in remote and isolated locations, severe climatic conditions, limited availability of safe housing, lack of safe water supply, and lack of public health and safety legislation (e.g., lack of local solid waste ordinances, vehicle safety laws, or food safety laws). In accordance with congressional direction, these funds are distributed to the Areas based upon the workload and need associated with the two programs noted below.

- Sanitation Facilities Construction Program (SFC) – This program is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated for SFC to provide safe water supply and waste disposal facilities for AI/AN people and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have been reduced. Research supported by the Centers for Disease Control and Prevention states populations in regions with a lower proportion of homes with water service, reflect significantly higher hospitalization rates for pneumonia, influenza, and respiratory syncytial virus.[1] Researchers associate the increasing illnesses with the restricted access to clean water for hand washing and hygiene. The absence of clean water to sanitation facilities for tribal households exacerbate concern for the Indian Health Service Clinical Health Care program; further decreasing the quality of life for AI/ANs. Efforts by other public health specialists such as nutritionists and public health nurses are much more effective when safe water and adequate wastewater disposal systems are available in the home. In addition, the availability of such

[1] Thomas W. Hennessy, Troy Ritter, Robert C. Holman, Dana L. Bruden, Krista L. Yorita, Lisa Bulkow, James E. Cheek, Rosalyn J. Singleton, and Jeff Smith. The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives. American Journal of Public Health: November 2008, Vol. 98, No. 11, pp. 2072-2078.

facilities is of fundamental importance to social and economic development, which leads to an improved quality of life and an improved sense of well-being.

The SFC Program works collaboratively with tribes to assure all AI/AN homes and communities are provided with safe and adequate water supply and waste disposal systems as soon as possible. Under this program in FY 2022, staff managed and/or provided professional engineering services for 664 new sanitation projects with a total cost of over $1.1 billion, including IHS funds and contributions from Tribes and other agencies. The program manages annual project funding that includes contributions from Tribes, states, and other federal agencies. The SFC Program is the environmental engineering component of the IHS health delivery system. Services funded include management of staff, pre-planning, consultation with Tribes, coordination with other federal, state and local governmental entities, identifying supplemental funding outside of IHS, developing local policies and guidelines with Tribal consultation, developing agreements with Tribes and others for each project, providing professional engineering design and/or construction services for water supply and waste disposal facilities, assuring environmental and historical preservation procedures are followed, and assisting Tribes where the Tribes provide construction management.

Consistent with the 1994 Congressional set aside for "…tribal training on the operation and maintenance of sanitation facilities," $1 million of these support funds are used for technical assistance, training, and guidance to Indian families and communities regarding the operation and maintenance of water supply and sewage disposal facilities. Starting in FY 2021, Congress allocated an additional $3 million for tribal training for operation and maintenance of sanitation facilities.

In accordance with the Indian Health Care Improvement Act, the staff annually updates its inventory of sanitation facilities deficiencies for existing Indian occupied homes.[2] This is accomplished through extensive consultation with Tribes. The SFC staff also develops and updates an inventory of all open dump sites on Indian lands as required under the Indian Lands Open Dump Cleanup Act.[3] Both of these inventories are widely used by other governmental agencies in their evaluation and funding of sanitation facilities construction projects.

The IIJA appropriates $700 million in each year from FY 2022 – FY 2026, for a total of $3.5 billion for the IHS Sanitation Facilities Construction (SFC) program. These resources are available until expended, for the provision of domestic and community sanitation facilities for Indians, as authorized. Funding from the IIJA appropriation will be used to fund sanitation facilities construction projects listed in the IHS Sanitation Deficiency System.

Environmental Health Services (EHS) – National priority areas include: food safety, children's environments, healthy homes, vector-borne and communicable disease, and safe drinking water. The EHS Program identifies environmental hazards and risk factors in Tribal communities and proposes control measures to prevent adverse health effects. The EHS Program monitors and investigates disease and injury. The program provides inspections to identify environmental hazards in homes, healthcare facilities, food service establishments, Head Start centers, and many other types of Tribal establishments. In addition, EHS provides training, technical assistance, and

[2] Title III, Section 302(g) 1 and 2 of P.L. 94-437.
[3] P.L. 103-399.

cooperative agreements to enhance the capacity of Tribal communities to address environmental health issues.

EHS provides access to public health services to AI/ANs. Examples include: referrals for home investigations to reduce environmental triggers for asthma patients; home investigations to reduce exposure to lead-based paint or other lead hazards (including drinking water sources) for patients with elevated blood-lead levels; animal bite investigations in Tribal communities and potential patient exposure to rabies virus; home investigations to address fall risk for elderly and other patients at risk for falls; and referrals for investigation of communicable disease outbreaks from patient exposures to contaminated food or water.

The IHS Injury Prevention Program (IPP) leads IHS efforts to address injury disparities between AI/AN communities and U.S. all races. AI/AN experience injury mortality rates that are 2.5 to 8.7 times higher than the U. S. all races rates[4]. The IPP works with AI/AN, other agencies, and IHS programs to prevent unintentional injuries (e.g., motor vehicle-related, falls, burns, drowning, poisoning) and intentional injuries (e.g., suicide and violence-related) through technical assistance, training, and the Tribal Injury Prevention Cooperative Agreement Program (TIPCAP). Technical assistance is provided in the areas of data collection for project evaluation, building partnerships, implementing evidence-based strategies or innovative interventions, and developing tribal injury prevention programs.

The IHS Institutional Environmental Health (IEH) Program identifies hazards and risk factors in the built environment and proposes control measures to prevent adverse health effects to patients, staff, and visitors in health care and other community facilities. The IEH program supports development and management of safe, functional health care facilities which contributes to the quality of care and workforce retention. The IEH program collaborates with entities such as the National Institutes of Health, Administration for Children and Families, and Uniformed Services University to improve IEH practices in IHS facilities and in our tribal communities.

## OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT

## PROGRAM DESCRIPTION

The IHS Office of Environmental Health and Engineering Support activity (OEHE) provides funds for executive management activities, personnel, contracts, contractors, and operating costs for the OEHE Headquarters. Personnel have management responsibility for IHS facilities and environmental health programs, provide direct technical services and support to Area personnel, perform management functions and have responsibility for all construction contracting in excess of $150,000.

<u>Management activities include</u>:

- national policy development and implementation
- budget formulation, project review and approval
- congressional report preparation
- quality assurance (e.g., internal control reviews, Federal Managers Financial Integrity Act activities and other oversight)
- technical assistance (e.g., consultation and training)

[4] Trends in Indian Health 2017 Edition, IHS, Division of Program Statistics

- construction contracting
- long range planning
- meetings (with HHS, Tribes, and other federal agencies)
- recruitment and retention efforts.

Typical direct support functions are:

- Project officers and contracting officer representatives for health care facilities construction projects: reviewing and/or writing technical justification documents, participating in design reviews and site surveys, conducting onsite inspections, and monitoring project funding status.
- Staff support real property asset management requirements. These actions are to ensure management accountability and the efficient and economic use of federal real property.
- Staff serving as contracting officer representatives and project officers in support of data systems, cooperative agreements, inter-agency agreements, and community-based projects.

In accordance with appropriation committee direction, OEHE staff develop, maintain, and utilize data systems to distribute Facilities Appropriation resources to Area offices for facilities and environmental health activities and construction administration and management, based upon workload and need. Also, technical guidance, information, and training are provided throughout the IHS system in support of the Facilities Appropriation.

**BUDGET REQUEST**

The FY 2024 budget submission for Facilities and Environmental Health Support of $372 million is $73 million above the FY 2023 Enacted level.

FY 2023 Base Funding of $298 million – Supports Facilities and Environmental Health Support for existing IHS and Tribal facilities.

FY 2024 Funding Increase of $73 million includes:

- Infrastructure Investment and Jobs Act (IIJA) SFC Implementation: +$49 million to support the implementation of the $3.5 billion provided by the IIJA for SFC. This funding will support additional salary, expenses, and administrative costs beyond the 3 percent allowed in the IIJA. These funds would also be available to Tribal Health Programs, unlike the 3 percent administrative set-aside in the IIJA. This additional funding is necessary to maintain existing project completion deadlines and will support IHS and Tribes in successfully implementing IIJA resources. Specific activities supported will include:
    - Hiring additional engineering staff to manage project workload and fill current vacancies;
    - Hiring additional Contracting Specialists and Contracting Officer Representatives to support expanded contracting activities;
    - Hiring additional HR specialists to recruit and retain the staff necessary to complete these projects; and
    - Purchasing additional hardware and software licenses to support the additional project load.

- General Increase ($2 million): Increase the Facilities and Environmental Health Support funding line by $2 million to support staff to oversee and implement facilities projects. It is critical that funding grow sufficiently to ensure additional Facilities investments can be implemented.

- Current Services and Staffing of New Facilities: +$23 million, described on pages CJ-33 and CJ-35.

**FUNDING HISTORY**

| Fiscal Year | Amount |
|---|---|
| 2020 | $261,983,000 |
| 2021 | $263,982,000 |
| 2022 Final | $283,124,000 |
| 2023 Enacted | $298,297,000 |
| 2024 President's Budget | $371,530,000 |

**PROGRAM ACCOMPLISHMENTS – FACILITIES SUPPORT**

Maintaining effective and efficient healthcare buildings and equipment improve the ease and access to care, facilitate successful behavioral health services, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment to deliver services. This is all integral to quality health care for AI/ANs.

The Facilities Support Account and associated staffing level directly supports to the medical equipment, maintenance and repair of, and adjustments/modifications to IHS and Tribal healthcare sites to prevent, prepare for, and respond to coronavirus/COVID-19 medical services.

In FY 2022, total utility costs were $16.8 million and total utility costs per Gross Square Feet (GSF) were $3.19/GSF. In FY 2024, the total utility cost is expected to be $18 million reflecting an 8 percent annual increase. The cost per GSF is expected to rise to approximately $3.45/GSF. IHS makes conscious efforts to help stem the growth in utility costs to ensure appropriations are sufficient to fund these needs. For example, IHS constructs new space that is at least 30 percent more energy efficient than building code requires and expects LEED Silver certification at those facilities. Additionally, IHS seeks opportunities to fund renewable energy systems at IHS and tribally owned installations. For example, a current project is installing additional solar panels at the Fort Yuma Health Care Center in Yuma, Arizona, which has the potential to make the site net zero electricity.

**PROGRAM ACCOMPLISHMENTS - ENVIRONMENTAL HEALTH SUPPORT**

Environmental Health Services (EHS) staff have been involved with all aspects and at all levels of the National COVID-19 Pandemic response and recovery. The Division of Environmental Health Services continues to collaborate with Federal partners such as, National Indian Gaming Commission, Centers for Disease Control and Prevention, Department of the Interior, and the Bureau of Indian Education by serving as Subject Matter Experts for policy and guidance on the reopening and safe operation of Tribal gaming facilities and tribal schools nationally. EHS staff remain focused on the community-based environmental health services by assisting tribal operations and businesses establish procedures to safely reopen, operate, and respond to changing COVID-19 guidance and conditions. EHS staff throughout the Indian Health Service continue serving in critical leadership positions of the COVID-19 response and recovery. For example,

many Environmental Health staff serve as Incident Commanders, Safety Officers, IHS Area Emergency Management Points-of-Contact, and Liaisons to state and local emergency management entities. EHS staff accomplishments reduce the need for direct healthcare services when environmentally related diseases and injuries are prevented. For example, the IHS Injury Prevention Program has been instrumental in reducing the injury mortality rate of AI/ANs by implementing a public health approach based upon effective strategies and initiatives to reduce the devastating burden of injuries. Preventing severe, debilitating injuries reduces the cost and need for healthcare service; however, the challenge remains that unintentional injuries are still the leading cause of death for AI/ANs ages 1-44.[5]

From 1997-2022 the TIPCAP funded 106 fulltime tribal injury prevention positions and provided over $38 million in funding. Through these efforts the IHS IPP has contributed to the 58 percent decrease in injury mortality rates since 1973 and continues to invest in preventing injuries, instead of treating the impacts of injury and violence through our health care delivery system. In FY 2022 $2.4M were awarded to 27 tribes or tribal programs across eleven IHS Areas. This funding was used to address motor vehicle related injuries, older adult falls, poisoning/opioids, suicide, traumatic brain injury, and establish new databases.

The IEH Program provides extensive technical assistance and training to safety and facility management staff as well as the many inter-related medical program and leadership staff. These efforts have led to a reduction in the IHS total occupational injury & illness case rate which has decreased from 4.35 injuries/100 employees in 2004 to 2.41 injuries & illness/100 employees in 2021.

The IEH program supports healthcare management by providing local accreditation support including mock environment of care surveys in which regulatory requirements and conditions for general safety, environmental infection control, fire safety, and chemical safety are assessed and recommendations for corrective action are provided. The IEH Program works to foster multi-disciplinary engagement amongst all levels of the organization to improve transparency and efficiency.

Staff engage Tribal, county, and state public health and public safety officials in Tribal communities. For example, staff engage local Bureau of Indian Affairs law enforcement or Tribal police to enhance motor vehicle related injury prevention efforts through child safety seat interventions and enhanced police enforcement activities such as seat belt usage or driving under the influence checkpoints. Staff work extensively with Tribal, county, and state health departments on a variety of public health issues including response to foodborne (i.e., salmonellosis), vector borne (i.e., bubonic plague, Rocky Mountain spotted fever, hantavirus), and waterborne (i.e. legionellosis) disease outbreaks. Other examples of collaboration include surveillance activities related to emerging diseases and public health emergency preparedness.

In February 2022, the Notifiable Disease and External Cause of Injury (NDECI) reporting system version 2 launched into production and, for the first time, was made available for field use. NDECI is the Division of Environmental Health Services (DEHS) internally developed disease and injury surveillance system. The original system has been in service for decades but was recently transitioned onto the business intelligence platform, “Qlik Sense.” The purpose of the upgrade was to improve access to high-quality data that will assist Environmental Health programs, at all levels of the agency, in describing the nature and extent of illnesses and injuries within their service population. In addition, with its enhanced functionality, NDECI can assist

[5] Indian Health Focus: Injuries, 2017 Edition

programs with identifying program priorities, demonstrating health disparities, developing targeted public health interventions, and strengthening applications for public health-related funding opportunities. Finally, NDECI can serve as a dashboard of key indicators to monitor public health status and assist with program evaluation.

**PROGRAM ACCOMPLISHMENTS - OFFICE OF ENVIRONMENTAL HEALTH AND ENGINEERING SUPPORT PROGRAM DESCRIPTION**

The following are activities which focus on the IHS mission and priorities:

- review and approval of Program Justification Documents (PJDs) and Program Of Requirements (PORs)
- announcement and review of Joint Venture and Small Ambulatory projects
- awarding and monitoring contracts for all aspects of the Facilities Appropriation, including all types of construction contracts and 638 construction project agreements.
- OEHE coordinating construction, environmental health, and real property activities through the 12 Area Offices to ensure program consistency, to ensure the most effective use of resources across IHS, and to support field programs through budget preparation and required reporting, thus ensuring the most effective, accountable use of resources to improve access to quality healthcare services.

OEHE strengthens the overall management of IHS by reviewing and approving the planning documents for health care facilities construction projects called PJDs and PORs. OEHE also reviews joint venture and small ambulatory projects which address assessing health care and improving health care delivery. These programs include behavioral health services. These programs include behavioral health services. The OEHE facilities programs integrate strategic planning, performance, and program integrity into the office's daily business practices. One example is the Sanitation Facilities Construction Strategic planning efforts and identification of needs. Implementation of this plan has improved project management, reduced project durations and transformed the data system used by IHS and federal partners to manage sanitation programs in Indian country. Another example is the Environmental Health program strategic visioning and the Ten Essential Environmental Health Services as a framework. Implementation of these initiatives is ongoing.

**OUTPUTS / OUTCOMES**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| EHS-5 Number of persons who received injury prevention training (Output) | FY 2022: 484 trained Target: 473 trained (Target Exceeded) | 473 trained | 473 trained | Maintain |
| EHS-6 Percent of food establishments | FY 2022: 81.5% Target: 87.5% | 87.5% | 87.5% | Maintain |

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| with Certified Food Protection Manager (CFPM) (Output) | (Target Not Met) | | | |

**Performance Discussion**

In FY 2021, a new performance cycle was established with two new measures. The EHS-5 measure is the number of persons who received injury prevention training. The EHS-6 measure is the percent of food establishments with a Certified Food Protection Manager (CFPM).

*Injury Intervention:* In FY 2022, data from the Web-based Environmental Health Reporting System (WebEHRS) was used to determine 484 people were trained in injury prevention. This measure focusses on the importance of injury prevention training in building the capacity of staff and tribes to prevent injuries and deaths due to injuries in tribal communities. It raises awareness and empowers individuals and communities. Training is also one of the components of 3Es (Education, Environmental modifications and Enforcement) that are essential in a comprehensive approach to reduce health impacts from injuries.

*Environmental Surveillance:* In FY 2022 WebEHRS data was used to determine 81.5 percent of food establishments had a CFPM present at time of inspection. Food service establishments includes restaurants and kitchens within other establishments. It is based on a Centers for Disease Control and Prevention Environmental Health Specialist-Network study that determined the presence of a CFPM reduces the risk of foodborne illness outbreaks for an establishment and was a distinguishing factor between restaurants/food services that experienced a foodborne illness outbreak and those that had not. The measure aligns with the DEHS Operational Model and Ten Essential Environmental Health Services and the data can be collected in WebEHRS. Because field staff are not able to achieve 100 percent survey completion rates for all facilities in the establishment list annually, the establishments surveyed (and therefore those that serve as data points for this metric) differ from year to year based on survey schedule. This fact may account for minor numeric fluctuation in metric results.

**GRANT AWARDS**

In FY 2022, the TIPCAP 2021-2025 five year funding cycle entered its second year in which 27 tribes or tribal programs from eleven IHS Areas we awarded a cumulative total of $2.4 million per year. This cycle of funding addresses motor vehicle related injuries, falls, and other emerging issues based on tribal needs. This includes, poisoning/opioids, suicide, and traumatic brain injury.

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $30,464 | $32,598 | $45,077 | +$12,479 |
| FTE* | -- | -- | -- | -- |

*FTE numbers reflect only Federal staff and do not include increases in Tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**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 2024 Authorization**.........................................................................................Permanent

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

**PROGRAM DESCRIPTION**

Equipment funds are used for maintenance, upgrades, replacement, and the purchase of new medical equipment systems at Indian Health Service (IHS) and Tribal healthcare facilities. It directly supports the Agency's priorities of Partnerships and Quality.

Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment/systems to assure the best possible health diagnosis. The IHS and Tribal health programs manage approximately 90,000 devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $700 million. With today's medical devices/systems having an average life expectancy of approximately six to eight years and rapid technological advancements, medical equipment replacement is a continual process making it necessary to replace worn out equipment or provide equipment with newer technology to enhance the speed and accuracy of diagnosis and treatment. To replace the equipment at the end of its six to eight-year life would require approximately $100 million per year.

Many of the IHS hospital administrators reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance with the Medicare Hospital Conditions of Participation. Further, the administrators reported that maintaining aging buildings and equipment is a major challenge. Over one third of all IHS hospitals' deficiencies have been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors.

The Facilities Program, of which the Facilities and Biomedical staffing and activities, Maintenance and Improvement funding, Medical Equipment funding, and Personnel Quarters/Housing are important elements, directly or indirectly supports:

HHS Strategic Goal 1 - Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare; Objective 1.2 - Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs; and Objective 1.5 - Bolster the health workforce to ensure delivery of quality services and care.

HHS Strategic Goal 2 - Safeguard and Improve National and Global Health Conditions and Outcomes; Objective 2.2 - Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available diagnostics, treatments, therapeutics, medical devices and vaccines; and Objective 2.4 - Mitigate the impacts of environmental factors, including climate change, on health outcomes.

HHS Strategic Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability; Objective 5.4 - Ensure the security and climate resiliency of HHS facilities, technology, data, and information, while advancing environment-friendly practices.

How the Facilities Program is implementing: In consultation with Tribes and the Federal healthcare sites, IHS is allocating funding to the IHS Area Offices to complete BEMAR projects to make renovations and improvements, replace and modernize medical equipment, and provide staff quarters necessary to support health care delivery in the health care facilities and to modernize the health care facilities to support health care delivery and expand access to quality health care services.

Equipment Funds Allocation Method

In FY 2022, the IHS Equipment funds were allocated in four categories: Tribally-constructed health care facilities, TRANSAM program, Tribal emergency generator, and new and replacement equipment:

1. Tribally-Constructed Health Care Facilities **-** The IHS provides medical equipment funds to support the initial purchase of equipment for tribally-constructed health care facilities. FY 2022 funds supported approximately $5 million for competitive awards to Tribes and Tribal organizations that construct new or expand health care facilities space using non-IHS funding sources. Tribes and Tribal organizations will use these funds to serve approximately 500,000 patients with newly purchased medical equipment.

2. TRANSAM Program **-** Equipment funds may be used to acquire new and like-new excess medical equipment from the Department of Defense (DoD) or other sources through the TRANSAM (i.e., Transfer of DoD Excess Medical and Other Supplies to Native Americans) Program and to procure ambulances for IHS and Tribal emergency medical services programs.[1] FY 2022 and FY 2023 appropriations included $500,000 for the TRANSAM Program from the Equipment budget. Under the TRANSAM Program, excess equipment and supplies, at an annual estimated value of $5 million, are acquired for distribution to federal and Tribal sites.

3. Tribal Emergency Generator **-** The IHS provides medical equipment funds to support the purchase of emergency generators at Tribally-operated health care facilities. FY 2022 funds support approximately $3 million for Tribal Health Programs located in areas impacted by de-energization events. Funding is allocated to the Tribal Health Program using the IHS ISDEAA compact/contract.

[1] The IHS Facilities appropriation allocates $500,000 of Equipment funding for the TRANSAM Program.

4. New and Replacement Equipment **-** Approximately $24.1 million allocated to IHS and Tribal health care facilities to maintain existing and purchase new medical equipment, including the replacement of existing equipment used in diagnosing illnesses. The funding allocation is formula based.

**BUDGET REQUEST**

The FY 2024 budget submission for Equipment of $45 million is $13 million above the FY 2023 Enacted level.

FY 2023 Base Funding of $32.6 million – Supports Equipment for existing IHS and Tribal facilities.

FY 2024 Funding Increase of $10 million.

- Equipment: +$10 million for maintenance and upgrades for existing medical equipment, and procurement of new medical equipment to replace units that are at the end of their useable lifecycle at IHS and Tribal healthcare facilities.

- Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment/systems to assure the best possible health diagnosis and prognosis. Many IHS hospital administrators have reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance with the Medicare Hospital Conditions of Participation.

- Today's medical devices and systems have an average life expectancy of approximately six to eight years. The average six year life cycle combined with rapid technological advancements means that medical equipment replacement is a continuous process that requires the replacement of aging equipment, and equipment that does not meet newer technological standards, to enhance the speed and accuracy of diagnosis and treatment. To replace equipment at IHS and Tribal health facilities at the end of its six-year life would require approximately $100 million per year, growing at an approximate 2 percent inflation rate per year.

- Along with aging buildings, aging equipment presents challenges for maintaining accreditation, providing high quality care and ensuring patient safety. It also affects the recruitment and retention of high quality health care professionals. Having access to modern equipment and the ability to maintain skills and training on particular devices or equipment are important factors in our providers' decisions about working for IHS.

The total $45 million funding request for FY 2024 would support:

- Approximately $37 million for new and routine replacement medical equipment to over 1,500 federally and tribally-operated healthcare facilities;

- $5 million for new medical equipment in tribally-constructed health care facilities;

- $3 million for emergency generators at Tribal Health Programs located in areas impacted

by de-energization events; and

- $500,000 for the TRANSAM program.

- Current Services: +$2.5 million, described on pages CJ-33.

**FUNDING HISTORY**

| Fiscal Year | Amount |
|---|---:|
| 2020 | $28,087,000 |
| 2021 | $29,087,000 |
| 2022 Final | $30,464,000 |
| 2023 Enacted | $32,598,000 |
| 2024 President's Budget | $45,077,000 |

**TRIBAL SHARES**

Equipment funds are subject to tribal shares and are transferred to Tribes when they assume the responsibility for operating the associated programs, functions, services, and activities at a Federal or Tribe healthcare site.

**OUTPUTS / OUTCOMES**

This program measures outcomes through its inventory of medical equipment. Maintaining and fielding modern medical equipment improve the ease and access to care, enhance the diagnostic capabilities leading to better health outcomes, and enable the hiring and retention of healthcare professionals by giving them modern space and equipment with which to deliver services.

IHS targets Equipment funding and supplements these funds with collections where available, toward equipment purchases to reduce the backlog of over-age equipment and field new, state-of-the-art equipment and systems. A few examples of these purchases include: digital x-ray systems (dental, 3D panoramic x-ray, full radiology rooms, 3D mammography, computed tomography), optometry equipment (visual field analyzers, simultaneous fundus and optical coherence tomography), lab analyzers for in-house testing, sterilization equipment, specialized microscopes, patient lifting equipment, picture archiving & communications systems (PACS), central patient monitoring systems, and ultrasound systems. This equipment will improve diagnostic capabilities, provide faster analysis, and facilitate provision of services to American Indian and Alaska Native communities.

**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 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $10,000 | $11,500 | $11,500 | -- |
| FTE* | -- | -- | -- | -- |

*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.*

*1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities..

**Authorizing Legislation** ........................................................................25 U.S.C. 13, Snyder Act; 42 U.S.C. 2001, Transfer Act; Indian Health Care Improvement Act (IHCIA), as amended 2010; Public Law 98-473, Sec. 320, as amended

**FY 2024 Authorization**.........................................................................................Permanent

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

## PROGRAM DESCRIPTION

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

The Facilities Program, of which the Facilities and Biomedical staffing and activities, Maintenance and Improvement funding, Medical Equipment funding, and Personnel Quarters/Housing are important elements, directly or indirectly supports:
HHS Strategic Goal 1 - Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare; Objective 1.2 - Reduce costs, improve quality of healthcare services, and ensure access to safe medical devices and drugs; and Objective 1.5 - Bolster the health workforce to ensure delivery of quality services and care.

HHS Strategic Goal 2 - Safeguard and Improve National and Global Health Conditions and Outcomes; Objective 2.2 - Protect individuals, families, and communities from infectious disease and non-communicable disease through equitable access to effective, innovative, readily available

diagnostics, treatments, therapeutics, medical devices and vaccines; and Objective 2.4 - Mitigate the impacts of environmental factors, including climate change, on health outcomes.

HHS Strategic Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability; Objective 5.4 - Ensure the security and climate resiliency of HHS facilities, technology, data, and information, while advancing environment-friendly practices.

How the Facilities Program is implementing: In consultation with Tribes and the Federal healthcare sites, IHS is allocating funding to the IHS Area Offices to complete BEMAR projects to make renovations and improvements, replace and modernize medical equipment, and provide staff quarters necessary to support health care delivery in the health care facilities and to modernize the health care facilities to support health care delivery and expand access to quality health care services.

**BUDGET REQUEST**

The FY 2024 budget submission for Staff Quarters of $11.5 million.

The IHS has increased the total number of quarters by about 6 percent since 2017, which is approximately 2 percent annually.  In addition, OMB Circular A-45, "Rental and Construction of Government Housing" requires agencies with employee housing to adjust rent and related charges for inflation based on the Consumer Price Index (CPI).  For 2022, the CPI adjustment is +2.6% in regions that were not resurveyed for market values/rental rates.  Regions with new market values/rental rates surveys, the new rent and utilities rates will be implemented.

As a result of the growth in the total number of quarters, and increasing rental rates, the IHS collections were approximately $10 million in FY 2022, and anticipates collections of approximately $11.5 million in FY 2023.

As a result, the FY 2024 request includes anticipated collections of $11.5 million to address potential additional growth from FY 2022 to FY 2024.

These funds support the following activities:

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

**FUNDING HISTORY**

| Fiscal Year | Amount |
|---|---:|
| 2020 | $9,100,000 |
| 2021 | $9,100,000 |
| 2022 Final | $10,000,000 |
| 2023 Enacted | $11,500,000 |
| 2024 President's Budget | $11,500,000 |

**OUTPUTS / OUTCOMES -** This program measures outcomes through the inventory of staff quarters.  Well-maintained and modern housing units are an essential element in recruiting and retaining healthcare professionals at IHS and Tribal healthcare sites. Rent collections, augmented with Maintenance & Improvement funding and collections where available, are used to maintain,

repair, and modernize existing quarters. Typically work may include painting, carpeting, new appliances, roof replacement, etc.

**GRANT AWARDS –** This program has no grant awards.

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**INDIAN HEALTH SERVICE**
**FY 2024 Performance Budget Submission to Congress**

## TABLE OF CONTENTS

### Mandatory


Page

Contract Support Costs ........................................................................................234
ISDEAA 105 *(l)* Leases ........................................................................................237
Special Diabetes Program for Indians ..............................................................240
Mandatory Narrative ............................................................................................248

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

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $880,000 | $969,000 | $1,168,000 | +$199,000 |
| FTE* | -- | -- | -- | -- |

*Contract Support Costs are not currently 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 2024 Authorization**..........................................................................................Permanent

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

**PROGRAM DESCRIPTION**

The Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, provides Tribes or Tribal Organizations (T/TO) the authority to contract with the Department of Health and Human Services, through the Indian Health Service (IHS), to operate Federal programs serving eligible persons and to receive not less than the amount of funding that the Secretary would have otherwise provided for the direct operation of the program for the period covered by the contract (otherwise known as the "Secretarial amount"). The 1988 amendments to the Act authorized Contract Support Costs (CSC) be paid in addition to the Secretarial amount. CSC supports the HHS Strategic Plan, Strategic Goal 1: Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare, Objective 1.5: Bolster the health workforce to ensure delivery of quality services and care

CSC are defined as necessary and reasonable costs for activities that T/TO must carry out to ensure compliance with the contract and prudent management but that the Secretary either did not normally carry out in his or her direct operation of the program or provided from resources other than those transferred under contract. The IHS CSC policy was established in 1992 and most recently revised on August 6, 2019, which updates from the October 2016 policy revisions,[1] an update to reflect necessary changes. These changes include the method by which Congress has funded CSC, and moves from limited to uncapped awards, and the provision of CSC to an indefinite appropriation. CSC supports the HHS Strategic Plan, Goal 5: Advance Strategic Management to Build Trust, Transparency, and Accountability, Objective 5.1: Promote effective enterprise governance to ensure programmatic goals are met equitably and transparently across all management practices and Objective 5.2: Sustain strong financial stewardship of HHS resources to foster prudent use of resources, accountability, and public trust.

[1] *Indian Health Manual*, Part 6 – Services to Tribal Governments and Organizations, Chapter 3 – Contract Support Costs, *available at* http://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p6c3.

CSC is administered for IHS by the Office of Direct Services and Contracting Tribes (ODSCT), an office with responsibility for three primary functions that directly impact the relationship with each Indian T/TO. The ODSCT serves as the primary conduit between the IHS and the Direct Service Tribes, management of P.L. 93-638 Title I, ISDEAA contracts, and CSC in support of both Title I contracts and Title V compacts.

**BUDGET REQUEST**

The FY 2024 budget submission for Contract Support Costs of $1.2 billion is $199 million above the FY 2023 Enacted level. The budget request includes a mandatory indefinite appropriation for Contract Support Costs, which would continue to fully-fund Contract Support Costs payments to Tribes using the IHS estimation methodology, which is based on historical data and is familiar to both Congress and Tribes. Reclassifying this account to mandatory funding is more appropriately aligned with these costs, which are indefinite in nature and legally mandated to be paid in full.

Contract Support Costs General Increases: +$199 million for activities that T/TO must carry out to ensure compliance with the contract and prudent management, but that the Secretary either did not normally carry out in his or her direct operation of the program or provided from resources other than those transferred under contract

The overall funding level varies with need that is adjusted to meet the actual need for each fiscal year, which means that the appropriated amount will continue to fluctuate until the CSC need is fully reconciled for each year. The requested funding level reflects IHS's best current estimate of the need.

**PROGRAM ACCOMPLISHMENTS**

- Following is a summary CSC funds for FY 2017 – FY 2022, as of February 21, 2023:

| | FY 2017 | FY 2018 | FY 2019 | FY 2020 |
|---|---|---|---|---|
| Appropriations* | $ 714,642,272 | $ 762,642,272 | $ 822,277,000 | $ 855,000,000 |
| Paid to Tribes | $ (734,958,759) | $ (773,716,215) | $ (797,256,032) | $ (893,571,032) |
| Balance* | $ (20,316,487) | $ (11,073,943) | $ 25,020,968 | $ (38,571,032) |

| | FY 2021 | FY 2022 |
|---|---|---|
| Appropriations* | $ 916,000,000 | $ 880,000,000 |
| Paid to Tribes | $ (1,043,500,378) | $ (816,943,092) |
| Balance* | $ (127,500,378) | $ 63,056,908 |

*Funds remain in process for payment to tribes and/or pending final reconciliation with tribes to determine final amounts

- IHS developed a SharePoint to track CSC requirements for COVID-19 funds. Separate data set are maintained for the period of funds availability for each Supplemental Appropriation.

- IHS Headquarters reconciles CSC fund requests on a quarterly basis and allocates funds to each Area office to pay tribes.

- IHS uses the CSC automated data system to track and monitor all CSC activity. The CSC data set is used to track all CSC funds, including any new and expanded assumption, renegotiation of CSC amounts, and distribution and payment of funds. IHS also uses the system to project

CSC need based on the most current data.

- IHS continues to use the internal electronic database to monitor each Title I and V ISDEAA negotiation, including CSC negotiations. The database monitors each phase of a negotiation to ensure that IHS uses a consistent agency business approach, meet statutory deadlines, and accurately calculate required funding amounts. In addition, the database tracks new and expanded assumptions and is used to determine the status of funds, workload, planning of resources, and subsequent years' funding needs.

- IHS continues to make progress in resolving Contract Disputes Act claims from T/TO for additional CSC funding for prior years. As of January 20, 2023, the IHS has extended settlement offers on 1,716 of the 1,861 claims, with total settlement payments of approximately $977 million that has been tentative or confirmed for payment from the Judgment Fund.

## FUNDING HISTORY

| Fiscal Year | Amount |
|---|---|
| 2019 | $822,227,000 |
| 2020 | $820,000,000 |
| 2021 | $916,000,000 |
| 2022 Final | $880,000,000 |
| 2023 Enacted | $969,000,000 |
| 2024 President's Budget | $1,168,000,000 |

## AREA ALLOCATION

**CONTRACT SUPPORT COSTS**

(dollars in thousands)

| **DISCRETIONARY SERVICES** | FY 2022 Final | | | FY 2023 Enacted /1 | | | FY 2024 Estimated /1 | | | FY '24 +/- FY '23 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Federal | Tribal | Total | Federal | Tribal | Total | Federal | Tribal | Total | Total |
| Alaska | $0 | $261,085 | $261,085 | $0 | $287,490 | $287,490 | $0 | $346,531 | $346,531 | $59,041 |
| Albuquerque | 0 | 21,772 | 21,772 | 0 | 23,974 | $23,974 | 0 | 28,898 | 28,898 | $4,924 |
| Bemidji | 0 | 46,607 | 46,607 | 0 | 51,320 | $51,320 | 0 | 61,860 | 61,860 | $10,539 |
| Billings | 0 | 16,361 | 16,361 | 0 | 18,016 | $18,016 | 0 | 21,716 | 21,716 | $3,700 |
| California | 0 | 73,286 | 73,286 | 0 | 80,698 | $80,698 | 0 | 97,271 | 97,271 | $16,573 |
| Great Plains | 0 | 8,370 | 8,370 | 0 | 9,217 | $9,217 | 0 | 11,109 | 11,109 | $1,893 |
| Nashville | 0 | 37,936 | 37,936 | 0 | 41,772 | $41,772 | 0 | 50,351 | 50,351 | $8,579 |
| Navajo | 0 | 69,477 | 69,477 | 0 | 76,504 | $76,504 | 0 | 92,215 | 92,215 | $15,711 |
| Oklahoma | 0 | 132,935 | 132,935 | 0 | 146,379 | $146,379 | 0 | 176,440 | 176,440 | $30,061 |
| Phoenix | 0 | 48,256 | 48,256 | 0 | 53,136 | $53,136 | 0 | 64,048 | 64,048 | $10,912 |
| Portland | 0 | 67,416 | 67,416 | 0 | 74,234 | $74,234 | 0 | 89,479 | 89,479 | $15,245 |
| Tucson | 0 | 27,945 | 27,945 | 0 | 30,772 | $30,772 | 0 | 37,091 | 37,091 | $6,319 |
| Headquarters | 0 | 68,554 | 68,554 | 0 | 75,487 | $75,487 | 0 | 90,990 | 90,990 | $15,503 |
| **Total, CSC** | **$0** | **$880,000** | **$880,000** | **$** | **$969,000** | **$969,000** | **$0** | **$1,168,000** | **$1,168,000** | **$199,000** |

1/ Note: 2023 and 2024 are estimates.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Section 105(*l*) Leases: 75-0200-1-551
**ISDEAA SECTION 105(*l*) LEASES**

(Dollars in Thousands)

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $150,000 | $111,000 | $153,000 | +$42,000 |
| FTE* | -- | -- | -- | -- |

* FTE numbers reflect only Federal staff and do not include increases in tribal staff.
1/ Information on Current Services and Staffing for Newly Constructed Facilities can be found on page CJ -33 for Current Services funding levels and page CJ-35 for Staffing of Newly Constructed Facilities.

**Authorizing Legislation** ........................................................................ 25 U.S.C. § 5324(*l*)
Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended

**FY 2024 Authorization**.........................................................................................Permanent

**Allocation Method** ..................................P.L. 93-638 Self-Determination Contract and Compacts,
Lease Cost Agreements

**PROGRAM DESCRIPTION**

The Indian Self-Determination and Education Assistance Act (ISDEAA), at 25 U.S.C. § 5324(*l*), also referred to as Section 105(*l*), requires the Indian Health Service (IHS) to enter a "lease" upon the request of a Tribe or Tribal Organization furnishing a tribally owned or leased facility used in support of its tribally operated ISDEAA contract or compact. IHS does not directly use or occupy the tribal facility under the lease. Through regulations contained in 25 C.F.R. Part 900, Subpart H, IHS identified elements of compensation included in a Section 105(*l*) lease.

A 2016 Federal Court's decision (Maniilaq Association v. Burwell) prohibits IHS from capping funding under Section 105(*l*) at the level that IHS would have otherwise spent to operate a facility if it were to carrying out the Federal health programs. There is no statutory or regulatory limitation on when proposals may be submitted to the IHS, so IHS is unable to reliably predict or project annual costs. Lease costs have grown exponentially, since the Maniilaq decision, and quadrupled between FY 2018 and FY 2019. Because IHS has not had sufficient dedicated funding for leases, IHS has been forced to reprogram funds twice in FY 2019 totaling $62 million and once in FY 2018 totaling $25 million. A funding increase in FY 2020 temporarily reduced the likelihood of reprogramming. This changed in FY 2021 where Congress added appropriation language essentially authorizing full funding to cover all FY 2021 105(l) lease costs. This language continued in FY 2022 and is expected to continue going forward.

The prevalence of Section 105(*l*) leases in FY 2017 was largely confined to the Alaska Area. However, by FY 2020, leases have proliferated throughout the IHS system and proposals have been received in all 12 IHS Areas.

This new, separate funding source supports IHS Strategic Plan goals and objectives for increasing access to care by establishing a dedicated funding source for these required costs and preventing

the redirection of other IHS funds intended for health care services (*Goal 1, Access, Objective 1.3, Increase access to quality health care services*).

**BUDGET REQUEST**

The FY 2024 budget submission for ISDEAA Section 105(*l*) leases of $153 million is $42 million above the FY 2023 Enacted level. The budget request includes a mandatory indefinite appropriation for ISDEAA Section 105(*l*) leases to fully-fund tribal lease payments. Reclassifying this account to mandatory funding is more appropriately aligned with these costs, which are indefinite in nature and legally mandated to be paid in full.

The overall funding level varies with need that is adjusted to meet the actual need for each fiscal year, which means that the appropriated amount will continue to fluctuate until the leases need is fully reconciled for each year. The requested funding level reflects IHS's best current estimate of the need.

**PROGRAM ACCOMPLISHMENTS**

IHS has received 596 proposals in FY 2023 to date, with a current total of $210 million. This amount is likely to increase before the end of the fiscal year.

For FY 2022, the IHS received 458 proposals for a total of $199 million. FY 2022 costs were 76.3 times higher than in FY 2017.

Based on the exponential growth of Section 105(*l*) leases from 37 proposals totaling $6 million in FY 2017, to 76 proposals totaling $21 million in FY 2018, to 189 proposals totaling $85 million in FY 2019, and 296 proposals totaling $123 million in FY 2020, costs for future years are expected to continue growing as more Tribes and Tribal Organizations submit additional proposals.

In FY 2021, the IHS received an indefinite discretionary appropriation for section 105(*l*) leases, scored at $101 million. Unlike in prior years when section 105(*l*) lease costs were paid from the IHS lump sum appropriation for the Indian Health Services account, the IHS will not have to reallocate funding from other budget lines to address unanticipated lease proposals with the indefinite discretionary appropriation.

The IHS conducted Tribal Consultation and Urban Confer in FY 2018 and again in FY 2019 on short-term and long-term options for meeting requirements of the ISDEAA related to Section 105(*l*). Tribal and Urban Indian Organization feedback strongly recommended seeking additional resources, such as through a separate indefinite appropriation, and remained critical of any redirection of existing funding, which diminishes the Indian health system's ability to provide direct health care services. At the recommendation of Tribes and Tribal Organizations, the IHS established a technical subgroup to help collect and analyze information necessary for developing cost projections. The subgroup includes representatives from the IHS Tribal Self-Governance Advisory Committee, the IHS Direct Services Tribes Advisory Committee, the IHS Facilities Appropriation Advisory Board, the IHS National Tribal Budget Formulation Workgroup (NTBFW), and subject matter experts from the IHS. This subgroup operates under the auspices of the NTBFW and their on-going work is included in the IHS's annual Tribal Consultation and Urban Confer on the budget.

In accordance with Congress's direction in the FY 2021 annual appropriation, the IHS partnered with the Department of Interior on an initial consultation regarding the development of a section 105(*l*) policy on August 27, 2021.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
**SPECIAL DIABETES PROGRAM FOR INDIANS**

*(Dollars in thousands)*

| | FY 2022 | FY 2023 | FY 2024 | |
|---|---|---|---|---|
| | Final | Enacted | President's Budget | FY 2024 +/- FY 2023 |
| PL | $147,000 | $147,000 | $250,000 | +$103,000 |
| FTE* | 111 | 111 | 111 | -- |

** FTE numbers reflect only Federal staff and do not include increases in tribal staff.*
/1 Reflects mandatory sequester of 2%.

**Authorizing Legislation** ................................................ 111 Stat. 574, 1997 Balanced Budget Act (P.L. 105-33), Consolidated Appropriation Act 2001 and amendment to Section 330C (c)(2)(c) Public Health Service Act through Senate Bill 2499 (passed the Senate 12/18/07) to extend funding through FY 2009, the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) Title III Special Diabetes Program for Indians (SDPI) to extend funding through FY 2011, the H.R. 4994 Medicare and Medicaid Extenders Act of 2010 to extend SDPI funding through FY 2013, the American Taxpayer Relief Act of 2012 (P.L. 112-240) to extend funding through FY 2014, the Protecting Access to Medicare Act of 2014 (P.L. 113-93; H.R. 4302) to extend funding through FY 2015. P.L. 114-10 – The Medicare Access and CHIP Reauthorization Act of 2015 authorized SDPI for FY 2016 and FY 2017, P.L. 115-63 — Disaster Tax Relief and Airport and Airway Extension Act authorized SDPI for the first quarter of FY 2018, and P.L. 115-96— Department of Homeland Security Blue Campaign Authorization Act of 2017 authorized SDPI for the second quarter of FY 2018, P.L. 115-123 – Bipartisan Budget Act of 2018 authorized SDPI for the rest of FY 2018 and all of FY 2019, the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019 (P.L. 116-59) authorized SDPI through November 21, 2019, the Further Continuing Appropriations Act, 2020, and Further Health Extenders Act of 2019 (P.L. 116-69) authorized SDPI through December 20, 2019. SDPI was authorized through May 22, 2020 through the Further Consolidated Appropriations Act, 2020 (P.L. 116-94). The Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-36) authorized SDPI through November 30, 2020. The Continuing Appropriations Act, 2021 and Other Extensions Act (P.L. 116-159) authorized SDPI through December 11, 2020. The Further Continuing Appropriations Act, 2021, and Other Extensions Act (P.L. 116-215) authorized SDPI through December 18, 2020. The Consolidated Appropriations Act, 2021 (P.L. 116-260) authorized SDPI until September 30, 2023.

**FY 2024 Authorization**....................................................................... Expires September 30, 2023

**Allocation Method** ........................................................................................ Grants and Contracts

**PROGRAM DESCRIPTION**

The Special Diabetes Program for Indians (SDPI) grant program provides funding for diabetes treatment and prevention to 302 Indian Health Service (IHS), Tribal, and Urban (I/T/U) Indian health grant programs. Funds for SDPI were first authorized in FY 1998; as such, FY 2024 would be the 27th year of the SDPI. SDPI is currently authorized through September 30, 2023. The IHS Office of Clinical and Preventive Services (OCPS) Division of Diabetes Treatment and Prevention (DDTP) provides leadership, programmatic, administrative, and technical oversight to the SDPI grant program.

The mission of the DDTP is to develop, document, and sustain public health efforts to prevent and control diabetes in American Indians and Alaska Natives (AI/ANs) by promoting collaborative strategies through its extensive diabetes network. This mission aligns with *Goal 1 of the IHS Strategic Plan, To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to American Indian and Alaska Native people and Objective 2.2 of the HHS Strategic Plan, Provide care to better meet the health care needs of American Indian and Alaska Native communities*. The diabetes network consists of a national program office, Area Diabetes Consultants in each of the 12 IHS Areas, and 302 SDPI grants at I/T/U sites across the country.

**Target Population: American Indians and Alaska Natives**

Diabetes and its complications are major contributors to death and disability in nearly every Tribal community. AI/AN adults have the highest age-adjusted rate of diagnosed diabetes (14.5 percent) among all racial and ethnic groups in the United States, more than twice the rate of the non-Hispanic white population (7.4 percent).[1] In some AI/AN communities, more than half of adults 45 to 74 years of age have diagnosed diabetes, with prevalence rates reaching as high as 60 percent.[2]

**Allocation Method**

In the Balanced Budget Act of 1997, Congress instructed the IHS to use SDPI funds to "establish grants for the prevention and treatment of diabetes" to address the growing problem of diabetes among AI/AN people. The entities eligible to receive these grants were I/T/Us. The IHS distributes this funding to 302 I/T/U sites annually through a process that includes Tribal Consultation/Urban Confer, development of a formula for distribution of funds, and a formal grant application and administrative process. *This process supports Objective 5.1 of the HHS Strategic Plan to ensure responsible financial management.*

**Strategy**

The SDPI brings Tribes together to work toward a common purpose and share information and lessons learned. The Tribal Leaders Diabetes Committee, established in 1998, reviews information on the SDPI progress and provides recommendations on diabetes-related issues to the IHS Director. Through partnerships with federal agencies, private organizations, and an extensive I/T/U network, DDTP undertook one of the most strategic diabetes treatment and prevention efforts ever attempted in AI/AN communities and demonstrated the ability to design, manage, and measure a complex, long-term project to address this chronic condition. Because of the significant costs associated with treating diabetes, I/T/Us have used best and promising practices for their local SDPI funding to address the primary, secondary, and tertiary prevention of diabetes and its complications. *These efforts increase the availability and accessibility of*

[1] Centers for Disease Control and Prevention. National Diabetes Statistics Report website. https://www.cdc.gov/diabetes/data/statistics-report/index.html. Accessed 3/17/2022.
[2] Lee ET, Howard BV, Savage PJ, et al. Diabetes and impaired glucose tolerance in three American Indian populations aged 45-74 years: the Strong Heart Study. *Diabetes Care*. 1995;18:599-610.

*comprehensive, culturally appropriate personal and public health services to AI/AN people, which supports Objective 1.3 of the HHS Strategic Plan.*

This collaborative approach supports the strategic planning process necessary to identify the goals and objectives needed to achieve the intended SDPI outcomes.

## BUDGET REQUEST

The FY 2024 budget submission for the Special Diabetes Program for Indians is $250 million which is $103 million above the FY 2023 Enacted level. The budget includes a legislative proposal to reauthorize the SDPI for three-years at the following funding levels: $250 million in FY 2024, $260 million in FY 2025, and $270 million in FY 2026. The proposal would also exempt the program from sequestration. Increased funding will allow the program to serve additional grantees, and will enable current grantees to more effectively conduct long-term program planning.

The SDPI is currently authorized at $150 million annually through September 30, 2023, under the Consolidated Appropriations Act, 2021. The FY 2023 funding level of $147 million reflects mandatory sequester of two percent.

## PROGRAM ACCOMPLISHMENTS

### SDPI: Two Major Components

As directed by Congress and Tribal consultation, the SDPI consists of two major components: (1) SDPI Grant Program; and (2) Diabetes data and program delivery infrastructure.

1. <u>SDPI Grant Program</u>

The SDPI grant program (formerly called the SDPI Community-Directed grant program) provides $138.7 million per year in grants and technical assistance for local diabetes treatment and prevention services at I/T/U health programs in 35 states. Each of the communities served by the SDPI grant program is unique in that its diabetes treatment and prevention needs and priorities are defined locally. Based on these local needs and priorities, the SDPI grant programs implement interventions to address the diabetes epidemic.

The Consolidated Appropriations Act of 2001 established statutory authority for SDPI to implement a best practices approach to diabetes treatment and prevention. As such, the SDPI has incorporated Indian Health Diabetes Best Practices into the SDPI grant application process used throughout AI/AN communities. Grant programs are required to document the use of one SDPI Diabetes Best Practice,[3] corresponding evaluation measures, and progress in achieving program objectives in order to enhance accountability. Grantees receive training on how to collect, evaluate, and improve their data collection and use it to improve their outcome results.

[3] *Available at* https://www.ihs.gov/sdpi/sdpi-community-directed/diabetes-best-practices/

***Impact of the SDPI Grant Programs***

SDPI funding has enabled staff and programs at the local and national levels to increase access to diabetes treatment and prevention services throughout the Indian health system. The following table demonstrates substantial increases in access to many activities and services:

| **Diabetes treatment and prevention services available to AI/AN individuals** | **Access in 1997** | **Access in 2019** | **Absolute Percentage increase** |
|---|---|---|---|
| Diabetes clinical teams | 30% | 95% | +65% |
| Diabetes patient registries | 34% | 96% | +62% |
| Nutrition services for adults | 39% | 94% | +55% |
| Access to registered dietitians | 37% | 85% | +48% |
| Culturally tailored diabetes education materials | 36% | 96% | +60% |
| Access to physical activity specialists | 8% | 84% | +76% |
| Adult weight management services | 19% | 76% | +57% |

*Clinical Diabetes Outcomes during SDPI*

At the same time that access to these diabetes services increased, key outcome measures for AI/ANs with diabetes showed improvement or maintenance at or near national targets. These results have been sustained throughout the inception of SDPI. Examples include:

- *Improving Blood Sugar Control*
  Blood sugar control among AI/ANs with diabetes served by the IHS has improved over time. The average blood sugar level (as measured by the A1C test) decreased from 9.0 percent in 1996 to 8.1 percent in 2022, nearing the A1C goal for most patients of less than 8 percent.
- *Improving Blood Lipid Levels*
  Average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 88 mg/dL in 2022, surpassing the goal of less than 100 mg/dL.
- *Reducing Kidney Failure*
  The rate of new cases of kidney failure due to diabetes leading to dialysis declined by more than half (54 percent) in AI/AN people from 1996 to 2013. This is a much larger decline than in any other racial group in the US.[4]

2. <u>Diabetes Data and Program Delivery Infrastructure</u>

The IHS has used funding from the SDPI to strengthen the diabetes data infrastructure of the Indian health system by improving diabetes surveillance and evaluation capabilities. The SDPI supports the development and implementation of the IHS Electronic Health Record, and the IHS Diabetes Management System in all 12 IHS Areas.

[4] Bullock A, Burrows NR, Narva AS, et al. Vital Signs: Decrease in Incidence of Diabetes-Related End-Stage Renal Disease among American Indians/Alaska Natives — United States, 1996–2013. MMWR Morb Mortal Wkly Rep 2017;66:26-32. DOI: http://dx.doi.org/10.15585/mmwr.mm6601e1.

Facilities associated with SDPI programs participate in the annual IHS Diabetes Care and Outcomes Audit. The Diabetes Audit is the cornerstone of the IHS DDTP diabetes care surveillance system, tracking annual performance on diabetes care and health outcome measures. Data collection for the Diabetes Audit follows a standardized protocol to ensure statistical integrity and comparability of measures over time. The 2022 Diabetes Audit included a review of 134,070 patient charts at 313 I/T/U health facilities. The Diabetes Audit enables IHS and the SDPI programs to monitor and evaluate yearly performance at the local, regional, and national levels, as well as enhance quality improvement capabilities across AI/AN communities. DDTP provides Diabetes Audit training through online and webinar formats. DDTP receives evaluations on all trainings provided to guide improvements for future sessions.

**Key Performance/Accomplishments**

Annual SDPI assessments have shown significant improvements in the availability of diabetes clinical care and community services provided over time when compared to the baseline SDPI assessment in 1997 (see table above titled "Diabetes treatment and prevention services available to AI/AN individuals").

Ongoing efforts to improve blood glucose, blood pressure, and cholesterol values will continue to reduce the risk for microvascular, as well as macrovascular complications (see "Outputs/Outcomes" table below).

**Reporting**

In addition to internal monitoring of the SDPI Grant Program, the DDTP has completed six SDPI Reports to Congress to document the progress made since 1997. The SDPI Reports to Congress are as follows:

- January 2000 Interim Report to Congress on SDPI;
- December 2004 Interim Report to Congress on SDPI;
- 2007 SDPI Report to Congress: On the Path To A Healthier Future;
- 2011 SDPI Report to Congress: Making Progress Toward A Healthier Future;
- 2014 SDPI Report to Congress: Changing the Course of Diabetes: Turning Hope into Reality; and
- 2020 SDPI Report to Congress: Changing the Course of Diabetes: Charting Remarkable Progress.

Following Tribal consultation, beginning in FY 2016, SDPI funding has been distributed as follows:

## Special Diabetes Program for Indians – Total Yearly Costs

| **CATEGORY** | Percentage of the total | (Dollars in Millions) |
|---|---|---|
| SDPI Grant Programs (272 Tribal and IHS grants, sub-grants, and technical assistance in FY 2020). | **88.6%** | **$130.2** |
| Administration of SDPI grants (includes program support funds to IHS Areas, Tribal Leaders Diabetes Committee, DDTP, Grants Management, evaluation support contracts, etc.) | **2.1%** | **$3.1** |
| Urban Indian Health Program SDPI Grant Programs ($8.5M allocated to 29 grants and technical assistance in FY 2020) | **5.8%** | **$8.5** |

| Funds to strengthen the Data Infrastructure of IHS | **3.5%** | **$5.2** |
|---|---|---|
| **TOTAL:** | **100%** | **$147.0** |

**OUTPUTS / OUTCOMES**

| Measure | Year and Most Recent Result / Target for Recent Result / (Summary of Result) | FY 2023 Target | FY 2024 Target | FY 2024 Target +/-FY 2023 Target |
|---|---|---|---|---|
| 53 Controlled BP <140/90 (Outcome) | FY 2022: 53.0 % Target: 57.0 % (Target Not Met but Improved) | 52.4% | 52.4% | Maintain |
| 54 Statin Therapy to Reduce Cardiovascular Disease Risk in Patients with Diabetes (Intermediate Outcome) | FY 2022: 58.5 % Target: 56.8 % (Target Exceeded) | 54.5% | 54.5% | Maintain |
| 86 Reduce the proportion of American Indians/Alaska Natives with diagnosed diabetes who have poor glycemic control (A1c >9%). (Outcome)[1] | FY 2022: 14.6 % Target: 15.6 % (Target Exceeded) | 14.4% | 14.4% | Maintain |

1. The decrease shows improvement in percentage of AI/AN diagnosed with poor glycemic control.

**GRANTS AWARDS**

The SDPI provides grants for diabetes treatment and prevention services to I/T/U health programs in 35 states. The SDPI grant programs provide local diabetes treatment and prevention services based on community needs.

| *(whole dollars)* | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget |
|---|---|---|---|
| Number of Awards | 302 | 302 | 302 |
| Average Award | $452,011 | $459,367 | $459,367 |
| Range of Awards | $25,000 - $7,553,570 | $22,500 - $7,553,570 | $25,000 - $7,553,570 |

## FY 2024 State/Formula Grants

CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2023 Annual Financial Assistance Awards[5]

| State | State Name | FY 23 Total # Grant Programs | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget |
|---|---|---|---|---|---|
| AK | Alaska | 20 | 10,191,326 | $10,191,326 | $10,191,326 |
| AL | Alabama | 1 | 279,211 | 279,211 | 279,211 |
| AZ | Arizona | 28 | 28,915,564 | 35,522,502 | 35,522,502 |
| CA | California | 36 | 9,720,825 | 9,670,825 | 9,670,825 |
| CO | Colorado | 3 | 903,625 | 903,625 | 903,625 |
| CT | Connecticut | 2 | 232,777 | 232,777 | 232,777 |
| FL | Florida | 2 | 486,980 | 486,980 | 486,980 |
| IA | Iowa | 1 | 304,592 | 304,592 | 304,592 |
| ID | Idaho | 4 | 935,841 | 935,841 | 935,841 |
| IL | Illinois | 1 | 281,832 | 281,832 | 281,832 |
| KS | Kansas | 5 | 937,919 | 937,919 | 937,919 |
| LA | Louisiana | 4 | 364,530 | 364,530 | 364,530 |
| MA | Massachusetts | 2 | 168,316 | 168,316 | 168,316 |
| ME | Maine | 5 | 543,580 | 543,580 | 543,580 |
| MI | Michigan | 12 | 2,363,824 | 2,363,824 | 2,363,824 |
| MN | Minnesota | 9 | 3,274,552 | 3,378,922 | 3,378,922 |
| MS | Mississippi | 1 | 1,256,112 | 1,256,112 | 1,256,112 |
| MT | Montana | 13 | 5,564,865 | 6,869,529 | 6,869,529 |
| NE | Nebraska | 5 | 1,931,172 | 1,931,172 | 1,931,172 |
| NV | Nevada | 12 | 5,203,730 | 4,649,823 | 4,649,823 |
| NM | New Mexico | 24 | 12,613,849 | 7,693,403 | 7,693,403 |
| NY | New York | 6 | 1,264,077 | 1,481,491 | 1,481,491 |
| NC | North Carolina | 1 | 1,351,228 | 1,351,228 | 1,351,228 |
| ND | North Dakota | 5 | 3,168,173 | 3,168,173 | 3,168,173 |
| OK | Oklahoma | 26 | 23,460,585 | 23,396,634 | 23,396,634 |
| OR | Oregon | 9 | 1,832,727 | 1,832,727 | 1,832,727 |
| RI | Rhode Island | 1 | 113,475 | 113,475 | 113,475 |
| SC | South Carolina | 1 | 163,399 | 163,399 | 163,399 |
| SD | South Dakota | 10 | 6,014,743 | 6,294,326 | 6,294,326 |
| TX | Texas | 4 | 784,901 | 784,901 | 784,901 |
| UT | Utah | 5 | 2,051,292 | 2,031,434 | 2,031,434 |
| VA | Virginia | 4 | 0 | 417,983 | 417,983 |
| WA | Washington | 26 | 4,792,337 | 4,272,980 | 4,272,980 |

[5] Please note that the numbers provided for FY 2024 are likely to change due to the start of the new SDPI grant cycle.

| CFDA No. 92.237 / Special Diabetes Program for Indians Grant Programs by State and FY 2023 Annual Financial Assistance Awards[5] | | | | | |
|---|---|---|---|---|---|
| State | State Name | FY 23 Total # Grant Programs | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget |
| WI | Wisconsin | 12 | 3,421,213 | 3,421,213 | 3,421,213 |
| WY | Wyoming | 2 | 1,032,196 | 1,032,196 | 1,032,196 |
| | **Total States** | **302** | $136,055,369 | $136,055,369 | $136,055,369 |
| | **Indian Tribes** | **256** | $113,985,031 | $113,985,031 | $113,985,031 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
**MANDATORY FORMULA**

## SUMMARY OF THE BUDGET REQUEST

Beginning in FY 2024, the budget proposes mandatory funding for Contract Support Costs and section 105(l) Leases. Beginning in FY 2025, the budget proposes full mandatory funding for all of IHS, and exempts IHS funding from sequestration. The enactment of a mandatory funding formula will take critical steps towards:

1. Securing adequate, stable and predictable funding to improve the overall health status of AI/ANs;

2. Improving access to high quality health care through strategic investments; and

3. Addressing shortfalls that have resulted from chronic underfunding.

This mandatory formula culminates in a total funding level of approximately $44 billion in FY 2033. In total, the mandatory formula would provide approximately $288 billion for the IHS over ten-years. When accounting for the discretionary baseline, the net-total for the proposal is $192 billion over ten-years.

The IHS recognizes that we must continue to work in consultation with Tribes and confer with urban Indian organizations, and with our partners in Congress. To this end, a joint OMB and HHS tribal consultation and urban confer will be conducted to review this proposal and receive feedback to inform further refinements to the mandatory formula structure shortly after the release of the FY 2024 President's Budget.

Formula components include:

- **Inflationary growth:** The budget accounts for inflationary and population growth across IHS funding accounts. Population growth is estimated at 1.8% percent in FY 2024. This includes current services funding, which consists of pay costs, medical and non-medical inflation, and population growth. Under the mandatory proposal, current services will be fully funded each fiscal year.

  For the Services account, the proposal applies the current CPI-U medical inflation factor each year (currently estimated at 4 percent in FY 2025 and 3.9 percent in FY 2026-2033) to the entire Services account base from the prior year, and then adds any other programmatic and policy increases on top of the inflated base.

  For the Facilities account, the proposal applies the current CPI-U inflation factor each year (currently estimated at 2.3 percent from FY 2025-FY 2033) to the entire Facilities account base from the prior year, and then adds any other programmatic and policy increases on top of the inflated base.

- **Staffing of Newly Constructed Facilities:** The FY 2024 President's Budget fully funds staffing and operating costs for newly opening facilities every year for 10 years. These estimates are based on the existing methodology for calculating staffing and operating

costs associated with such facilities, and will be updated annually through the budget formulation process. Under the mandatory proposal, staffing of newly constructed facilities will be fully funded each fiscal year.

- **Level of Need Funded Gap:** Over five years, from FY 2025 to FY 2029, the budget addresses the funding gap for direct healthcare services documented in the FY 2018 level of need funded analysis. The level of need gap analysis calculated $11.2 billion as the point in time estimated funding shortfall identified for a baseline of health services in FY 2018. At that time, the overall funds needed were determined to be $16.203 billion. In FY 2018, the IHS received $4.9 billion in resources for direct health care services, which leaves a funding deficiency of $11.2 billion. The Budget grows the funding deficiency of 11.2 billion by CPI-U medical for a revised funding deficiency total of $11.7 billion, which is addressed in five years. From FY 2030-FY 2033, the budget provides additional funding to address any additional needs. This funding would be distributed using the Indian Health Care Improvement Fund (IHCIF) formula. The formula is used to target IHCIF appropriations to the sites with the greatest need, as compared to the benchmark of National Health Expenditure Data, which is maintained by CMS. The formula is the product of longstanding consultation with Tribes. The IHS uses the Level of Need Funded percentage to allocate IHCIF appropriations increases to IHS and Tribal facilities. The methodology allocates funds to sites with the lowest Level of Need Funded percentages.

- **Electronic Health Record:** The budget fully-funds the IHS Electronic Health Record modernization effort from FY 2024-FY 2029. In FY 2024, the budget provides $913 million in discretionary funding for EHR modernization. The budget then builds funding for EHR by +$1.1 billion each year from FY 2025-FY 2029. Once the EHR modernization effort is complete, the budget ensures sufficient recurring funding is maintained for ongoing maintenance of the new system.

- **Public Health Capacity Building:** The budget authorizes and appropriates funding for a new public health infrastructure and capacity building funding stream under the formula. This includes $150 million in the first year, and would grow for inflation in the outyears under the formula, for a total of $500 million over nine-years. Funding would enable IHS to implement a public health infrastructure system for IHS, Tribal, and urban Indian health programs, which is a key lesson learned from the pandemic and a top priority of tribal leaders. Additional resources are necessary to develop appropriate public health and emergency preparedness capacity in AI/AN communities to prevent these disproportionate impacts in the future. Tribes do not receive dedicated public health funding from CDC, and the IHS does not currently have substantial funding to support ongoing public health and emergency preparedness infrastructure. Specifically, most tribes do not currently have well established public health systems – as of 2021, only four tribal public health agencies are accredited through the Public Health Accreditation Board. Comparatively, 40 State and 305 local public health agencies were accredited as of 2021.[1] The proposal complements the budget's proposed investments in public health readiness and pandemic preparedness by ensuring IHS and Tribal communities have comparable resources to prepare for the next pandemic.

[1] https://health.gov/healthypeople/objectives-and-data/browse-objectives/public-health-infrastructure/increase-number-tribal-public-health-agencies-are-accredited-phi-03/data

- **One Time Base Increase:** The budget increases funding for the Services account for select priority items. These activities will grow by the inflationary factors mentioned above and continue to stay in the base as one-time dedicated funding increases:

    - ***COVID-19 Recovery:*** +$130 million to support IHS patients in recovery from the long-lasting effects of the COVID-19 pandemic, including treatment for long haul COVID-19. Based on data from 14 states, age-adjusted COVID-19 associated mortality among AI/AN was 1.8 times that of non-Hispanic Whites. In 23 states with adequate race and ethnicity data, the cumulative incidence of laboratory-confirmed COVID-19 among AI/AN was 3.5 times that of non-Hispanic Whites. In the state of Montana, COVID-19 incidence and mortality rates among AI/AN were 2.2 and 3.8 times those among White persons, respectively.

    - ***Sustaining American Rescue Plan Act Investments:*** +$220 million to partially sustain the American Rescue Plan Act (ARPA) investments that were provided to expand access to mental health and substance abuse prevention and treatment services, and to expand the public health workforce in Indian Country. ARPA funds were provided on a one-time basis. The additional resources included in the budget will prevent a sharp reduction in services as one-time ARPA funds are exhausted.

- **Health Care Facilities Construction:** The budget provides an additional $10.3 billion over ten years to fully-fund the 1993 Priority List over the first 5-years. After the 1993 Priority List is eliminated in 2030, funding begins to address other remaining needs, starting in 2031. IHS hospitals are approximately 40 years old on average, which is almost four times the age of the average hospital in the United States. Infrastructure deficiencies directly contribute to poorer health outcomes for AI/AN. This investment proposes a holistic approach to addressing infrastructure needs by going beyond the 1993 Priority List.

- **Sanitation Facilities Construction:** Beginning in FY 2027, Budget provides an additional $250 million to address operation and maintenance costs related to the completion of the Sanitation Deficiencies System backlog with Infrastructure Investment and Jobs Act (IIJA) resources. FY 2027 is the first year IHS will not receive Infrastructure Investment and Jobs Act (IIJA) resources.

- **Maintenance and Improvement:** The budget provides an additional +$511 million in each of FYs 2025 and 2026 to fully fund the 2022 Backlog of Essential Maintenance, Alteration, and Repair for IHS and Tribal facilities of $1.02 billion. Beginning in FY 2027, the budget maintains sufficient outyear recurring funding to address future maintenance backlogs.

- **Equipment:** The budget provides an additional +$227 million in each of FYs 2025 and 2026 to fully fund the medical equipment backlog. Beginning in FY 2027, the budget maintains sufficient outyear recurring funding to address future equipment needs.

- **Facilities and Environmental Health Support:** The budget increases the Facilities and Environmental Health Support funding line at 13 percent of the rate of growth in Sanitation Facilities Construction and 5 percent of the rate of growth in Health Care

Facilities Construction, consistent with historical funding needs and IHS' current estimation methodology. This funding supports staff to oversee and implement facilities projects, as well as a comprehensive environmental health program within IHS. Within this increase, the IHS will utilize $10 million in to support a nation-wide analysis to understand the cost implications of implementing 25 US.C. 1632 of the Indian Health Care Improvement Act, which authorizes funding for operations and maintenance costs for tribes who choose to directly compete their own SFC projects. The results of this analysis will be utilized and implemented as part of the updated mandatory formula structure. These funds would be used by tribes to ensure that existing SFC projects are reaching their maximum life-cycle and operations of these projects are sustainable for as long as possible.

- **Direct Operations:** The budget grows Direct Operations by 25% each year to ensure there are sufficient resources to implement these large-scale activities. This funding level ensures adequate administrative and oversight capacity by enhancing core management functions, patient safety and quality initiatives, and implementation of GAO and OIG recommendations. This approach also ensures IHS' administrative funding would continue to grow commensurate with overall budget growth. Funds are eligible to be administered through tribal shares.

- **New Tribes:** The budget fully-funds the cost of providing health care to newly federally-recognized tribes (estimated $1 million per year). Costs would be evaluated and adjusted consistent with IHS' standard methodology for determining funding estimates for new tribes.

- **Contract Support Costs and Section 105*(l)* Leases:** The budget fully funds Contract Support Costs and Section 105*(l)* Leases by maintaining an indefinite mandatory appropriation for both of these programs. Over ten-years, funding for Contract Support Costs culminates to a total of $19.0 billion and funding for Section 105(l) Leases totals $1.8 billion.

Mandatory Budget Ten-Year Table

*(dollars in millions)*

| | 2024/ 1 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | 2033 | 2024-2033 Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Services and Facilities Accounts** | -- | 14,387 | 19,796 | 24,235 | 29,282 | 34,528 | 31,535 | 34,617 | 37,805 | 41,111 | 267,296 |
| **Contract Support Costs** | 1,168 | 1,340 | 1,498 | 1,652 | 1,806 | 1,961 | 2,118 | 2,291 | 2,481 | 2,691 | 19,005 |
| **Section 105(l) Leases** | 153 | 159 | 165 | 170 | 175 | 180 | 185 | 190 | 195 | 201 | 1,772 |
| **Mandatory Request , Total /2** | -1,321 | 15,886 | 21,458 | 26,057 | 31,263 | 36,668 | 33,838 | 37,098 | 40,481 | 44,002 | 288,073 |
| **Estimated Discretionary Baseline /3** | -1,321 | -9,617 | -9,838 | -10,065 | -10,297 | -10,534 | -10,776 | -11,024 | -11,277 | -11,535 | -96,284 |
| **Net Cost, Mandatory Proposal** | **--** | **6,269** | **11,620** | **15,992** | **20,966** | **26,134** | **23,062** | **26,074** | **29,204** | **32,467** | **191,789** |

1/ The Budget requests discretionary resources for Services and Facilities and mandatory resources for CSC and Leases in 2024. All accounts will be mandatory starting in 2025.

2/ This table excludes funding for the Special Diabetes Program for Indians.

3/ Reflects estimated baseline discretionary spending if IHS were to remain discretionary. This figure is used to calculate the net-cost of the mandatory funding proposal, and does not represent a reduction in funding for the IHS budget.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**INDIAN HEALTH SERVICE**
**FY 2024 Performance Budget Submission to Congress**

## TABLE OF CONTENTS

### Drug Budget


Page

Drug Control Programs.......................................................................................253

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
Drug Control Budget
FY 2024

| Budget Authority (in Millions) | | | |
|---|---|---|---|
| | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget |
| Drug Resources by Function[1] | | | |
| Prevention | 34.613 | 34.816 | 37.325 |
| Treatment | 103.359 | 104.070 | 105.031 |
| Total Drug Resources by Function | $137.972 | $138.886 | $142.356 |
| Drug Resources by Decision Unit | | | |
| Alcohol and Substance Abuse[1] | 134.350 | 135.793 | 139.263 |
| Urban Indian Health Program | 3.622 | 3.093 | 3.093 |
| Total Drug Resources by Decision Unit | $137,972 | $138.886 | $142.356 |
| Drug Resources Personnel Summary | | | |
| Total FTEs (direct only) | 171 | 171 | 171 |
| Drug Resources as a Percent of Budget | | | |
| Agency Budget | $ 6,601.598 | $ 6,958.223 | $ 8,079.000 |
| Drug Resources Percentage | 2.08% | 1.99% | 1.76% |

[1] Adult Treatment funds are excluded from the ONDCP Drug Control Budget and Moyer Anti-Drug Abuse methodologies because this program reflects the original authorized program for IHS with the sole focus of alcoholism treatment services for adults. This determination was made in consultation with ONDCP when the drug control budget was initially developed in the early - 1990s.

## 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 Indian and Alaska Native (AI/AN) people. IHS supports alcohol and substance abuse disorder prevention and treatment 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 funds that

partially come from the National Institute on Alcohol Abuse and Alcoholism programs transferred to the IHS under the Urban Indian Health budget.

**BUDGET SUMMARY**

In FY 2024, IHS requests $309, which is an increase of $42 million over the FY 2023 Enacted level.

**Alcohol and Substance Abuse**
**FY 2024 Request: $309 million**

In FY 2024, the IHS budget request for its drug control activities supports the Office of National Drug Control and Policy (ONDCP) funding priorities as well as the ONDCP *Strategy*. The *Strategy* emphasizes the partnership between Federal agencies and their state, local, Tribal, and international counterparts and reduce drug-induced mortality. IHS is also working with Federal partners to implement ONDCP's efforts to address the current crisis.

The Administration's ONDCP *Strategy* guides and expands Federal government efforts to: 1) expand access to evidence-based treatment ; 2) advancing racial equity issues in our approach to drug policy; 3) enhancing evidence-based harm reduction efforts; 4) supporting evidence-based prevention efforts to reduce youth substance use; 5) reducing the supply of illicit substances; 6) advancing recovery-ready workplaces and expanding the addiction workforce; and, 7) expanding access to recovery support services. The *Strategy* offers a valuable opportunity for IHS to advance its mission by strengthening existing programs to control and reduce substance use and eliminate its deleterious effects on the health and safety of AI/AN patients and communities.

The IHS Alcohol and Substance Abuse program serves AI/ANs impacted by substance use disorders through IHS, Tribal, and Urban Indian operated treatment and prevention programs and Youth Regional Treatment Centers (YRTCs).

The IHS established a multi-disciplinary workgroup to form the IHS National Committee on Heroin, Opioids, and Pain Efforts (HOPE). The HOPE Committee is comprised of a multidisciplinary membership to include clinical representation from family medicine, pharmacy, behavioral health, nursing, pediatrics, rehabilitation therapy, epidemiology, and injury prevention. The HOPE Committee work plan supports the HHS Opioid Overdose Prevention Strategy with a specific focus on: 1) better pain management; 2) improving access to culturally relevant prevention, treatment, and recovery support services; 3) increasing availability of harm reduction services; and, 4) improved public health data reporting and surveillance.

The IHS Division of Behavioral Health administers community-based grants that promote the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to substance misuse from a community-driven context.

<u>Expanding Access to Evidence-Based Treatment:</u>

*Increasing Access to Medications for Opioid Use Disorder*: In June 2019, IHS released the Special General Memorandum *Assuring Access to MAT* that requires federal IHS facilities create an action plan to identify or create local medication-assisted treatment resources and coordinate

patient access to these services when indicated.[1] Key components of these approaches include enhanced screening and early identification of opioid use disorders; improved care coordination and patient referral for treatment; and workforce development strategies to increase education and resources surrounding using medications in the support of recovery. In addition, the IHS created workforce development strategies that include SUD training for healthcare workers and technical assistance materials to support sites with creating integrated SUD approaches to care. The IHS continues to provide additional technical assistance through enhanced collaboration with the National Clinical Consultation Center Substance Use Disorder warmline that provides on-demand clinical consultation and assistance with site-level systems-based improvements.

The IHS also supports enhanced team-based care approaches. In 2021, the IHS launched the Advancing Pharmacist Roles in Substance Use Disorder Treatment and Recovery Teams ECHO. Participants increase knowledge surrounding patient screening, assessments, evidence-based practices for the management of Opioid Use Disorders, and trauma-informed care principles. A total of 307 continuing education credits have been issued in the first six months of the program. This project is also exploring methods to expand tele- Medications for Opioid Use Disorder (MOUD) services using hub-and-spoke models. Additionally, the IHS has established an Academic Detailing Service pilot project in one IHS Area. Two IHS sites were selected to create tailored peer-to-peer interventions to support opioid stewardship activities, increase access to treatment services, and promote quality of care. Sample action plans and evaluation strategies are being developed to share with other IHS regions and programs and Federal partners.

The IHS does face challenges in providing MAT in certain sectors within Indian Country. The rural and frontier nature of where AI/ANs live creates barriers to accessing health facilities. This is especially evident in Alaska where patients often have only access to a community health aide serving within a village-based clinic, and live hours away by plane from a larger health center. Additionally, IHS has felt the impact of a declining supply of specific health professionals who could support the IHS workforce and address behavioral health needs. The IHS recognizes that telemedicine is one tool for increasing access to specialized medical services, such as MAT. The IHS has published a policy in the Indian Health Manual (Chapter 38) entitled *Internet Eligible Controlled Substance Prescriber Designation* to assure access to MAT using telemedicine models for remotely located Tribal members.[2] In December 2019, the IHS processed the first tribal clinician application to receive this designation. In 2020, the IHS developed and released a tele-MOUD toolkit to assist sites with creating and supporting tele-MOUD services.

The IHS has also established pilot programs and tailored strategies for acute services and special populations. In 2021, the IHS Pain and Addiction Care in the Emergency Department pilot program intervention funded six projects in direct-service Emergency Departments. The objective of this intervention is to improve access to MOUD or improve pain management outcomes in acute care settings. Secondary objectives include leveraging the opioid surveillance dashboard to inform stewardship activities, to create a learning collaborative to share promising practices, and to assist sites with obtaining relevant accreditation. The IHS has also collaborated to produce a cultural adaptation of best practices for Plans of Safe Care/Family Wellness Plans for pregnant persons who use substances. This cooperative project shares best practices for providers and sample patient resources to improve outcomes for pregnant persons and families.

[1] https://www.ihs.gov/ihm/sgm/2019/assuring-access-to-medication-assisted-treatment-for-opioid-use-disorder/

[2] https://www.ihs.gov/ihm/pc/part-3/chapter-38-internet-eligible-controlled-substance-provider-designation/

*IHS Opioid Grant Program:* In FY 2021, IHS awarded a total of $16 million in grants to combat the opioid crisis. IHS awarded thirty-five grants under the Community Opioid Intervention Pilot Project (COIPP) for AI/ANs. These grants support the development of innovative, locally-designed, culturally-appropriate prevention, treatment, recovery, and aftercare services for opioid use disorders. The projects will focus on increasing public awareness and education about the impact of MOUD on individuals, families and communities; and create comprehensive support teams to strengthen and empower families addressing the opioid crisis. Finally, all projects will prioritize efforts to reduce unmet needs and opioid overdose deaths through increased access to MAT. The IHS COIPP is a three-year program and supports the HHS Overdose Strategy.

*IHS Substance Abuse and Suicide Prevention (SASP)*: The SASP is a nationally-coordinated grant program (formerly referred to as the Methamphetamine and Suicide Prevention Initiative (MSPI)) which focuses on substance abuse and suicide prevention providing intervention resources targeted to Tribes, Tribal programs, and Urban Indian communities with the greatest need for these programs. Due to the COVID-19 pandemic, the majority of the 174 SASP projects reduced and/or ceased activities. Only a limited number of projects continued to operate and did so according to their local, state, and federal guidelines for COVID-19 by modifying in-person activities to virtual events. In June 2020, the IHS requested and received a 1-year extension for all SASP grants from the Department of Health and Human Services (DHHS) due to the impact of COVID-19 with all SASP grant programs project period ending on September 29, 2021.

The primary objectives of the SASP program was to increase IHS, Tribal, and Urban (I/T/U) capacity to operate successful substance abuse prevention, treatment, and aftercare and/or suicide prevention, intervention, and postvention services through implementing community and organizational needs assessment and strategic plans; in so doing, communities would develop and foster data sharing systems among I/T/U behavioral health service providers to demonstrate efficacy and impact; develop and implement culturally appropriate and community tailored prevention, treatment, and aftercare strategies; identify and address suicide ideations, attempts, and contagions among AI/AN populations using culturally appropriate and community relevant prevention, intervention, and postvention strategies; increase provider and community education on suicide and substance use by offering appropriate trainings; and promote positive AI/AN youth development and family engagement through the implementation of early intervention strategies to reduce risk factors for suicidal behavior and substance use.

All projects funded have a training objective to increase and expand the types of healthcare providers trained in SUD screening, assessment or treatment, including Brief Intervention and Motivational Interviewing. Projects also seek to hire additional behavioral health staff (i.e., licensed behavioral health providers and paraprofessionals, including but not limited to peer specialists, mental health technicians, and community health aides) specializing in child, adolescent, and family services. These new staff will be responsible for implementing project activities that address all of the required objectives listed. As with other IHS Behavioral Health Initiatives, these funded projects support ONDCP's efforts to *advance recovery-ready workplaces and expanding the addiction workforce.*

Successful outcomes during the fourth year of the program include expanded behavioral health services offered through school settings and home visiting with a total of 1,475 patients receiving care. Over 270 providers were trained in behavioral health integration with 163 of those providers located within a primary care setting. Project accomplishments include 67,168 individuals screen for suicide ideation, 54 percent of the SASP program suicide prevention projects implemented an enhanced process for suicide screening, and over 11,003 community members have been trained in suicide and/or substance use prevention. Fifty-three percent of

projects hosted a successful prevention education community event. Twenty-nine percent reported implementation and documentation of a system change. In addition, among projects supported, a total of 76,054 individuals received cultural services, a high percentage of projects have continued to offer integrated traditional healing into care, extended service hours, provision of follow-up care, new counseling and case management services. In summary, the SASP program continues to support tribes, tribal organizations, urban Indian organizations (UIOs), and federal facilities offering care.

In FY 2022, the IHS funded 72 new Tribal, and Urban SASP projects at a maximum of 400,000 per year for a period of five years. In this new cohort 36 awardees will focus specifically on objectives identified for substance abuse prevention, treatment, and aftercare (SAPTA); and the remaining 36 grantees will prioritize suicide prevention, intervention, and postvention (SPIP) efforts.

*Preventing Alcohol-Related Deaths (PARD):* In the 2017 Senate Appropriations Committee Report 114-281, the Committee directed IHS to "allocate $2,000,000 of the increase provided for the alcohol and substance abuse program to fund essential detoxification and related services." Specifically, in the report the number of alcohol related deaths in the community of Gallup, New Mexico was addressed with the report stating, "these deaths underscore the urgent need for substance abuse treatment, residential services and detoxification services" in this community. In addition to Gallup, New Mexico, IHS was aware of the urgent need for alcohol detoxification services in the Great Plains Area after the removal of liquor licenses and alcohol sales in White Clay, Nebraska, leading to the potential for increased mortality if services were unavailable for alcohol detoxification. As a result, funds were made available through cooperative agreements to the City of Gallup, New Mexico and to the Oglala Sioux Tribe to address this urgent need. The project period is for five years and will run from September 15, 2017, to September 14, 2022. The City of Gallup has reported detoxification services to 9,482 unique individuals with over 75 percent of those clients including males. In addition to services offered for monitoring, supervising and managing detoxification, this site has increased coordination and transportation with the Gallup Indian Medical Center Emergency Department; and established a contract with the Gallup Police Department to transport patients to the detoxification center. The Oglala Sioux Tribe has used the funding to increase coordination with behavioral health programs, provide screenings and brief interventions to individuals incarcerated in jails, and serve as an immediate placement for individuals who are in need of treatment services following detoxification. The Oglala Sioux Tribe has reported an increased percentage of individuals held in detoxification for more than two weeks were successfully admitted into a higher level of residential treatment care for their SUD.

During the COVID-19 pandemic, services were temporarily interrupted at the City of Gallup detoxification site, and the Great Plains Area PARD site. IHS continues to work with both sites to ensure each has adopted guidelines provided by the local and state health departments, and the CDC for continued operations for detoxification services.

The IHS published a notice of funding opportunity March 1, 2023. The current funding of $2.5 million will continue to support the services provided and expand detoxification services to an additional center within the I/T/U health system.

<u>Supporting Evidence-Based Prevention Efforts to Reduce Youth Substance Use:</u>

*IHS SASP - Generation Indigenous (Gen-I):* Of the newly awarded 72 SASP, SAPTA and SPIP projects funded, all will focus on substance use prevention, treatment, and aftercare and suicide

prevention interventions for Native youth. IHS established the Universal Alcohol Screening (UAS) as a national measure to increase screening and improve detection and intervention strategies among patients' ages 9 through 75 years of age. In FY 2021, 31.1 percent of eligible patients were screened for risky alcohol use, which is less than the IHS target of 39.0 percent.

*Youth Regional Treatment Centers (YRTC):* The YRTCs provide residential substance use disorder and mental health treatment services to AI/AN youth. The IHS received funding for 12 YRTCs located throughout the country with six federally-operated centers and six tribally-operated centers. The YRTCs provide quality holistic behavioral health care for AI/AN adolescents that integrate traditional healing, spiritual values, and cultural identification. The IHS anticipates opening a new YRTC, Sacred Oaks Healing Center, in the summer of 2022.

*YRTC Aftercare Pilot Project:* Two YRTC facilities, Desert Sage and the Healing Lodge of the Seven Nations are in the last year of an IHS supported aftercare pilot project. YRTCs have an important role in maintaining the health of patients after discharge. This aftercare pilot emphasizes developing culture-based treatment that prevents alcohol and substance abuse relapse among youth discharged. An evaluation of the project is forthcoming, and examines the capacities and challenges in improving coordination of aftercare and case management, increasing training of community supports for the adolescents, improving identification of transitional living, increasing awareness of the use of treatment engagement through social media, and improving follow-up with data collection after discharge.

The IHS is currently preparing for a new notice of funding opportunity with an anticipated start date in FY 2023.

The U.S. Department of the Interior through the Bureau of Indian Affairs (BIA) and the Bureau of Indian Education (BIE), and with the IHS, have a Memorandum of Agreement (MOA) on Indian Alcohol and Substance Abuse Prevention, which was amended in 2011 as a result of the permanent reauthorization of the Indian Health Care Improvement Act. Through this MOA, BIA, BIE, and IHS coordinate and implement plans in cooperation with Tribes to assist Tribal governments in their efforts to address behavioral health issues. The MOA includes coordination of data collection, resources, and programs of IHS, BIA, and BIE.

The Tribal Law and Order Act (TLOA) requires interagency coordination and collaboration among HHS (IHS and SAMHSA), DOI (BIA and BIE), DOJ (Office of Justice Programs and Office of Tribal Justice), and the Office of the Attorney General. The 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 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.

<u>Enhancing Evidence-Based Harm Reduction Efforts:</u>

The IHS has expanded access to harm reduction interventions that include increased access to the opioid overdose reversal medication, naloxone. Since 2015, the IHS has maintained an ongoing collaboration with the Bureau of Indian Affairs (BIA) to train and provide naloxone to BIA Law Enforcement Officers (LEO) for responding to opioid overdoses. These initial efforts have evolved into a robust harm reduction strategy that includes a combination of policy and

workforce development efforts. In March 2018, the IHS implemented a policy in the Indian Health Manual (Chapter 35) entitled *Prescribing and Dispensing of Naloxone to First Responders* to require IHS federal pharmacies to provide naloxone to Tribal law enforcement agencies and other trained first responders. A revision to Chapter 35 was released in 2020 to further expand first responder definitions to community members and to reduce administrative reporting requirements related to requests for resupply. The IHS has also created a naloxone toolkit for tribal communities that includes a culturally responsive training video and a digital story from two LEOs involved in a naloxone 'save'. This toolkit contains a train the trainer curriculum and standardized forms to support first responder initiatives. The IHS has created sample protocols and pharmacist collaborative practice agreements to expand access to co-prescribed naloxone for patients on long-term opioid therapy or at increased risk for opioid overdose. In November 2019, the IHS developed and released a health education video that shared best and promising practices surrounding naloxone distribution and the way IHS and the Red Lake Nation are responding to the opioid crisis. A companion video was released in August 2020 that shares basic information related to opioids, naloxone, treatment and prevention.

The IHS has further adapted the toolkit and strategy to equip community first responders and paraprofessionals with training on opioid overdose response and naloxone. These expanded collaborations with local law enforcement and community first responders resulted in an initial pilot community-health naloxone train-the-trainer program to include naloxone distribution. The IHS has adapted these training materials to record a virtual naloxone train-the-trainer program as free technical assistance to tribes to support access to naloxone in a virtual and contactless approach. Additionally, the IHS has expanded the number of regional harm reduction mentors to assist sites with harm reduction implementation and expansion.

The IHS continues to develop and share best practices surrounding expanded harm reduction activities including safe syringe services programs and fentanyl test strips. Sample patient education resources, fact sheets, and recommendations have been developed and shared as technical assistance for sites and tribes. The IHS has participated in multiple webinars to share evidenced based strategies and site-to-site technical assistance to increase access to harm reduction services.

The strategic goal is to support Tribal programs and UIOs in their continued substance abuse prevention, treatment, and infrastructure development. These efforts represent an innovative partnership with IHS to deliver services developed by the communities themselves, with a national support network for ongoing program development and evaluation.

Substance use disorders continue to rank high on the concern list of Tribal partners. IHS believes that a shift in emphasis to earlier intervention is required to be successful in reducing the consequences of substance use disorders. IHS proposes focusing on early intervention with adolescents and young adults and preventing further progression by recognizing and responding to the source of the alcohol and substance abuse.

IHS continues to support the integration of substance use disorder treatment into primary care and emergency services through its activities to implement the ONDCP *Strategy*. Integrating treatment services into outpatient primary care offers opportunities for healthcare providers to identify patients with substance use disorders, provide them with medical advice, help them understand the health risks and consequences, and refer patients with more severe substance use-

related problems to treatment.[3] One integration activity is the Screening, Brief Intervention, and Referral to Treatment (SBIRT) method, which is an early intervention and treatment service for people with substance use disorders and those at risk of developing these disorders.

IHS has increased efforts to implement the SBIRT across IHS facilities as an evidence-based practice to identify patients with alcohol related problems. The SBIRT is a Government Performance and Results Act (GPRA) measure that IHS reports annually. In FY 2021, the SBIRT was administered at 15.8 percent for AI/AN ages 9-75, exceeding the target of 14.3 percent screened. IHS promotes the use of this clinical process by training providers in clinical and community settings. IHS currently offers 10 SBIRT on-demand trainings. SBIRT is intended to meet the public health goal of reducing the harms and societal costs associated with substance use by reducing diseases, accidents, and injuries. As an additional resource, IHS developed an Alcohol and Substance Abuse Program webpage: https://www.ihs.gov/asap/providers/sbirt/.

The IHS requires all prescribers to conduct a full patient medical history and physical examination including a review of the patient's current psychosocial status, any history of mental health or substance abuse concerns, and assessment for relevant signs of misuse or abuse of substances. Examination is done at the time of consideration for chronic opioid therapy and periodically during active pain management treatment. Patient screening surveys and urine drug tests are helpful in determining the risk of opioid misuse and guiding the frequency of ongoing monitoring. Screening surveys are incorporated into the triage/nurse screening process prior to seeing the clinician. IHS developed a Pain Management website: https://www.ihs.gov/painmanagement/substancescreening/.

Patients treated for SUD often present with a need to address co-occurring mental disorders. In FY 2017, the IHS Division of Behavioral Health awarded 12 new grantees through the Behavioral Health Integration Initiative (BH2I), a nationally-coordinated grant program that provides funding to Tribes, Tribal organizations, UIOs and federal facilities to plan, develop, implement and evaluate behavioral health integration with primary care. A primary goal of the BH2I is to formalize integration across the system, develop care teams, strengthen infrastructure, and enhance clinical processes including increased depression screenings in primary care clinics. Additionally, IHS contracted with a technical assistance (TA) provider to guide this pilot project through the implementation of their integrated care efforts with expertise from psychiatrists, primary care physicians, and social workers. Thus far, BH2I projects have reported successes such as new behavioral health integration policies and procedures including same day access to behavioral health providers within primary care and emergency room settings. Sites have also reported increased screening rates for depression, anxiety, trauma and early childhood development disabilities and reduction in wait times to see a mental health counselor and psychiatrist. In response to the COVID-19 pandemic, these efforts were extended into FY 2021, providing additional time in the project period to complete proposed activities with a focus on meeting the needs of the community and developing sustainability plans.

In FY 2022, IHS awarded $5.5 million to 14 Tribal and Urban Indian Organizations for a new five-year cohort. Additionally, IHS contracts with a technical assistance provider to assist grantees with the implementation of integrated care efforts.

[3] ONDCP. Integrating Treatment into Healthcare. *Available at* http://www.whitehouse.gov/ondcp/integrating-treatment-and-healthcare.

While screenings remain critical to ensure that appropriate health services are available to AI/AN population, IHS acknowledges the importance of understanding a patient's life experiences in order to deliver effective care and improving treatment adherence. In FY 2020, IHS released a trauma informed care policy to provide guidance to IHS facilities to improve patient engagement and health outcomes, as well as supporting provider and staff wellness. IHS continues to implement the principles of trauma informed care to ensure that those in its system understands the prevalence and role of trauma in patient care. In FY 2021, IHS released 13 Trauma Informed Care on-demand trainings, attended by 211 staff. These efforts ensure that comprehensive, culturally appropriate services are provided and support the *Strategy's* priority to *advance racial equity issues in our approach to drug policy.*

In FY 2022, IHS released the new trauma informed care on-demand, online training for clinical and non-clinical staff titled "Overview of Trauma Informed Care and Historical Trauma Guidance" in the HHS LMS. This training will provide guidance to IHS facilities in delivering trauma-informed care services along with promoting self-care to prevent secondary traumatic stress, which can lead to compassion fatigue and burnout.

Reducing the Supply of Illicit Substance:

*Increase Mandatory Prescriber Education and Continuing Training on Best Practices and Current Clinical Guidelines:* The IHS implemented the "Chronic Non-Cancer Pain Management Policy" to promote appropriate pain management as a primary prevention tool. In February 2018, IHS released a revised policy to include clinical practice guidelines contained in the 2016 *CDC Guideline for Prescribing Opioids for Chronic Pain*. This revised policy adopts CDC guidance and specifically requires IHS sites to establish and implement local chronic non-cancer pain protocols and procedures; requires prescribers to complete training on appropriate and effective use of controlled substance medications; and establishes the requirement to initiate opioid treatment as a shared decision between the prescriber and the patient to respect and support the patient's right to optimal pain assessment and management.

*Substance Use Disorder and Chronic Pain Case Consultation Services:* To provide ongoing clinical support for providers, IHS, in partnership with the University of New Mexico Pain Center, provided a Substance Use Disorder and Chronic Pain ECHO. ECHO is a case-based learning model in which consultation is offered through virtual clinics to healthcare providers by an expert team to share knowledge and elevate the level of specialty care available to patients. In FY 2021, a total of 20 ECHO sessions were offered with over 748 attendees.

In May 2019, the IHS released its "*Recommendations for Management of Acute Dental Pain*" for prescribing opioids for acute pain secondary to common general dentistry conditions and procedures. These guideline limit opioid prescribing for patients who cannot safely use alternative pain medication. The guidelines also include a decision tree for pre- and post-operative pain management, as well as recommended dosage limits for analgesics based on the degree of anticipated operative pain. The IHS collaborated to create content for a five-part CEU webinar series to influence dental prescribing practices and enhance screening for substance use disorders in general dentistry.

In March 2019, the IHS released the *Recommendations to the Indian Health Service on American Indian/Alaska Native Pregnant Women and Women of Childbearing Age with Opioid Use Disorder* developed in collaboration with the American College of Obstetricians and

Gynecologists' (ACOG) Committee on American Indian and Alaska Native Women's Health.[4] This resource will help providers improve maternal participation in early prenatal care, improve screening for substance use disorder, and increase access to MAT for pregnant women and women of child-bearing age. The goal of these clinical recommendations is to foster relationships and improve awareness surrounding trauma-informed approaches to maternal opioid use that may lead to recovery, hope, and healing. Additionally, the IHS and the American Academy of Pediatrics Committee on Native American Child Health (CONACH) recently released the *Recommendations to the Indian Health Service on Neonatal Opioid Withdrawal Syndrome* that includes clinical recommendations on the prevention and management of neonatal opioid withdrawal syndrome.[5] These recommendations provide standards of care for screening, diagnosing, support, and treatment of pregnant mothers and infants affected by prenatal opioid exposure. In August 2019, the IHS developed and released two additional Clinical Reporting System measures to track implementation of the ACOG recommendations and substance use disorder screening in women of childbearing age.

*Proper Pain Management and Opioid Stewardship Training:* The IHS has created and released a comprehensive Opioid Stewardship workbook to assist sites with creating best practices surrounding safe opioid prescribing recommendations and increasing access to integrative pain treatments. The workbook emphasizes utilizing opioid surveillance strategies to evaluate population health outcomes, target opioid interventions, enhance clinical decision support, and create professional practice evaluation strategies. The IHS opioid stewardship program evaluation considers metrics that evaluate trends in Morphine Milligram Equivalents versus a restricted focus on total opioid prescription fills, include analysis of risk reduction strategies with co-prescribed naloxone, and monitor patient conversion to chronic opioid therapy. These efforts support the IHS Strategic Plan *Goal 3, Objective 3.3 Modernize information technology and information systems to support data driven decisions.*

In May 2016, the IHS implemented a policy on mandatory opioid training requiring all federally controlled substance prescribers to complete the "IHS Essential Training on Pain and Addiction" with required refresher training every 3 years. This training is now available on demand with continuing education credits. The IHS released its Refresher training course in January 2018, including four sessions of its mandatory five-hour training course for providers on proper opioid prescribing. In FY 2021, 276 new clinicians completed this course. The mandate also includes an additional refresher training after three years. In FY 2021, 327 participants completed the Essential Training on Pain and Addiction Refresher course.

The IHS has also established a robust workforce development strategy to include didactic training. In September 2019, the IHS launched its Pain Management and Opioid Use Disorder Continuing Medical Education series. The IHS has hosted learning sessions in this series that include expanded harm reduction services, using ketamine in the acute care setting, buprenorphine micro-induction, and MOUD bridge services in the Emergency Department setting. Additional didactic training is supported through ECHO tele-education and training.

Enhanced communication during the opioid crisis response is vital to program development, policy implementation, and ongoing evaluation. The IHS created an Opioid Information Sheet that serves as a public-facing logic model to share opioid-related measure, agency goals, and available resources for both clinicians and tribal stakeholders. The IHS opioid strategy and a host

[4] https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/acogguidelines2018.pdf

[5] https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/aapnowsrecommendationstoihs.pdf

of available resources is housed on two IHS webpages that support a unified user experience in addition to publication of a quarterly opioid newsletter.

In August 2021, the IHS released enhanced clinical decision support tools for RPMS to assist providers in meeting documentation standards outlined in IHM, Part 3 - Chapter 30. The EHR Reminders and dialog note templates facilitate accurate and timely documentation to support best practice and implementation of pain management policy requirements. The tools also address OIG findings from recent IHS prescribing reviews.

In December 2021, the IHS released the Opioid Prescribing Dashboard (v 1.0) that includes a set of six opioid prescribing metrics for development of an opioid surveillance dashboard to assist with the analysis of opioid-related data on national, regional, and local levels. The data will be used to evaluate population health outcomes, target opioid interventions, enhance clinical decision support, and create professional practice evaluation strategies. An additional nine measures are planned in Phase II.

*Increase Prescription Drug Monitoring Program (PDMP) Interoperability and Usage:* The IHS has also implemented IHM Chapter 32 “State Prescription Drug Monitoring Programs” that establishes policy requirement for Federal facilities to participate with state-based Prescription Drug Monitoring Programs (PDMP). Controlled substance prescribers working in IHS federal-government-operated facilities must query state PDMP databases prior to prescribing opioids for pain treatment longer than seven days and periodically throughout chronic pain treatment. In FY 2019, IHS developed and released software programming to automate controlled substance dispensing reports to state-based PDMPs to near real-time reporting to improve the fidelity of IHS dispensing data in state PDMP databases. The IHS is in active software development and design for PDMP interoperability and integration into the IHS Electronic Health Record. These efforts support the IHS Strategic Plan *Goal 3, Objective 3.3 Modernize information technology and information systems to support data driven decisions.*

*Reducing Availability of Illicit and Dangerous Drugs:* The IHS supports the safe and effective disposal of unused pharmaceuticals at the enterprise level through the provision of reverse distributor services at Federal pharmacies for unopened expired controlled substances. The agency has participated in interagency efforts to support proper collection and disposal of pain medications. I/T/U pharmacies have continued to enroll as DEA collectors and to participate in prescription drug disposal efforts. A revision to the IHS medication disposal webpage was released in August 2022 and can be found:
https://www.ihs.gov/opioids/harmreduction/medicationdisposal/.

On the IHS pain management website, IHS provides resources for tribal and urban Indian communities on Take-Back Event, Permanent Collection Sites, Mail-Back Programs and Environmentally Safe Options from Home. The website also has two sessions focused on safe storage of medications and medication disposal for providers on proper opioid disposal.
https://www.ihs.gov/painmanagement/disposal/patientdisposal/

**Urban Indian Health Program – Alcohol and Substance Abuse Title V Grants**
**FY 2024 Request: $3 million**

The 41 UIOs are an integral part of the Indian health care system and serve as resources to both tribal and urban communities. Urban Indians are often invisible in the urban setting and face unique challenges when accessing healthcare. A large proportion of Urban Indians live in or near poverty and face multiple barriers such as the lack of quality and culturally relevant health care

services in cities. UIOs are an important support to Urban Indians seeking to maintain their tribal values and cultures and serve as a safety net for our urban patients. UIOs that offer inpatient and outpatient substance use disorder treatment have become reliable referral sites for Tribes and Urban Indians. In FY 2024, the IHS is proposing $3.1 million for the urban ONDCP budget. AI/AN people who live in urban centers present a unique morbidity and mortality profile. Urban AI/AN populations suffer disproportionately higher mortality from certain causes in sharp contrast to mainstream society. These unique challenges require a targeted response. Existing UIOs see their efforts in health education, health promotion, and disease prevention as essential to impacting the behavioral contributors to poor health[6]:

- Alcohol-induced death rates are 2.8 times greater for urban AI/AN people than urban all races.
- Chronic liver disease death rates are 2.1 times greater for urban AI/AN people than urban all races.
- Accidents and external causes of death rates are 1.4 times greater for urban AI/AN people than urban all races.

Alcohol and drug-related deaths continue to plague urban AI/AN people. Alcohol-induced mortality rates for urban AI/AN people are markedly higher than for urban all races. All regions, with the exception of eastern seaboard cities in the Nashville Area, show dramatically higher rates for urban AI/AN people than for all races who live in the same communities: the Billings Area is 4 times greater, the Phoenix Area is 6 times greater, the Tucson Area is 6.7 times greater, and the Great Plains Area has a 13.4 times greater alcohol-induced rate of mortality.[7]

Urban AI/AN populations are more likely to engage in health risk behaviors. Urban AI/AN people are more likely to report heavy or binge drinking than all-race populations and urban AI/AN people are 1.7 times more likely to smoke cigarettes. Urban AI/AN people more often view themselves in poor or only fair health status, with 22.6 percent reporting fair/poor health as compared to 14.7 percent of all races reporting as fair/poor.

Fetal alcohol spectrum disorders is a term used to describe a range of effects that can occur in someone whose mother consumed alcohol during pregnancy. Fetal alcohol spectrum disorders include disorders such as fetal alcohol syndrome, alcohol-related neuro developmental disorder, and alcohol-related birth defects. Interventions are needed in urban centers to address prevention efforts for urban AI/AN people with fetal alcohol spectrum disorders. The IHS policy requires the IHS to confer with UIOs “to develop and implement culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol spectrum disorders clinics for use in Indian communities and urban centers." Heavy drinking during pregnancy can cause significant birth defects, including fetal alcohol syndrome. Fetal alcohol syndrome is the leading and most preventable cause of intellectual disability. The rates of fetal alcohol syndrome are higher among AI/AN people 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 fetal alcohol syndrome.

The UIOs emphasize integrating behavioral health, health education, health promotion, and disease prevention into primary care offered within a culturally appropriate framework, which leads to positive outcomes for urban AI/AN people. Urban AI/AN people in need of substance

[6] Indian Health Service, Report to Congress: New Needs Assessment of the Urban Indian Health Program and the Communities it Services at 10 (Mar. 31, 2016) (hereinafter New Needs Assessment), available at https://www.ihs.gov/urban/includes/themes/newihstheme/display_objects/documents/ReportToCongressUrbanNeedsAssessment.pdf.
[7] Ibid.

use disorder treatment commonly exhibit co-occurring disorders. UIOs have recognized the need for more mental health and substance use disorder counselors to adequately address the needs presented by AI/AN people with co-occurring disorders. Stakeholders reported the need for more age and gender-appropriate resources for substance use disorder outpatient and residential treatment. While male AI/AN people can encounter wait times for treatment admission up to six months, treatment options for youth, women, and women with children can be greater than six months. Some of the most successful AI/AN treatment programs for youth, women, and women with children are administered by UIOs. UIOs have operated culturally appropriate initiatives to reduce health risk factors. Affecting lifestyle changes among urban AI/AN families requires a culturally sensitive approach. The continued efforts of UIOs to target behavioral or lifestyle changes offer the best hope for impacting the major health challenges of the urban AI/AN population.

The IHS has contracts and grants with 41 UIOs to provide health care and referral services for Urban Indians in 22 states. These IHS contracts and grants with UIOs address the *IHS Strategic Plan Goal 1 by ensuring that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people.* UIOs provide high quality, culturally relevant prevention, early intervention, outpatient and residential substance abuse treatment services, and recovery support to address the unmet needs of the Urban Indian communities they serve. Social determinants of health play a key role in health and wellness and UIOs are addressing a range of factors, which contribute to improved health outcomes.

According to the most recent urban Indian data, 79,502 AI/AN patients access services through UIO programs. Also, UIOs performed 699,237 visits for AI/AN patients including medical, dental, behavioral health, other professional and enabling services directly or by paid referral. Data also indicates that members from 529 of the 574 (92 percent) federally recognized Tribes accessed services from at least one of the 41 UIOs.

In FY 2021, the IHS Office of Urban Indian Health Programs awarded 4-in-1 grants to 33 UIOs. The grantees are awarded for a five-year funding cycle from April 1, 2022 - March 31, 2027. These grants provide funding to UIOs to make health care services more accessible for AI/ANs residing in urban areas. Funding is used to support four health program areas: health promotion and disease prevention services; immunization services; alcohol and substance abuse related services; and mental health services. Grantees are required to participate in a national evaluation of the 4-in-1 grant program, which addresses. The national evaluation includes reporting on the cultural interventions integrated into the 4-in-1 program activities, and practice based and evidence based approaches that are implemented or modified to meet the needs of the Urban Indian service population.

Many of the grantees reported interruptions/changes with their programs due to the COVID-19 pandemic:

- Many clinics run by UIOs had to temporarily close because they did not have the resources to provide a safe visit experience.
- Nearly all UIOs reported expanding telehealth services.
- There was an increase in demand for substance abuse and mental health treatment due to elevated levels of anxiety and stress.
- All non-essential in-person activities were halted.

- Many programs across various UIOs were switched to a virtual format. Some activities, such as a back-to-school health fair, were transitioned to be a drive-thru process.
- Despite the importance of many of these virtual services, many clients that UIOs serve lack internet capabilities, creating a significant barrier to accessing services.
- Elders expressed less desire in meeting virtually.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**INDIAN HEALTH SERVICE**
**FY 2024 Performance Budget Submission to Congress**

## TABLE OF CONTENTS

### Supplemental Tables

Page

*Exhibits*

Budget Authority by Object Class .......................................................................267
Salaries and Expenses .......................................................................................268
Detail of Full-Time Equivalent Employment (FTE) ......................................................269
Detail of Positions .............................................................................................270
Cyber Activity Funding ......................................................................................271

**Object Classification**

Indian Health Service

*(Dollars in Thousands)*

| | FY 22 Enacted | FY 23 Enacted | FY 24 Pres Bud | FY 2024 +/- FY 2023 |
|---|---|---|---|---|
| **[Object Class]** | | | | |
| Personnel compensation: | | | | |
| Full-time permanent (11.1) | $540,464 | $611,826 | $735,271 | $123,445 |
| Other than full-time permanent (11.3) | $21,401 | $21,401 | $22,698 | $1,297 |
| Other personnel compensation (11.5) | $101,453 | $101,453 | $107,603 | $6,150 |
| Military personnel (11.7) | $100,424 | $100,424 | $105,135 | $4,711 |
| Special personnel services payments (11.8) | $412 | $412 | $412 | $0 |
| **Subtotal personnel compensation** | **$764,154** | **$835,516** | **$971,119** | **$135,603** |
| Civilian benefits (12.1) | $246,755 | $270,305 | $316,136 | $45,831 |
| Military benefits (12.2) | $14,800 | $14,800 | $15,596 | $796 |
| Benefits to former personnel (13.0) | $41 | $41 | $41 | $0 |
| **Subtotal Pay Costs,** | **$1,025,751** | **$1,120,663** | **$1,302,893** | **$182,230** |
| Travel and transportation of persons (21.0) | $26,877 | $28,232 | $45,213 | $16,981 |
| Transportation of things (22.0) | $7,235 | $7,247 | $7,638 | $391 |
| Rental payments to GSA (23.1) | $17,274 | $26,083 | $41,520 | $15,437 |
| Rental payments to others (23.2) | $8,352 | $5,359 | $8,710 | $3,351 |
| Communication, utilities, and misc. charges (23.3) | $25,483 | $31,703 | $37,636 | $5,933 |
| Printing and reproduction (24.0) | $63 | $63 | $64 | $1 |
| Other Contractual Services: | | | | |
| Advisory and assistance services (25.1) | $197,726 | $199,202 | $209,503 | $10,301 |
| Other services (25.2) | $213,528 | $248,555 | $801,752 | $553,197 |
| Purchase of goods and services from government accounts (25.3) | $127,956 | $128,912 | $159,343 | $30,431 |
| Operation and maintenance of facilities (25.4) | $17,989 | $18,123 | $18,767 | $644 |
| Research and Development Contracts (25.5) | $0 | $0 | $0 | $0 |
| Medical care (25.6) | $240,615 | $268,509 | $552,584 | $284,075 |
| Operation and maintenance of equipment (25.7) | $82,382 | $86,487 | $222,628 | $136,141 |
| Subsistence and support of persons (25.8) | $46,647 | $47,070 | $48,321 | $1,251 |
| AP Branch Services (25.9) | $126,904 | $127,852 | $131,254 | $3,402 |
| **Subtotal Other Contractual Services** | **$1,139,033** | **$1,223,399** | **$2,284,935** | **$1,061,536** |
| Supplies and materials (26.0) | $62,443 | $65,736 | $139,991 | $74,255 |
| Equipment (31.0) | $16,304 | $19,295 | $124,759 | $105,464 |
| Land and Structures (32.0) | $3,400 | $4,192 | $4,531 | $339 |
| Investments and Loans (33.0 | $0 | $0 | $0 | $0 |
| Grants, subsidies, and contributions (41.0) | $4,383,439 | $4,524,322 | $5,542,265 | $1,017,943 |
| Insurance payments (42.0) | $211 | $211 | $213 | $2 |
| Interest and dividends (43.0) | $28 | $28 | $29 | $1 |
| Refunds (44.0) | $0 | $0 | $0 | $0 |
| Unvouchered (91.0) | $376.80 | $377 | $384 | $7 |
| **Subtotal Non-Pay Costs** | **$5,605,235** | **$5,837,560** | **$8,097,107** | **$2,259,547** |
| **Total Direct Obligations** | **$6,630,986** | **$6,958,223** | **$9,400,000** | **$2,441,777** |

| Salary and Expenses<br>INDIAN HEALTH SERVICE<br>(Budget Authority in Thousands) | | | |
|---|---|---|---|
| Object Class | **FY 2022 Final Level** | **FY 2023 Enacted Level** | **FY 2024 President's Budget** |
| Personnel compensation: | | | |
| Full-time permanent (11.1) | $540,464 | $611,826 | $735,271 |
| Other than full-time permanent (11.3) | $21,401 | $21,401 | $22,698 |
| Other personnel compensation (11.5) | $101,453 | $101,453 | $107,603 |
| Military personnel (11.7) | $100,424 | $100,424 | $105,135 |
| Special personnel services payments (11.8) | $412 | $412 | $412 |
| **Subtotal personnel compensation** | $764,154 | $835,516 | $971,119 |
| Civilian benefits (12.1) | $246,755 | $270,305 | $316,136 |
| Military benefits (12.2) | $14,800 | $14,800 | $15,596 |
| Benefits to former personnel (13.0) | $41 | $41 | $41 |
| **Subtotal Pay Costs** | $1,025,750 | $1,120,663 | $1,302,893 |
| Travel (21.0) | $26,877 | $28,232 | $45,213 |
| Transportation of things (22.0) | $7,235 | $7,247 | $7,638 |
| Communication, utilities, and misc. charges (23.3) | $25,483 | $31,703 | $37,636 |
| Printing and reproduction (24.0) | $63 | $63 | $64 |
| Other Contractual Services: | | | |
| Advisory and assistance services (25.1) | $197,726 | $199,202 | $209,503 |
| Other services (25.2) | $213,528 | $248,555 | $801,752 |
| Purchase of goods and services from government accounts (25.3) | $127,956 | $128,912 | $159,343 |
| Operation and maintenance of facilities (25.4) | $17,989 | $18,123 | $18,767 |
| Research and Development Contracts (25.5) | $0 | $0 | $0 |
| Medical care (25.6) | $240,615 | $268,509 | $552,584 |
| Operation and maintenance of equipment (25.7) | $82,382 | $86,487 | $222,628 |
| Subsistence and support of persons (25.8) | $46,647 | $47,070 | $48,321 |
| **Subtotal Other Contractual Services** | $926,843 | $996,859 | $2,012,899 |
| Supplies and materials (26.0) | $62,443 | $65,736 | $139,991 |
| **Subtotal Non-Pay Costs** | $1,048,944 | $1,129,840 | $2,243,441 |
| **Total Salary and Expenses** | | | |
| Rental Payments to GSA(23.1) | $17,274 | $26,083 | $41,520 |
| Rental Payments to Others(23.2) | $8,352 | $5,359 | $8,710 |
| **Grant Total, Salaries & Expenses and Rent** | $2,100,320 | $2,281,945 | $3,596,564 |
| **Direct FTE 1/** | 8,367 | 8,325 | 9,255 |

1/ Reflects staff paid for only within Indian Health Services and Indian Health Facilities Accounts.

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

| | FY 2022 Final | FY 2023 Estimate | FY 2024 Estimate |
|---|---|---|---|
| Headquarters | | | |
| Sub-Total, Headquarters | 687 | 685 | 727 |
| Area Offices | | | |
| Alaska Area Office | 285 | 284 | 302 |
| Albuquerque Area Office | 1,032 | 1,029 | 1,092 |
| Bemidji Area Office | 557 | 555 | 589 |
| Billings Area Office | 989 | 986 | 1,046 |
| California Area Office | 152 | 152 | 161 |
| Great Plains Area Office | 2,116 | 2,110 | 2,239 |
| Nashville Area Office | 184 | 184 | 195 |
| Navajo Area Office | 4,128 | 4,117 | 4,370 |
| Oklahoma City Area Office | 1,753 | 1,748 | 1,854 |
| Phoenix Area Office | 2,603 | 2,596 | 2,755 |
| Portland Area Office | 509 | 508 | 539 |
| Tucson Area Office | 246 | 245 | 260 |
| Sub-Total, Area Offices | 14,554 | 14,514 | 15,400 |
| TOTAL FTES[1] | 15,241 | 15,199 | 16,127 |

[1] Total does not include Trust Funds FTEs (21)

## INDIAN HEALTH SERVICE
## DETAIL OF POSITIONS

(Dollars in Thousands)

| | FY 2022 Final | FY 2023 Enacted | FY 2024 President's Budget |
|---|---|---|---|
| Total - ES...................... | 21 | 18 | 24 |
| Total - ES Salaries....................... | $4,012 | $3,827 | $4,046 |
| | | | |
| GS/GM-15............................................... | 505 | 503 | 532 |
| GS/GM-14............................................... | 451 | 449 | 475 |
| GS/GM-13............................................... | 664 | 660 | 697 |
| GS-12....................................................... | 1,464 | 1459 | 1,544 |
| GS-11....................................................... | 1,518 | 1512 | 1,602 |
| GS-10....................................................... | 581 | 579 | 615 |
| GS-9......................................................... | 1,078 | 1076 | 1,144 |
| GS-8......................................................... | 479 | 476 | 504 |
| GS-7.......................................................... | 1,354 | 1350 | 1,430 |
| GS-6............................................................ | 1,627 | 1622 | 1,719 |
| GS-5......................................................... | 1,761 | 1762 | 1,877 |
| GS-4.......................................................... | 787 | 790 | 844 |
| GS-3......................................................... | 104 | 105 | 113 |
| GS-2.......................................................... | 14 | 14 | 16 |
| GS-1.......................................................... | 0 | 0 | 0 |
| Subtotal.................................................. | 12,386 | 12,357 | 13,112 |
| Total - GS Salaries................................ | $655,473 | $931,498 | $1,095,647 |
| | | | |
| CO-08....................................................... | 3 | 3 | 3 |
| CO-07....................................................... | 3 | 3 | 4 |
| CO-06....................................................... | 258 | 258 | 274 |
| CO-05....................................................... | 428 | 428 | 456 |
| CO-04....................................................... | 529 | 527 | 558 |
| CO-03....................................................... | 267 | 266 | 282 |
| CO-02....................................................... | 21 | 21 | 21 |
| CO-01....................................................... | 17 | 17 | 17 |
| Subtotal.................................................. | 1,526 | 1,523 | 1,616 |
| | | | |
| Total - CO Salaries | $90,556 | $115,224 | $120,731 |
| | | | |
| Ungraded................................................ | 1,307 | 1,301 | 1,376 |
| Total - Ungraded Salaries | $49,617 | $70,380 | $82,750 |
| | | | |
| Average ES level................................. | ES | ES | ES |
| Average ES salary.............................. | $174 | $184 | $189 |
| Average GS grade............................... | 8 | 9 | 9 |
| Average GS salary.............................. | $66 | $67 | $68 |

Cyber Activity Funding

Indian Health Service

(Dollars in Millions)

| **Cyber Category** | **FY 2022 Final** | **FY 2023 Enacted** | **FY 2024 President's Budget** | **FY 2024 +/- FY 2023** |
|---|---|---|---|---|
| Detect - Data Loss Prevention | 0.155 | 0.565 | 0.565 | -- |
| Detect - Intrusion Prevention | 0.050 | 1.590 | 1.590 | -- |
| Detect - Other Detect Capabilities | 1.543 | 1.228 | 1.228 | -- |
| Identify - Data Categorization and Classification | 5.531 | 7.006 | 7.006 | -- |
| Identify - Other Identify Capabilities | 0.275 | 0.415 | 0.415 | -- |
| Protect - Counterintelligence | 0.850 | 3.000 | 3.000 | -- |
| Protect - Credentialing and Access Management | 0.390 | 0.373 | 0.373 | -- |
| Protect - Security Log Management | 2.186 | 2.497 | 2.497 | -- |
| Protect - Security Training | 0.080 | 0.088 | 0.088 | -- |
| Protect - Trusted Internet Connections | 1.963 | 3.138 | 3.138 | -- |
| Respond - Incident Management and Response | 0.029 | 0.010 | 0.010 | -- |
| Respond - Other Respond Capabilities | 2.097 | 2.500 | 2.500 | -- |
| **Total** | **15.149** | **22.410** | **22.410** | **--** |

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**INDIAN HEALTH SERVICE**
**FY 2024 Performance Budget Submission to Congress**

## TABLE OF CONTENTS

### Operating Division-Specific Requirements

Page

*IHS-Specific Requirements*


Federal & Tribal Operated Service Units & Medical Facilities ......................................272
Summary of Inpatient Admissions and Outpatient Visits...............................................273
Immunization Expenditures ...........................................................................................274
Annual Facilities Plan ....................................................................................................277
Federal/Tribal Crosswalk Tables ...................................................................................278
Legislative Proposals .....................................................................................................281

Department of Health & Human Services
Indian Health Service
**Number of Service Units and Facilities**
**Operated by IHS and Tribes, December 9, 2022**

| Type of Facility | TOTAL | IHS Total | TRIBAL Total | TRIBAL Title I [a] | TRIBAL Title V [b] |
|---|---|---|---|---|---|
| Service Units | 172 | 54 | 118 | | |
| Hospitals | 43 | 21 | 22 | 3 | 19 |
| Ambulatory | 649 | 90 | 559 | 134 | 425 |
| Health Centers | 383 | 53 | 330 | 100 | 230 |
| School Health Centers | 19 | 12 | 7 | 0 | 7 |
| Health Stations | 101 | 25 | 76 | 29 | 47 |
| Alaska Village Clinics | 146 | 0 | 146 | 5 | 141 |

[a] Operated under P.L. 93-638, Self Determination Contracts
[b] Operated under P.L. 106-260, Tribal Self-Governance Amendment of 2000

**Indian Health Service**
**Summary of Inpatient Admissions and Outpatient Visits**
**Federal and Tribal**
**FY 2022 Data**

**Direct Care Admissions**

| | IHS | Tribal | TOTAL |
|---|---|---|---|
| | | | |
| **TOTAL** | **10,255** | **11,556** | **21,811** |
| Alaska | * | 11,860 | 11,860 |
| Albuquerque | 636 | * | 636 |
| Bemidji | 123 | * | 123 |
| Billings | 606 | * | 606 |
| California | * | * | 0 |
| Great Plains | 2,765 | * | 2,765 |
| Nashville | * | 903 | 903 |
| Navajo | 6,062 | 3,838 | 9,900 |
| Oklahoma | 957 | 7,189 | 8,146 |
| Phoenix | 3236 | 487 | 3,723 |
| Portland | * | * | 0 |
| Tucson | * | 42 | 42 |

* No direct inpatient facilities in FY 2022

**Direct Care Outpatient Visits**

| | IHS | Tribal | TOTAL |
|---|---|---|---|
| | | | |
| **TOTAL** | **4,731,482** | **5,199,301** | **14,386,694** |
| Alaska | ** | 1,293,268 | 4,450,470 |
| Albuquerque | 447,497 | 57,431 | 1,262,575 |
| Bemidji | 249,475 | 266,878 | 1,583,276 |
| Billings | 408,499 | 60,470 | 1,092,803 |
| California | 1,738 | 413,470 | 1,086,536 |
| Great Plains | 699,419 | 183,790 | 1,868,202 |
| Nashville | 18,550 | 230,357 | 1,253,959 |
| Navajo | 1,174,944 | 437,901 | 4,171,546 |
| Oklahoma | 731,573 | 1,516,815 | 7,204,403 |
| Phoenix | 758,117 | 335,229 | 2,603,970 |
| Portland | 241,670 | 298,456 | 1,849,223 |
| Tucson | ** | 105,236 | 444,213 |

** No IHS facilities in FY 2022

## INDIAN HEALTH SERVICE
## Immunization Expenditures[1]

| | FY 2020 Estimate | FY 2021 Estimate | FY 2022 Estimate | FY 2023 Estimate | FY 2024 Estimate | Increase or Decrease |
|---|---|---|---|---|---|---|
| Infants, ≤2 yrs± | $17,637,372 | $16,999,814 | $27,697,493 | $30,729,864 | $37,006,856 | +$6,276,992 |
| Children, 4 yrs* | -- | -- | $1,903,618 | $2,181,400 | $2,626,981 | +$445,581 |
| Children, 11 yrs* | -- | -- | $2,638,457 | $3,058,125 | $3,682,789 | +$624,664 |
| Children, 16 yrs* | -- | -- | $492,106 | $592,244 | $713,218 | +$120,974 |
| Influenza, 3-18 yrs* | -- | -- | $7,011,952 | $8,208,396 | $9,885,073 | +$1,676,677 |
| Adolescents, 13-17 yrs** | $14,539,873 | $14,751,715 | -- | -- | -- | -- |
| HPV vaccine, Female 19-26 yrs | $1,888,480 | $2,234,867 | $1,661,872 | $4,362,851 | $5,841,971 | +$1,479,120 |
| HPV Vaccine, Males 19-26 yrs± | $3,007,340 | $3,471,040 | $8,348,651 | $11,371,327 | $11,460,808 | +$89,481 |
| Tdap, 19+ yrs | $5,642,763 | $6,881,091 | $8,011,379 | $14,506,783 | $14,999,354 | +$492,571 |
| Hepatitis B for diabetics, 19-59 yrs | $5,001,855 | $2,596,434 | $983,972 | $368,495 | $1,152,575 | +$784,079 |
| Influenza, 19+ yrs | $26,722,962 | $26,869,430 | $28,389,102 | $31,572,305 | $39.689,513 | +$8,117,208 |
| Zoster, 50+ yrs± | $749,722 | $600,430 | $5,072,640 | $10,710,516 | $16,871,985 | +$6,161,469 |
| Pneumococcal (PPSV23), 65+ yrs | $1,263,179 | $367,796 | $1,766,053 | $2,836,502 | $3,269,807 | +$433,305 |
| Pneumococcal (PCV13), 65+ yrs§ | $6,107,426 | $6,676,690 | $7,371,107 | -- | -- | -- |
| COVID-19, 5+ yrs | -- | -- | -- | -- | $36,714,324 | +$36,714,324 |
| Monitoring | $137,207 | $138,579 | $143,984 | $149,599 | $151,153 | +$1,554 |
| TOTAL | $82,698,180 | $81,587,886 | $101,492,384 | $120,648,412 | $184,066,408 | +$63,417,996 |

†Expanded age range beginning with FY 2021 estimate
*Newly added stratified measures beginning FY 2021 for improved capture and accuracy of estimates among these patient groups
**Retired aggregate measure replaced with newly added stratified measures as indicated
§PCV13 vaccine no longer recommended beginning FY2022

The Indian Health Service (IHS) patient care data system does not calculate itemized costs for the prevention or treatment of various conditions including vaccinations. Because the cost of vaccines for children < 19 years of age is covered by the Vaccines for Children (VFC) program, only the costs for vaccine administration, which are not covered by the VFC program, are included for this age group.

Estimated immunization expenditures include projected costs for routine, on-schedule immunizations among core patient demographic groups based on current age-appropriate immunization schedules. Other individuals outside these core patient groups may be regular

1. The immunization estimates do not include the Hepatitis B and Haemophilus Immunization (AK) program; estimates for these immunizations are included under the Immunization Alaska budget.

recipients of immunizations (e.g., health care workers; patients at specific increased risk for certain vaccine-preventable diseases). However, there is not currently a methodology to accurately estimate the size or vaccination coverage rates for all of these patient groups. Therefore, some special patient groups are excluded from these expenditure estimates.

Costs for monitoring of immunization coverage were also included and represent a 1.039 percent increase over the FY 2022 estimate:

- FY 2019 Estimated Costs = FY 2017 cost plus 3.9 percent
- FY 2020 Estimated Costs = FY 2018 cost plus 1.0 percent
- FY 2021 Estimated Costs = FY 2019 cost plus 1.0 percent
- FY 2022 Estimated Costs = FY 2020 cost plus 1.0 percent
- FY 2023 Estimated Costs = FY 2021 cost plus 1.0 percent

For FY 2024, $183,915,255 is estimated for immunization costs, and $151,153 for immunization monitoring costs, for a total of $184,066,408 estimated for all immunization expenditures. This represents a $63,417,996 increase from the FY 2023 estimate attributable to changes in vaccine costs including administering COVID-19 immunizations, shifting population sizes among age categories targeted for immunization, and progress towards immunization coverage goals aligned with Healthy People 2030 targets (i.e., fewer individuals still needing vaccination which translates to reduced forecasted costs). Calculations for the costs included as part of the FY 2023 estimated immunization costs were based on the assumptions outlined in the table below:

| | Estimated User Population (FY 2020)¶ | 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 | 59,554 | 80% | NA | 47,643 | $0.00 | $31.07 | 25 | $776.75 | $37,006,856 |
| Children, 4 yrs | 26,422 | 80% | NA | 21,138 | $0.00 | $31.07 | 4 | $124.28 | $2,626,981 |
| Children, 11 yrs | 29,633 | 80% | NA | 23,706 | $0.00 | $31.07 | 5 | $155.35 | $3,682,789 |
| Children, 16 yrs | 28,694 | 80% | NA | 22,955 | $0.00 | $31.07 | 1 | $31.07 | $713,218 |
| Influenza, 3-18 years | 454,507 | 70% | NA | 318,155 | $0.00 | $31.07 | 1 | $31.07 | $9,885,073 |
| HPV Females, 19-26 yrs | 109,720 | 60% | 51% | 10,204 | $159.77 | $31.07 | 3 | $572.52 | $5,841,971 |
| HPV Males, 19-26 yrs | 84,110 | 60% | 36% | 20,018 | $159.77 | $31.07 | 3 | $572.52 | $11,460,808 |
| Tdap, 19+ yrs | 1,153,832 | 90% | 67% | 265,381 | $25.45 | $31.07 | 1 | $56.52 | $14,999,354 |
| Hepatitis B, diabetics 19-59 yrs | 119,000 | 60% | 55% | 5,950 | $33.50 | $31.07 | 3 | $193.71 | $1,152,575 |
| Influenza, 19+ yrs | 1,153,832 | 70% | NA | 807,682 | $18.07 | $31.07 | 1 | $49.14 | $39,689,513 |
| Zoster, 50+ yrs | 416,104 | 60% | 44% | 64,912 | $98.89 | $31.07 | 2 | $259.92 | $16,871,985 |
| Pneumococcal (PPSV23) 65+yrs | 174,988 | 90% | 72% | 30,973 | $74.50 | $31.07 | 1 | $105.57 | $3,269,807 |
| COVID-19, 5+yrs[α] | 1,550,436 | 70% | 40% | 458,929 | $0 | $40.00 | 2 | $80.00 | $36,714,324 |
| Immunization Costs | | | | | | | | | $183,915,255 |
| Monitoring | | | | | | | | | $151,153 |
| Total Costs | | | | | | | | | $184,066,408 |

¶Reflects the most current user population counts available.
†Based on Healthy People 2030, where applicable. All targets are used for illustrative purposes only, and none reflect an official target set by the IHS.

*Coverage estimates based on most current coverage levels available (FY 2022 Quarter 1); coverage estimates for diabetics ages 19-59 years includes those patients immune to Hepatitis B for reasons other than immunization; HPV estimate is based on 3 dose series; coverage listed as 'NA' either not applicable due to age-related cohort turnover each year or recurring annual immunization requirement each year (i.e., influenza).
**Cost per dose for routine childhood vaccines administered up to and including age 18 are covered by the Vaccines for Children program; cost per dose determined from the CDC Adult Vaccine Price List dated April 1, 2022. Lowest published price is generally used where multiple products or formulations are available.
https://www.cdc.gov/vaccines/programs/vfc/awardees/vaccine-management/price-list/index.html
§Vaccine administration fees for all vaccines except COVID-19 vaccines are based on an average of CMS 2022 locality-adjusted payment amounts for administration of influenza vaccines as a proxy for all vaccines, except for COVID-19. COVID-19 vaccine administration costs are based on Medicare reimbursement rates specific to COVID-19 immunization for any vaccine doses.
[α]Due to the evolving COVID-19 vaccine landscape, estimates are preliminary and may not be reliable.

Overall, the estimated costs above reflect projected costs for routine, on-schedule immunizations but with caveats:

1. Other individuals outside these core patient 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 currently a methodology to estimate the size of these groups to effectively track vaccination coverage rates.
2. CMS reimbursement rates for vaccine administration were used to estimate indirect costs because there is no specific methodology to estimate indirect costs or administrative overhead associated with the administration of immunizations system-wide, or operation of the overall immunization program.

# FY 2024 Annual Facilities Planning (Five-Year Plan) a/

(Dollars in Thousands)

| FACILITY | Prior to FY 23* | FY 23 Approx. | FY 24 Est. | FY 25 Est. | FY 26 Est. | FY 27 Est. | Out years Est. | Total Cost ** |
|---|---|---|---|---|---|---|---|---|
| **Planning Studies** | - | | 1000 | 500 | 500 | | 500 | |
| **Inpatient Facilities b/ c/ d** | | | | | | | | |
| PIMC, AZ, Health Care System | | | | | | | | |
| Central - Hospital & ACC 1/ 8/ | 36,228 | 48,500 | 0 | 0 | 290,000 | 500,000 | 2,330,000 | 3,204,728 |
| Whiteriver, AZ, Hospital 2/ | 135,000 | 0 | 200,000 | 250,000 | 360,000 | 150,000 | 0 | 1,095,000 |
| Gallup, NM Hospital 3/ 8/ | 26,000 | 40,000 | 0 | 0 | 300,000 | 300,000 | 500,000 | 1,166,000 |
| **Outpatient Facilities b/ c/ d/** | | | | | | | | |
| Alamo, NM | 97,000 | 35,000 | | 29,000 | | | | 161,000 |
| Pueblo Pintado, NM | 171,400 | 36,000 | 24,000 | | | | | 231,400 |
| Bodaway Gap, AZ 4/ | 121,200 | 60,000 | | 76,000 | | | | 257,200 |
| Albuquerque Health Care System | | | | | | | | |
| Albuquerque West, NM 5/ 8/ | 164,143 | | | 88,000 | | | | 252,143 |
| Albuquerque Central, NM 6/ | 20,734 | | | | 151,000 | 190,000 | | 361,734 |
| Sells, AZ 7/ | 150,008 | | 0 | 200,000 | 178,000 | 130,000 | | 658,008 |
| **Small Ambulatory Program (Section 306)** | | | | | | | | |
| Small Health Clinics | | 25,000 | 25,000 | | | | | |
| **Staff Quarters Program 25 U.S.C. 13, Snyder Act e/** | | | | | | | | |
| Staff Quarters | | 11,396 | 5,899 | | | | | |
| **Green Infrastructure (CWA)** | | | | | | | | |
| Sustainability Projects | | 5,000 | 5,000 | | | | | |
| **Joint Venture Construction Program (Section 818e)** | | | | | | | | |
| Equipment funding | | | | | | | | |
| **FY TOTALs** | | 260,896 | 260,899 | 643,500 | 1,279,500 | 1,270,000 | 2,830,500 | |
| **Priority Project Total cost** | | | | | | | | 7,387,213 |
| **UNFUNDED (FY 2023-Outyears) Priority Projects only** | | | | | | | | 6,246,000 |

NOTES:

a/ All funds appropriated prior to FY 2023 are consolidated including NEF for Albuquerque West & Sells projects.
b/ Cost based on mid-point of construction. FY 23 and earlier are know values, FY 24 and later are estimated values.
c/ This project list includes projects from the IHS Construction Priority List of 1992.
d/ Subject to the availability of funds and does not include M&I, or staffing.
e/ An initiative to fund new and replacement energy efficient staff quarters in isolated and remote locations.
1/ The total cost includes inpatient, outpatient, and a hostel. The budget will be updated when planning is complete.
2/ Total cost estimate includes 200 new staff quarters. The budget will be updated when planning is complete.
3/ The need for staff quarters is being evaluated. This estimate includes 100 staffing quarters units as a place holder. The cost includes the cost of land.
4/ Total estimate includes 92 staff quarters.
5/ The Albuquerque West Project was supplemented with $13.9 million of NEF. The budget will be updated when planning is complete.
6/ The budget will be updated when planning is complete.
7/ The Sells Project was supplemented with $30 million of NEF. The Cost includes 108 staff quarters. The budget will be updated when planning is complete.
8/ Land purchase is required for this Project

FY 2022 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

| | Federal Health Administration | | | | | | | | Tribal Health Administration | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sub Activity | Clinical Services | Preventive Health | Indian Health Professions | Federal Administration | Trbal Mgmt Grants | Self-Governance | Facilities | TOTAL Federal Health Admini-stration | Clinical Services | Preventive Health | Urban Health | Trbal Mgmt Grants | Management Training | Self-Governance | Contract Support | Tribal Lease Payments | Facilities | TOTAL Tribal Health Admini-stration | FY 2022 Final |
| **SERVICES** | | | | | | | | | | | | | | | | | | | |
| Hospitals & Health Clinics | 959,494 | 0 | 0 | 0 | 0 | 0 | 0 | 959,494 | 1,415,490 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,415,490 | 2,374,984 |
| Electronic Health Record | 125,000 | 0 | 0 | 0 | 0 | 0 | 0 | 145,019 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 145,019 |
| Dental Health | 90,933 | 0 | 0 | 0 | 0 | 0 | 0 | 90,933 | 141,633 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 141,633 | 232,566 |
| Mental Health | 46,264 | 0 | 0 | 0 | 0 | 0 | 0 | 46,264 | 74,845 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 74,845 | 121,109 |
| Alcohol & Substance Abuse | 88,502 | 0 | 0 | 0 | 0 | 0 | 0 | 88,502 | 169,522 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 169,522 | 258,024 |
| Purchased/Referred Care | 394,940 | 0 | 0 | 0 | 0 | 0 | 0 | 394,940 | 589,947 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 589,947 | 984,887 |
| IHCIF | 15,272 | 0 | 0 | 0 | 0 | 0 | 0 | 15,272 | 58,866 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 58,866 | 74,138 |
| Subtotal (CS) | 1,720,405 | 0 | 0 | 0 | 0 | 0 | 0 | 1,740,424 | 2,450,303 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,450,303 | 4,190,727 |
| Public Health Nursing | 0 | 33,846 | 0 | 0 | 0 | 0 | 0 | 33,846 | 0 | 67,795 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 67,795 | 101,641 |
| Health Education | 0 | 4,255 | 0 | 0 | 0 | 0 | 0 | 4,255 | 0 | 18,995 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 18,995 | 23,250 |
| Community Health Repr. | 0 | 2,356 | 0 | 0 | 0 | 0 | 0 | 2,356 | 0 | 61,323 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 61,323 | 63,679 |
| Immunization AK | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,148 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,148 | 2,148 |
| Subtotal (PH) | 0 | 40,457 | 0 | 0 | 0 | 0 | 0 | 40,457 | 0 | 150,261 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 150,261 | 190,718 |
| Urban Health Project | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 73,424 | 0 | 0 | 0 | 0 | 0 | 0 | 73,424 | 73,424 |
| Indian Health Professions | 0 | 0 | 51,683 | 0 | 0 | 0 | 0 | 73,039 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 73,039 |
| Tribal Management | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 2,466 | 0 | 0 | 0 | 0 | 0 | 2,466 | 2,466 |
| Direct Operations | 0 | 0 | 0 | 74,421 | 0 | 0 | 0 | 59,216 | 0 | 0 | 0 | 0 | 20,625 | 0 | 0 | 0 | 0 | 20,625 | 95,046 |
| Self-Governance | 0 | 0 | 0 | 0 | 0 | 5,511 | 0 | 5,511 | 0 | 0 | 0 | 0 | 0 | 339 | 0 | 0 | 0 | 339 | 5,850 |
| Subtotal (OS) | 0 | 0 | 51,683 | 74,421 | 0 | 5,511 | 0 | 137,766 | 0 | 0 | 73,424 | 2,466 | 20,625 | 339 | 0 | 0 | 0 | 96,854 | 249,825 |
| Total, Services | 1,720,405 | 40,457 | 51,683 | 74,421 | 0 | 5,511 | 0 | 1,918,647 | 2,450,303 | 150,261 | 73,424 | 2,466 | 20,625 | 339 | 0 | 0 | 0 | 2,697,418 | 4,631,270 |
| **CONTRACT SUPPORT COSTS** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 880,000 | 0 | 0 | 880,000 | 880,000 |
| **TRIBAL LEASE PAYMENTS** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 150,000 | 0 | 150,000 | 150,000 |
| **FACILITIES** | | | | | | | | | | | | | | | | | | | |
| Maintenance & Improvement | 0 | 0 | 0 | 0 | 0 | 0 | 88,565 | 88,565 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 81,099 | 81,099 | 169,664 |
| Sanitation Facilities Constr. | 0 | 0 | 0 | 0 | 0 | 0 | 69,224 | 69,224 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 128,559 | 128,559 | 197,783 |
| Health Care Facs. Constr. | 0 | 0 | 0 | 0 | 0 | 0 | 140,018 | 140,018 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 119,275 | 119,275 | 259,293 |
| Facs. & Env. Health Sup | 0 | 0 | 0 | 0 | 0 | 0 | 159,116 | 159,116 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 124,008 | 124,008 | 283,124 |
| Equipment | 0 | 0 | 0 | 0 | 0 | 0 | 13,343 | 13,343 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 17,121 | 17,121 | 30,464 |
| Total, Facilities | 0 | 0 | 0 | 0 | 0 | 0 | 470,266 | 470,266 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 470,062 | 470,062 | 940,328 |
| TOTAL, IHS | 1,720,405 | 40,457 | 51,683 | 74,421 | 0 | 5,511 | 470,266 | 2,388,913 | 2,450,303 | 150,261 | 73,424 | 2,466 | 20,625 | 339 | 880,000 | 0 | 470,062 | 4,047,480 | 6,601,598 |

FY 2022 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

| Sub Activity | Federal Health Administration | | | | | | | | | Tribal Health Administration | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Clinical Services | Preventive Health | Indian Health Professions | Federal Administration | Trbal Mgmt Grants | Self-Governance | Special Diabetes Program for Indians | Facilities | TOTAL Federal Health Admini-stration | Clinical Services | Preventive Health | Urban Health | Management Training | Trbal Mgmt Grants | Self-Governance | Contract Support | ISDEA 105*(l)* Leases | Facilities | TOTAL Tribal Health Admini-stration | FY 2023 Enacted |
| **SERVICES** | | | | | | | | | | | | | | | | | | | | |
| Hospitals & Health Clinics | 1,011,222 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,011,222 | 1,491,803 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,491,803 | 2,503,025 |
| Electronic Health Record | 217,564 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 217,564 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 217,564 |
| Dental Health | 97,006 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 97,006 | 151,092 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 151,092 | 248,098 |
| Mental Health | 48,579 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 48,579 | 78,592 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 78,592 | 127,171 |
| Alcohol & Substance Abuse | 91,389 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 91,389 | 175,051 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 175,051 | 266,440 |
| Purchased/Referred Care | 399,699 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 399,699 | 597,056 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 597,056 | 996,755 |
| IHCIF | 15,272 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 15,272 | 58,866 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 58,866 | 74,138 |
| Subtotal (CS) | 1,880,731 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,880,732 | 2,552,460 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,552,459 | 4,433,191 |
| Public Health Nursing | 0 | 36,890 | 0 | 0 | 0 | 0 | 0 | 0 | 36,890 | 0 | 73,892 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 73,892 | 110,782 |
| Community Health | 0 | 4,456 | 0 | 0 | 0 | 0 | 0 | 0 | 4,456 | 0 | 19,894 | 0 | 0 | 0 | | 0 | 0 | 0 | 19,894 | 24,350 |
| Health Education | 0 | 2,413 | 0 | 0 | 0 | 0 | 0 | 0 | 2,413 | 0 | 62,799 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 62,799 | 65,212 |
| Immunization AK | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,183 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,183 | 2,183 |
| Subtotal (PH) | 0 | 43,759 | 0 | 0 | 0 | 0 | 0 | 0 | 43,759 | 0 | 158,768 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 158,768 | 202,527 |
| Urban Health Project | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 90,419 | 0 | 0 | 0 | 0 | 0 | 0 | 90,419 | 90,419 |
| Indian Health Professions | 0 | 0 | 51,683 | 0 | 0 | 0 | 0 | 0 | 51,683 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 80,568 |
| Tribal Management | 0 | 0 | 0 | 0 | 2,986 | 0 | 0 | 0 | 2,986 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,986 |
| Direct Operations | 0 | 0 | 0 | 81,279 | 0 | 0 | 0 | 0 | 81,279 | 0 | 0 | 0 | 22,526 | 0 | 0 | 0 | 0 | 0 | 22,526 | 103,805 |
| Self-Governance | 0 | 0 | 0 | 0 | 0 | 5,816 | 0 | 0 | 5,816 | 0 | 0 | 0 | 0 | 0 | 358 | 0 | 0 | 0 | 358 | 6,174 |
| Subtotal (OS) | 0 | 0 | 51,683 | 81,279 | 2,986 | 5,816 | 0 | 0 | 141,764 | 0 | 0 | 90,419 | 22,526 | 0 | 358 | 0 | 0 | 0 | 113,303 | 283,952 |
| Total, Services | 1,880,731 | 43,759 | 51,683 | 81,279 | 2,986 | 5,816 | 0 | 0 | 2,066,255 | 2,552,460 | 158,768 | 90,419 | 22,526 | 0 | 358 | 0 | 0 | 0 | 2,824,530 | 4,919,670 |
| **CONTRACT SUPPORT COSTS** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,142,000 | 0 | 0 | 1,142,000 | 969,000 |
| **ISDEAA 105*(l)* Leases** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 150,000 | 0 | 150,000 | 111,000 |
| **FACILITIES** | | | | | | | | | | | | | | | | | | | | |
| Maintenance & Improvement | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 89,051 | 89,051 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 81,544 | 81,544 | 170,595 |
| Sanitation Facilities Constr. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 68,658 | 68,658 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 127,509 | 127,509 | 196,167 |
| Health Care Facs. Constr. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 140,884 | 140,884 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 120,012 | 120,012 | 260,896 |
| Facs. & Env. Health Sup | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 167,643 | 167,643 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 130,654 | 130,654 | 298,297 |
| Equipment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14,278 | 14,278 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 18,320 | 18,320 | 32,598 |
| Total, Facilities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 480,514 | 480,514 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 478,039 | 478,039 | 958,553 |
| TOTAL, IHS | 1,880,731 | 43,759 | 51,683 | 81,279 | 2,986 | 5,816 | 0 | 480,514 | 2,546,769 | 2,552,460 | 158,768 | 90,419 | 22,526 | 0 | 358 | 1,142,000 | 0 | 478,039 | 4,444,569 | 6,958,224 |

FY 2023 Crosswalk
Budget Authority
Estimated Distribution

(dollars in thousands)

| Sub Activity | Federal Health Administration | | | | | | | | | | Tribal Health Administration | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Clinical Services | Preventive Health | Indian Health Professions | Federal Administration | Trbal Mgmt Grants | Self-Governance | Special Diabetes Program for Indians | Facilities | Special Diabetes Program for Indians | TOTAL Federal Health Admini-stration | Clinical Services | Preventive Health | Urban Health | Management Training | Trbal Mgmt Grants | Self-Governance | Contract Support | ISDEA 105(*l*) Leases | Facilities | TOTAL Tribal Health Admini-stration | FY 2024 Pres Bud |
| **SERVICES** | | | | | | | | | | | | | | | | | | | | | |
| Hospitals & Health Clinics | 1,462,009 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,462,009 | 2,091,733 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,091,733 | 3,553,742 |
| Electronic Health Record | 913,186 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 913,186 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 913,186 |
| Dental Health | 126,655 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 126,655 | 192,374 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 192,374 | 319,029 |
| Mental Health | 63,006 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 63,006 | 100,986 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 100,986 | 163,992 |
| Alcohol & Substance Abuse | 110,453 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 110,453 | 198,248 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 198,248 | 308,701 |
| Purchased/Referred Care | 477,129 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 477,129 | 700,968 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 700,968 | 1,178,097 |
| IHCIF | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Subtotal (CS) | 3,152,437 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,152,438 | 3,284,310 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,284,309 | 6,436,747 |
| Public Health Nursing | 0 | 43,824 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 43,824 | 0 | 88,535 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 88,535 | 132,359 |
| Community Health | 0 | 5,368 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5,368 | 0 | 22,738 | 0 | 0 | 0 | | 0 | 0 | 0 | 22,738 | 28,106 |
| Health Education | 0 | 3,020 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,020 | 0 | 71,536 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 71,536 | 74,556 |
| Immunization AK | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,174 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,174 | 2,509 |
| Subtotal (PH) | 0 | 52,212 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 52,212 | 0 | 184,983 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 184,983 | 237,530 |
| Urban Health Project | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 115,156 | 0 | 0 | 0 | 0 | 0 | 0 | 115,156 | 115,156 |
| Indian Health Professions | 0 | 0 | 51,683 | 0 | 0 | 0 | 0 | 0 | 0 | 51,683 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 94,324 |
| Tribal Management | 0 | 0 | 0 | 0 | 2,659 | 0 | 0 | 0 | 0 | 2,659 | 0 | 0 | 0 | 0 | 1,828 | 0 | 0 | 0 | 0 | 0 | 4,487 |
| Direct Operations | 0 | 0 | 0 | 87,991 | 0 | 0 | 0 | 0 | 0 | 87,991 | 0 | 0 | 0 | 30,484 | 0 | 0 | 0 | 0 | 0 | 30,484 | 118,475 |
| Self-Governance | 0 | 0 | 0 | 0 | 0 | 5,630 | 0 | 0 | 0 | 5,630 | 0 | 0 | 0 | 0 | 0 | 596 | 0 | 0 | 0 | 596 | 6,226 |
| Subtotal (OS) | 0 | 0 | 51,683 | 87,991 | 2,659 | 5,630 | 0 | 0 | 0 | 147,963 | 0 | 0 | 115,156 | 30,484 | 1,828 | 596 | 0 | 0 | 0 | 146,236 | 338,668 |
| Total, Services | 3,152,437 | 52,212 | 51,683 | 87,991 | 2,659 | 5,630 | 0 | 0 | 0 | 3,352,613 | 3,284,310 | 184,983 | 115,156 | 30,484 | 1,828 | 596 | 0 | 0 | 0 | 3,615,528 | 7,012,945 |
| **CONTRACT SUPPORT COSTS** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,142,000 | 0 | 0 | 1,142,000 | 1,168,000 |
| **ISDEAA 105*(l)* Leases** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 150,000 | 0 | 150,000 | 153,000 |
| **FACILITIES** | | | | | | | | | | | | | | | | | | | | | |
| Maintenance & Improvement | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 82,944 | 0 | 82,944 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 104,584 | 104,584 | 187,528 |
| Sanitation Facilities Constr. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 70,357 | 0 | 70,357 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 130,664 | 130,664 | 201,021 |
| Health Care Facs. Constr. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 235,748 | 0 | 235,748 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 25,151 | 25,151 | 260,899 |
| Facs. & Env. Health Sup | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 212,032 | 0 | 212,032 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 159,498 | 159,498 | 371,530 |
| Equipment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 21,547 | 0 | 21,547 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 23,530 | 23,530 | 45,077 |
| Total, Facilities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 622,628 | 0 | 622,628 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 443,427 | 443,427 | 1,066,055 |
| **SDPI** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 37,570 | 37,570 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 147,000 |
| TOTAL, IHS | 3,152,437 | 52,212 | 51,683 | 87,991 | 2,659 | 5,630 | 0 | 622,628 | 37,570 | 4,012,812 | 3,284,310 | 184,983 | 115,156 | 30,484 | 1,828 | 596 | 1,142,000 | 0 | 443,427 | 5,200,955 | 9,547,000 |

## Indian Health Service

## Authorization for the Special Diabetes Program for Indians

Proposal: Reauthorize and increase funding for the Special Diabetes Program for Indians (SDPI) from FY 2024-FY 2026.

Current Law: The Balanced Budget Act of 1997 (P.L. 105-33, Section 4922) established the SDPI to address the need for diabetes prevention and treatment for American Indian and Alaska Native (AI/AN) populations. The SDPI, established under section 330C of the Public Health Service Act (42 U.S.C. § 254c-3), has been reauthorized through September 30, 2023.

Rationale: Absent additional Congressional action, SDPI will face a funding cliff in FY 2024. Reauthorization of the SDPI will be required to continue progress in prevention and treatment of diabetes in AI/AN communities. The proposal increases funding for the program from $150 million to $250 million in FY 2024, $260 million in FY 2025, and $270 million in FY 2026. The additional funding will provide more American Indian and Alaska Native communities with access to this critical resource and allow the program to accommodate the increasing costs of providing health care. The Budget also proposes to exempt this program and other IHS funding from sequestration.

The SDPI currently provides grant funding to 301 Indian Health Service (IHS), tribal, and urban Indian (I/T/U) programs in 35 states.

The SDPI has provided funding that has enabled AI/AN programs to implement and sustain quality diabetes treatment and prevention services. As the six SDPI Reports to Congress in FYs 2000, 2004, 2007, 2011, 2014, and 2020 have demonstrated, substantial improvements in clinical measures and outcomes have been associated with the diabetes prevention and treatment activities implemented with SDPI funding.

IHS data indicate that, after years of rising, the prevalence of diabetes in AI/AN people nationally decreased from 15.4 percent in 2013 to 14.6 percent in 2017, the first known decrease in this population[1]. Another positive trend is that rates of obesity in AI/AN children and youth aged 2-19 years remained nearly constant from 2006-2015[2].

Key clinical outcome measures have continued to improve overall at I/T/U facilities since the inception of the SDPI:

- Improved Blood Sugar Control: Blood sugar control among AI/ANs with diabetes served by the I/T/U system has improved over time. The average blood sugar level (as measured by the A1C test) decreased from 9.0 percent in 1996 to 8.1 percent in 2019[3], nearing the A1C goal for most patients of less than 8 percent.
- Improved Blood Lipid Levels: Average LDL cholesterol (i.e., "bad" cholesterol) declined from 118 mg/dL in 1998 to 90 mg/dL in 2019, surpassing the goal of less than 100mg/dL[4].
- Reduced Kidney Failure: The rate of new cases of kidney failure due to diabetes declined by more than half (54 percent) in AI/AN people from 1996 to 2013. This is a much larger decline

[1] Prevalence of diagnosed diabetes in American Indian and Alaska Native adults, 2006–2017, *BMJ Open*
[2] *Am. J. Public Health* 2017;107:1502-1507.
[3] IHS Diabetes Care and Outcomes Audit.
[4] *Id*.

than in any other US racial group and represents a significant decrease in the need for dialysis and kidney transplantation[5]. The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) released an Issue Brief on May 10, 2019 titled "The Special Diabetes Program for Indians: Estimates of Medicare Savings.[6]" ASPE estimated that the decrease in the incidence of diabetes-related kidney failure resulted in 2,200 to 2,600 fewer cases and $436 million to $520 million of savings to Medicare over a ten-year period. ASPE also discussed how the SDPI was a critical factor in these improvements.

The IHS proposes to continue support for data infrastructure improvements, focusing on the Diabetes Care and Outcomes Audit, estimates of diabetes prevalence, the National Data Warehouse, and updates to the Diabetes Management System and iCare programs. Given the complexity and number of the SDPI grant programs, the IHS will continue to provide administrative support to ensure appropriate implementation and evaluation.

The SDPI grantees have implemented diabetes prevention and treatment activities that are culturally appropriate, community-driven, and centered on evidence-based best practices. These programs will continue to implement specific prevention and treatment strategies and best practices for AI/AN adults, children, and youth.

Reauthorization is highly supported by AI/AN Tribes. In 2019, Tribes submitted testimony to the House Appropriations Subcommittee on Interior, Environment and Related Agencies on March 6, 2019, and to the Senate Committee on Indian Affairs on May 8, 2019, indicating SDPI progress and the need for continued support. Furthermore, this proposal is consistent with the recommendations of the IHS National Tribal Budget Formulation Workgroup.

Budget Impact: The reauthorization of this program will cost a total of $780 million over three years.

Effective Date: October 01, 2023

Equity Impact Assessment: Reauthorizing SDPI for three years at $250 million in 2024 and increasing funding by +$10 million in the outyears would give the funding continuity needed by programs to plan the needed long-term interventions and activities, resulting in continued overall positive clinical outcomes. It would also significantly enhance their ability to recruit and retain qualified staff in rural and remote locations, which funding unpredictability has made even more difficult. This will ultimately improve access to health care for AI/AN communities, who often experience unique challenges and barriers to care. Improving access to care by strengthening IHS workforce capacity can contribute to better outcomes for AI/AN people and reduce health disparities.

[5] Vital Signs: Decrease in Incidence of Diabetes-Related End-Stage Renal Disease among American Indians/Alaska Natives — United States, 1996–2013. *MMWR Morb Mortal Wkly Rep* (2017), available at: http://dx.doi.org/10.15585/mmwr.mm6601e1.

[6] Office of the Assistant Secretary for Planning and Evaluation (ASPE). The Special Diabetes Program for Indians: estimates of Medicare savings. ASPE Issue Brief. Department of Health and Human Services, May 10, 2019. https://aspe.hhs.gov/pdf-report/special-diabetes-program-indians-estimates-medicare-savings.

## Indian Health Service

### Sequestration Exemption for Indian Health Programs

Proposal: To amend current law to exempt the Indian Health Service permanently from future sequestration cuts.

Current Law: Sequestration is the legislatively mandated process of budget control consisting of automatic, across-the-board spending reductions to enforce budget targets to limit federal spending. It was first established by the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA, Title II of P.L. 99-177, 2 U.S.C. § 900-922) to enforce deficit targets. Section 255 of BBEDCA (2 U.S.C. § 905) identifies programs that are exempt from sequestration, and Section 256 of BBEDCA (2 U.S.C. § 906) establishes special rules.

BBEDCA requires a sequestration of non-exempt mandatory budgetary resources to be ordered with the release of the Budget and take effect the start of the fiscal year. Sequestration of these resources are required in each fiscal year through 2031. The sequestration percentage for all those years are set to be the same as the percentages calculated in FY2021 which is 5.7 percent for nondefense spending, 8.3 percent for defense programs, and 2 percent for Medicare and certain other health programs. IHS funding is listed in section 256 of BBEDCA and limits their sequestration to 2 percent per fiscal year.

Rationale: The Budget proposes to shift all funding to mandatory starting in FY 2025, which would trigger a 2 percent sequester per fiscal year for the IHS. This sequester would reduce funds for direct health care services.

All programs administered by the Department of Veterans Affairs are exempt from a sequestration reduction ordered under the BBEDCA. Through this exemption, Congress expressly indicated how critical it is for services provided by the VA not to be disrupted or reduced as a result of sequestration.

Section 255 of BBEDCA (codified at 2 U.S.C. § 905) identifies programs that are exempt from sequestration. These include programs providing critical support to vulnerable groups within the United States, including children (Children's Health Insurance Program (CHIP), Child Nutrition Programs, and foster care) and low income persons/families (Medicaid, TANF, Family Support Programs), health benefits to retirees, veterans and service members (Veterans Affairs, Annuitants, Employees Health Benefits, Postal Service Retiree Health Benefits Fund, Medical Benefits for Commissioned Officers, Public Health Service). Many of the exempted programs reimburse the IHS for services rendered including Medicaid, Medicare (treated under special limiting rules), CHIP, and Veterans Health program reimbursement.

The services provided by the IHS are no less critical. Budget reductions of any kind have implications for the services IHS, Tribes, and Urban Indian organizations provide to American Indian and Alaska Native patients and communities. In FY 2013, these reductions resulted in dramatic oversight and administration reductions to maintain service levels, limitations to patients being able to see outside specialists beyond Priority 1 (emergent or acutely urgent care), and reductions to services paid for through offsetting collections. Future sequesters would not only damage the lives and health of American Indians and Alaska Natives through reduced direct services and care, it would also impair IHS's efforts to improve medical quality, implement improvements/replacement to its Electronic Health Record System, and reduce critical health care staffing vacancies among other impacts.

The impact of a sequestration on the IHS will be highly variable, both based on the overall sequester level, as well as the availability of third party resources to ameliorate budget reductions to critical care areas.

Budget Impact: While resulting in no change to IHS's funding, this proposal would increase the amount of sequestered funding taken from remaining non-exempt agencies.

Effective Date: Upon enactment.

## Indian Health Service

### U.S. Public Health Service Commissioned Officers to be Detailed to Urban Indian Organizations to Cooperate In or Conduct Work Related to the Functions of the Department of Health and Human Services

Proposal: Amend federal law to permit U.S. Public Health Service Commissioned Officers (officers) to be detailed directly to Urban Indian Organizations (UIOs) to cooperate in or conduct work related to the functions of the Department of Health and Human Services (HHS).

Current Law: Current federal law permits HHS to detail officers or employees of the Public Health Service for particular enumerated purposes to specified entities, including State health authorities and certain nonprofit institutions (subsections (b) and (c) of section 214 of the Public Health Service Act (PHSA) (42 U.S.C. 215(b), (c)). This legislative proposal is limited to seeking authority to detail only officers to UIOs. Although UIOs are nonprofit organizations, section 214(c) of the PHSA (42 U.S.C. 215(c)) only authorizes details to nonprofit institutions engaged in health activities for special studies of scientific problems and for the dissemination of information related to public health. Because UIOs do not meet those restrictions, officers cannot be detailed directly to an UIO. The authority to detail an officer to State health authorities has been interpreted to authorize an indirect placement with an UIO by detailing an officer to a State health authority which may then designate the UIO as the officer's duty station. UIOs are part of the Indian health care system and provide health care services to eligible American Indians and Alaska Natives residing in urban centers.

Rationale: The Indian Health Service (IHS) enters into limited, competing contracts and grants with 41 501(c)(3) non-profit organizations to provide health care and referral services for Urban Indians throughout the United States. UIOs are defined in section 4(29) of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. 1603(29)) as a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a) of that Act (25 U.S.C. 1653(a)). UIOs provide unique access to culturally appropriate and quality health care for Urban Indians.

UIOs have requested that officers be detailed to them to fill many roles related to the functions of HHS, however, section 214 of the PHSA (42 U.S.C. 215) prevents IHS from detailing officers directly to UIOs. Subsection (b) of that section (42 U.S.C. 215(b)) has been interpreted as allowing IHS to detail an officer to a State health authority, which may then designate the UIO as the officer's duty station. The officer is authorized to perform work at an UIO that is related to the functions of HHS, which has been interpreted to include health care services and supportive functions. The process for such indirect details is completely dependent on the availability of a State or local health authority that is capable and willing to enter into such an arrangement. The process can be burdensome and time consuming for all involved, and State health authorities may be reluctant because of this burden, as well as their potential liability under such an arrangement.

Amending the law would provide IHS the discretionary authority to detail officers directly to an UIO to perform work related to the functions of HHS, to the same extent it may do so now through the indirect, burdensome process described above. Such authority would be comparable to the existing authority to detail officers to Indian Self Determination and Education Assistance Act (ISDEAA) contractors and compactors for the purpose of carrying out the provisions of their ISDEAA contracts (section 7 of the Act of August 5, 1954 (42 U.S.C. § 2004b).

This proposal aligns with the U.S. Public Health Service's goal to increase the number of officers. Currently, 1,614 officers of the U.S. Public Health Service are assigned to IHS. There are five officers assigned to States, whose duty stations are UIOs. See table below.

| **Urban Facility Name, City, State** | **#Officers** | **Category** |
|---|---|---|
| Gerald L. Ignace Indian Health Center<br>Milwaukee, Wisconsin | 1 | Pharmacy |
| Native American Rehabilitation Association<br>Portland, Oregon | 2 | Health Services Officer – Physician Assistant<br>Pharmacy |
| Oklahoma City Indian Clinic Oklahoma City, Oklahoma | 3 | Health Services Officer- Medical Technologist<br>Pharmacy Therapist - Physical |

American Indians and Alaska Natives experience unique challenges when attempting to access care, due to factors such as inadequate supply of health care providers and other workers. Providing IHS authority to detail officers directly to UIOs will help address these shortages so that UIOs can provide health care services to eligible American Indians and Alaska Natives (AI/AN) residing in urban centers.

Budget Impact: This is a non-budget related proposal.

Personnel Requirements: This proposal does not require additional personnel to implement.

Effective Date: Upon enactment.

Equity Impact Assessment: Permitting officers to be detailed directly to UIOs will address the need to improve access to health care for AI/AN communities, who often experience unique challenges and barriers to care. Improving access to care by strengthening IHS workforce capacity will contribute to better outcomes for AI/AN, and reduce health disparities.

## Indian Health Service

**Provide the Indian Health Service Discretionary Use of all Title 38 Personnel Authorities**

Proposal: The Indian Health Service (IHS) is seeking the discretionary use of all United States Code Title 38 authorities under Part V, Chapter 74, "Veterans Health Administration – Personnel", that are primarily available to the Department of Veterans Affairs (VA) in relation to health care positions. The term "health care occupations" refers to positions, other than positions in the Senior Executive Service (SES), that provide direct patient-care services or services incident to direct patient-care which would normally be covered by Title 5 of the United States Code.

Current Law: Title 38 Part V, Chapter 74, governs all aspects of personnel administration for the Veterans Health Administration (VHA) unless expressly overridden by another law or regulation. In many areas of personnel administration, the VHA is exempt from Title 5 laws and regulations by virtue of Title 38. The U.S. Office of Personnel Management (OPM), under the authority of section 1104 and 5371 of Title 5 of the United States Code, has authorized the Department of Health and Human Services (HHS) to use the Title 38 provisions pertaining to pay rates and systems, premium pay, classification, and hours of work. This delegation of authority is described in a delegation of authority between OPM and HHS – the latest version of which was effective March 6, 2019. If HHS, or an HHS Operating Division under the delegation of authority, chooses to use a Title 38 provision, the comparable authority under Title 5 is waived. However, 5 U.S.C. § 5371 does not provide authority to apply all personnel provisions of Title 38 in lieu of comparable Title 5 provisions.

Rationale: The IHS, as a primarily rural health care provider, has difficulty recruiting health care professionals. The IHS has critical hiring needs for health care professionals in IHS, Tribal, and Urban Indian programs including, but not limited to physicians, dentists, nurses, pharmacists, physician assistants, and nurse practitioners. The ability to use Title 38 for pay purposes as noted above is beneficial because the IHS can offer market pay to physicians, dentists, and podiatrists as well as special salary rates to individuals in other health care occupations. However, the IHS's use of these compensation authorities is not adequate by itself to compete with other public sector agencies and private sector organizations.

Typically, the private sector and the VHA can offer candidates better scheduling options and paid time off — particularly important benefits to providers who serve in remote and rural locations. The IHS faces specific public sector competition in the area of annual leave accrual. The VHA provides 1 day of annual leave per pay period for all (including new) physicians, dentists, podiatrists, optometrists, and chiropractors and 8 hours of annual leave accrual per pay period for all (including new) nurses, physician assistants, and expanded-function dental auxiliaries. Due to the limited scope of 5 U.S.C. § 5371, the IHS does not have the authority covered by 38 U.S.C. § 7421. "Personnel Administration: in general" that includes "leaves of absence of employees". Thus, when a candidate with just a few years of experience is choosing between the IHS and the VHA, he or she will invariably choose the organization offering 1 day/8 hours of annual leave accrual per pay period, as opposed to just 4 or 6 hours of annual leave accrual per pay period that the IHS offers. Supervisors report anecdotally that the IHS has lost many candidates due to this difference in accrual rates.

In addition to better scheduling options and paid time off, the IHS is seeking access to other Title 38 authorities to increase its competitive stance in the health care labor market and to create a more efficient and effective human resources program. This would include the potential for instituting two-year probationary periods for staff appointed under Title 38 and to have jurisdiction over appeals for adverse actions involving professional conduct or competence pertaining to direct patient care and clinical competence instead of going through the Merit Systems Protection Board. Title 38 also exempts the VHA

from collective bargaining and associated grievance procedures relating to issues concerning professional conduct competence, and peer review. In contrast, Title 5 permits the establishment of grievance procedures on any issue through the collective bargaining process.

Budget Impact: This proposal is budget neutral. The IHS will accommodate funding requirements within existing resources.

Effective Date: Upon enactment.

## Indian Health Service

### Meet Loan Repayment/Scholarship Service Obligations on a Half-Time Basis

Proposal: Permit both Indian Health Service (IHS) scholarship and loan repayment recipients to fulfill service obligations through half-time clinical practice, under authority similar to that now available to the National Health Service Corps (NHSC) Loan Repayment Program (LRP) and Scholarship Program.

Authority similar to that provided in section 331(i) of the Public Health Service Act (42 U.S.C. 254d(i)) would allow IHS loan repayment and scholarship recipients more options and flexibility to satisfy their service obligations through half-time clinical work (a minimum of 20 hours per week) for double the amount of service time (e.g., clinician who works 20 hours a week performing clinical duties with a two-year service obligation would increase to a four-year service obligation) or to accept half the amount of loan repayment award in exchange for a two-year service obligation. This would provide parity with NHSC programs and enable IHS to make better use of these tools to recruit and retain key professionals in a highly competitive environment.

Current Law: Sections 104 and 108 of the Indian Health Care Improvement Act (25 U.S.C. 1613a, 1616a) require employees who receive IHS scholarships or loan repayments to provide clinical services on a full-time basis. Section 331(i) of the Public Health Service Act was amended by section 10501(n) of the Patient Protection and Affordable Care Act (Public Law No. 111-148; 124 Stat. 1002) to permit certain NHSC loan repayment and scholarship recipients to satisfy their service obligations through half-time clinical practice for double the amount of time or, for NHSC loan repayment recipients, to accept half the loan repayment award amount in exchange for a two-year service obligation.

Section 331(j) of the Public Health Service Act (42 U.S.C. 254d(j)) defines “full-time” clinical practice as a minimum of 40 hours per week, for a minimum of 45 weeks per year. It also defines “half-time” as a minimum of 20 hours per week (not to exceed 39 hours per week), for a minimum of 45 weeks per year.

Rationale: The IHS, as a rural health care provider, has difficulty recruiting and retaining health care professionals. Recruiting physicians and other primary care clinicians has been especially challenging. Permitting IHS scholarship and loan repayment health professional employees to fulfill their service obligations through half-time clinical practice for double the amount of time and to offer half the loan repayment award amount in exchange for a two-year service obligation could increase the number of providers interested in serving in the Indian health system.

Additional half-time direct care employees could also reduce the number and cost of Purchased/Referred Care program referrals, especially at sites that do not need full-time specialty care services. There are also a number of smaller rural IHS sites where clinicians will be able to provide a minimum of half-time clinical services with the remainder of their time devoted to much needed administrative/management responsibilities. This proposal will provide flexibility for providers who might not otherwise consider service in IHS by allowing part-time practice in IHS to coincide with a part-time private practice, as well as part-time practice in IHS combined with part-time administrative duties within the IHS.

The NHSA was authorized to establish a demonstration project permitting loan repayment recipients to meet their service obligations through less than full-time clinical service in response to requests from clinicians and sites. The Patient Protection and Affordable Care Act (Public Law No. 111-148; 124 Stat. 119) t replaced this demonstration with permanent authority for two specific kinds of NHSC options (described above under Current Law). The IHS is equally concerned with the requests from clinicians and prospective candidates for loan repayment awards for half-time service by clinicians. Having similar

authority as the NHSC would increase the ability for the IHS to recruit and retain health care clinicians to provide primary health care and specialty services (e.g., Surgery, OG/GYN, Psychiatry, Radiology, and Anesthesiology) and otherwise support the IHS and HHS priorities.

The ability to provide scholarship and loan repayment awards for half-time clinical service would make these recruitment and retention tools more flexible and cost-effective, providing incentives for an additional pool of clinicians and other medical providers that otherwise may not consider a commitment to the IHS federal, Tribal, and Urban Indian sites. Having similar authority as the NHSC would increase the ability of the IHS to recruit and retain health care clinicians to provide primary health care and specialty services and otherwise support the IHS and HHS priorities.

Budget Impact: This is a budget neutral proposal. The IHS will accommodate funding requirements from within existing resources. Direct hire medical staff costs are lower than the costs to hire temporary, contractor staff.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal would increase IHS's ability to recruit and retain health care clinicians to provide primary health care and specialty services to American Indian/Alaska Native communities which disproportionately suffer from healthcare issues and lack the necessary clinical personnel to provide care to community members. The requested change will also foster equity between the IHS and NHSC loan repayment and scholarship programs which will incentivize clinicians to choose a career with IHS.

## Indian Health Service

### Provide Tax Exemption for Indian Health Service Health Professions Scholarship and Loan Repayment Programs

Proposal: The Indian Health Service (IHS) seeks tax treatment similar to that provided to recipients of scholarships and loan repayment from the National Health Service Corps (NHSC). The IHS seeks to allow scholarship funds for qualified tuition and related expenses received under the Indian Health Service Health Professions Scholarships to be excluded from gross income under section 117(c)(2) of the Internal Revenue Code of 1986 (IRC) and to allow participants in the IHS Loan Repayment Program to exclude from gross income, payments made by the IHS Loan Repayment Program under section 108(f)(4) of the IRC. With the above exemptions, the IHS programs would also be exempt from any Federal Employment Tax (FICA), making the IHS programs comparable to the current NHSC status.

Current Law: Generally, benefits 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:

- 26 U.S.C. § 117(c)(2), provides that tuition, fee, and other related cost payments by the National Health Service Corps scholarships are not taxable. This tax exemption was made permanent by Congress in December 2012 but did not include IHS scholarships.
- 26 U.S.C. § 108(f)(4) provides that funds received through the National Health Service Corps Loan Repayment Program authorized under 338B(g) of the Public Health Service Act (42 U.S.C. 254l-1) or a state loan repayment program described in section 338I of the Public Health Service Act (42 U.S.C. 254q-1) are permanently not subject to federal income tax.
- 26 U.S.C. § 3401(a)(19) excludes NHSC loan repayment from federal employment tax.

As IHS programs are not included in the exceptions, IHS health professions scholarships and loan repayment awards are taxed under the IRC.

Rationale: The IHS, as a rural health care provider, has difficulty recruiting and retaining health care professionals. There are over 1,330 vacancies for health care professionals including: physicians, 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 health care professionals needed to fill these vacancies. The IHS Health Professions Scholarship and IHS Loan Repayment Program are very similar to 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. Based on IHS' calculations, exempting the IHS Loan Repayment Program would allow IHS to award an additional 190 loan repayment contracts in a given year. Thus, the IHS would be better able to increase the number of health care providers entering and remaining within the IHS to provide primary health care and specialty services.

Budget Impact:

Federal Tax Revenue Foregone (in 2019 dollars):

| | |
|---:|---:|
| Loan | $8,920,705 |
| Scholarship | $188,773* |
| Total | $9,109,478 |

*Number indicates taxes withheld by IHS at recipient's request.

Budget impact is the amount of tax revenue withheld by IHS from IHS Health Professions Scholarship and Loan Repayment and forwarded to the Internal Revenue Service. This also includes the tax liability owed by the scholarship recipients.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal would increase IHS's ability to recruit and retain healthcare professionals to provide primary health care and specialty services to American Indian/Alaska Native communities which disproportionately suffer from healthcare issues and lack the needed clinical staff to treat community members. The requested change will also foster equity between the IHS and NHSC loan repayment and scholarship programs which will incentivize clinicians to choose a career with IHS.

## Indian Health Service

### Waiver of Indian Preference

Proposal: Amend Federal law to authorize the Department of Health and Human Services (HHS) Secretary to waive Indian Preference laws, and issue related regulations, applicable to IHS positions that fall under specific conditions in order to fill positions in cases where the Secretary determines there is an urgent staffing crisis or chronic persistent vacancies in health professions.

Problem: In August 2018, GAO reported that the IHS had a 25 percent vacancy rate for providers, including physicians, nurses, dentists, pharmacists, nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and physician assistants (GAO-18-580). This equates to over 1,400 current vacancies in IHS in these health professions. Long-standing vacancies have a negative effect on patient access, quality of care, and employee morale. IHS needs additional flexibilities to rapidly address chronic staffing needs. While extremely important, Indian Preference sometimes impacts the Agency's ability to hire highly competent personnel for essential provider or facility Chief Executive Officer (CEO) positions (e.g., in circumstances when an Indian Preference candidate is qualified at only the most basic level, or where an Indian Preference candidate has poor references, a record of disciplinary issues in Federal employment, or both). Allowing the HHS Secretary to waive Indian Preference as proposed may help to mitigate the persistent vacancies experienced across the Agency and improve access to highly qualified providers and CEOs.

Rationale: The proposal would allow the HHS Secretary to grant a waiver of the application of Indian Preference laws without the written waiver now required under section 2(c) of Public Law 96-135 (25 U.S.C. 5117(c)) from concerned tribal organizations, for any personnel action involving filling a vacant position at an IHS service unit in which 15 percent or more of the total positions or specific health profession positions in the service unit are not filled by a full-time employee of the IHS for a period of 6 months or longer. This flexibility will help IHS expedite recruitment and hiring for critical provider positions or a CEO position at any facility that is not able to fill vacancies for an extended period of time under the Indian Preference laws. Also, it can be impractical to obtain a Tribal waiver, as is currently required, at locations where an IHS facility serves multiple Tribes. The IHS will provide the Secretary adequate justification for the waiver when a situation at a facility meets the criteria.

Budget Impact: IHS currently uses temporary contractors, at 2-3 times the cost of federal staff, to fill vacancies. If the proposal is approved, significant cost savings may result as federal employees and commissioned officers would be used instead of contracted personnel.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal to waive Indian Preference requirements under limited, urgent situations will enable IHS to hire and retain mission-critical healthcare staff to provide healthcare to people in American Indian and Alaska Native (AI/AN) communities who disproportionately suffer from serious health issues and a shortage of needed healthcare providers. The requested change will allow IHS to hire the best qualified candidates and fill critical staffing shortages to ensure the highest quality of care for patients.

**Indian Health Service**

**Withhold Annuity and Retiree Pay for Retired Civil Service Employees Convicted of Moral Turpitude**

Proposal: Amend Federal law to allow for withholding or revoking of annuity and retiree pay for retired civil service employees convicted of moral turpitude, including crimes against children and rape, during the commission of their federal duties.

Current Law: Under 5 U.S.C. § 8312, a retired civilian employee's annuity and retiree pay may only be withheld for specific high crimes of treason, aiding the enemy, perjury, and subordination of perjury. The federal government needs additional authorities to address the pay of retirees who commit certain egregious and reprehensible crimes that outrage and offend the American Public's moral sensibility. Expansion of the list of offenses minimally should include crimes against children and rape perpetrated by federal employees during the commission of their federal duties, on federal property, or while otherwise using their federal position.

Rationale: In September 2018, a former U.S. Public Health Service Commissioned Corps officer and civil service employee at the IHS was convicted of sexual assault and exploitation of children for crimes committed while an active duty Corps officer assigned to the IHS facility in Browning, Montana. In September 2019, the same individual was convicted on additional charges in South Dakota for similar allegations while assigned to the IHS facility in Pine Ridge, South Dakota, and the case was appealed in February 2020. The sexual assailant's conviction exposes the limitations of current statute to fully address and adjudicate crimes of moral turpitude committed by retired federal employees during the commission of their duties while in the federal civil service.

In keeping with the limited scope of current law, e.g., 5 U.S.C. § 8312, the proposed amendment may be limited to the commission of crimes against children and rape, specifically while on duty, on federal property, or while using or misusing the authority of their federal position.

This proposed amendment is in line with the Department's mission of protecting vulnerable, underserved populations, and the recommendations from the Presidential Task Force on Protecting Native American Children in the Indian Health Service System.

Budget Impact: In the case of revoking of annuity and retiree pay for retired civil service employees convicted of moral turpitude, there would be a cost savings to the agency.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal will promote equity of treatment against convicted perpetrators of egregious crimes in regards to receipt of federal retirement benefits. The American Indian/Alaska Native population is already a vulnerable and underserved population, and this proposal seeks to deny retirement benefits to those who harm children, who are the most defenseless members of this population. There are restrictions in most states' laws preventing or limiting the receipt of a state pension for convicted felons and this proposal would make federal pensions more consistent with this model.

## Indian Health Service

## Provide the Indian Health Service with legislative authority to conduct mission-critical emergency hiring needs beyond 30-day appointments

Proposal: The Indian Health Service (IHS) seeks a legislative change to meet staffing needs during emergency situations. The change requested is to allow for a 60-day critical hiring need appointment authority with the possibility of a 60-day extension. In addition, the maximum number of days an employee is authorized to work in 12 months would be increased from 60 to 120 days.

Current Law: Under 5 CFR 213.3102(i)(2) agencies can appoint individuals for 30 days under an excepted service 30-day critical hiring need appointment. This type of appointment can be extended for up to 30 days if continued employment is essential to the agency's operations. The individual may not be employed for more than 60 days in 12 months. This regulation is for both senior-level and lower-level positions general schedule employees.

Rationale: Critical hiring occurs when an agency needs to fill positions to meet agency requirements brought on by natural disasters, emergencies, or threats. IHS has previously used this hiring authority to fill positions in nursing, facility management, radiology, and many other critical areas to ensure the operation of IHS facilities and quality patient care. In March 2020, the COVID-19 public health emergency emerged. This increased IHS' use of this hiring authority. The health care industry took a significant hit during the pandemic and staff shortages were a constant issue. Furthermore, the pandemic disproportionately affected American Indian and Alaska Natives across the country further stressing IHS hospitals and clinics and requiring the need for additional emergency hires.

To provide adequate services to staff health care facilities, emergency hires should have longer appointments, specifically 60 days instead of 30, with extensions possible for 60 days. This makes sense operationally and from a resource point of view. The effort to hire an individual, onboard them, and vet them through the pre-clearance and background investigation process is significant. To expend agency resources, both human and monetary, to hire someone for only 30 days is no longer the most viable solution to address staffing needs.

Budget Impact: This proposal may see a slight budget savings due to less frequent turnover of staff.

Effective Date: Upon enactment.

Equity Impact Assessment: This proposal will enable the Indian Health Service to recruit short- term emergency staff to provide, or support the provision of, healthcare to people in American Indian and Alaska Native (AI/AN) communities who disproportionately suffer from serious health issues and a shortage of needed healthcare providers. By lengthening the period of time for critical hiring need appointments access to care will be strengthened, and as a result, better health care outcomes for American Indians and Alaska Natives will be achieved.

Impact on Other Agencies: None.

## Indian Health Service

### Provide the Indian Health Service with Permanent Authority to Hire and Pay Experts/Consultants

Proposal: The Indian Health Service (IHS) needs the ability to hire experts/consultants to address challenging tasks in a particular field beyond the usual range of achievement of competent persons (5 CFR 304.102(d)). An expert/consultant can also provide valuable and pertinent advice generally drawn from a high degree of broad administrative, professional, or technical knowledge or experience. (5 CFR 304.102(b)).

Unlike most other Department of Health and Human Services (HHS) Operating Divisions and Staff Divisions, the IHS does not have a permanent authority via the 1993 appropriations law to hire expert/consultants and pay rates not to exceed the daily rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. §5376.2. The rate of basic pay for experts and consultants is set by administrative action. An agency must determine the appropriate rate of basic pay on an hourly or daily basis. Since experts/consultants are not general schedule employees, they are automatically covered by locality payments 5 U.S.C. 5304 and 5 CFR part 531, subpart 5. The pay may not exceed the GS-15 step 10. IHS had a temporary authority through the FY 2020 annual appropriations bill; however, that authority has expired.

Current Law: Agencies may appoint experts and consultants temporarily (i.e., not to exceed one year) or on an intermittent basis (i.e., without a regularly scheduled tour of duty). These employees are not covered by the standard provisions related to an appointment in the competitive service (5 CFR part 332), position classification (5 U.S.C. chapter 51), or General Schedule pay-setting (5 U.S.C. chapter 53, subchapter III).

According to HHS Instruction 304-1: Appointment of Experts and Consultants, the Department of Interior, Environment, and Related Agencies Appropriations Act, 2020 (Public Law 116-94 div. D (Dec. 20, 2019)), authorized IHS to set pay for services authorized by 5 U.S.C. §3109 at rates not to exceed the daily rate equivalent to the maximum rate payable for senior-level positions under 5 U.S.C. §5376.2. Since the end of FY 2020, IHS has not had an identified appropriation authority or other statute using 5 U.S.C. §3109, per 5 U.S.C. §3109(b).

Rationale: Hiring experts and consultants is another tool IHS can use to strengthen its workforce and better serve the American Indian/Alaska Native population. These highly specialized individuals can bring added skills, knowledge, and expertise to meet mission-critical tasks. To combat future pandemics, emergencies, and unique health-care challenges, it would be beneficial to hire experts/consultants to provide additional high-level resources to the IHS unavailable within the current workforce.

The IHS is at a disadvantage by not hiring experts/consultants that could temporarily provide specialized advice or assistance with projects or planning on a temporary or intermittent basis. IHS could benefit from experts/consultants by:

1. Gaining specialized diversity of thought needed to solve complex issues or perform tasks.

2. Obtaining advice from experts/consultants in their field of study.
3. Hiring experts/consultants from leading universities and colleges to advise on health care
4. Completing short-term mission-critical projects.
5. Filling short-term, high level positions with experts/consultants temporarily, which can be an efficient mechanism as well as a cost savings to the agency.

Budget Impact: This proposal is budget neutral. The IHS will accommodate funding requirements within existing resources.

Effective Date: Upon enactment of legislative authority and the creation of a new HR system.

Equity Impact Assessment: This proposal will enable the Indian Health Service to appoint experts and consultants to support the provision of healthcare to people in AI/AN communities who disproportionately suffer from serious health issues and a shortage of needed healthcare providers. By authorizing the use of experts and consultants, IHS can strengthen operations and patient care, and as a result, achieve better health care outcomes for American Indians and Alaska Natives.

## Indian Health Service

**<u>Provide the Indian Health Service (IHS) with an on-call pay authority through a revision to premium pay provisions under Title 5 of the United States Code (USC)</u>**

<u>Proposal</u>: The Indian Health Service (IHS) needs to be able to provide on-call pay to its health care staff under the premium pay system authorized under Title 5 of the United States Code. This will enable IHS to compensate clinical staff who agree to be on call and to achieve adequate on- site staffing levels when responding to fluctuating patient care demands.

<u>Current Law</u>: IHS uses the premium pay provisions under Title 5 of the USC to compensate employees for working extended hours (overtime pay) or for working at certain times such as at night, on Sundays or on holidays. Premium pay is paid under Title 5 legal and regulatory provisions and is subject to biweekly and annual aggregate pay limitations, under 5 U.S.C. chapter 55, subchapter V and 5 Code of Federal Regulations (CFR) part 550, subpart A. Current Title 5 premium pay law does not allow for on-call pay.

By comparison, a major pay feature used by the United States Department of Veterans Affairs (VA) and nonfederal health care employers is the ability to provide on-call premium pay to health-care staff. Under the VA's Title 38 premium pay provisions, on-call pay is paid at ten percent of the employee's overtime rate. This type of premium pay is provided when an employee is scheduled to be on call outside of working hours in the event that the employer needs to call the employee back to the work site to provide health-care services. During the on- call period, the employee must remain ready to work and must carry a cell phone or other device in order to be easily contacted in the event the work site needs his or her services. If the employee is called back to the work site, he or she is provided, at a minimum, two hours of overtime pay or more if the employee needs to work on site longer than two hours. The ability to have employees be on call allows the VA to quickly adjust its on-site staffing and is ultimately a cost-savings measure since there is no need to schedule additional staff on-site at their full regular or overtime rate just to prepare for the possibility of increased patient care demands. On- call pay is also a standard pay option in nonfederal health care facilities that are not bound by federal pay regulations.

<u>Rationale</u>: The IHS is the principal federal health care provider and health advocate for American Indians and Alaska Natives (AI/ANs). The IHS provides comprehensive health services for over 500 federally recognized tribes and serves over two million AI/ANs located across 37 states every year.

For various budgetary and administrative reasons, IHS has not adopted the full suite of premium pay provisions available under the delegated Title 38 pay authorities which allow for the payment of on-call premium pay. IHS often competes with the VA and nonfederal employers for needed allied health staff, and IHS's inability to pay on-call pay is a major recruitment and retention challenge.

The success of the IHS clinical mission rests on the ready availability of the appropriate clinical staff who can best address patient needs. To achieve this, IHS needs to be able to compensate employees who are on call, with formally agreed-upon on-call restrictions in place such as continued proximity to the work site, carrying a cell phone, and remaining in a ready and able to work physical condition. A legislative change to the Title 5 premium pay provisions would place IHS on more equal footing with the VA and nonfederal employers of clinical staff that can already provide on-call pay to staff.

<u>Budget Impact</u>: This proposal is budget neutral. The IHS will accommodate funding requirements within existing resources.

<u>Effective Date</u>: Upon enactment.

Equity Impact Assessment: This proposal will enable the IHS to hire and retain mission-critical healthcare staff to provide healthcare to people in AI/AN communities who disproportionately suffer from serious health issues and a shortage of needed healthcare providers. It will enable IHS to better manage its healthcare staff by compensating employees who serve on call. The requested change will make the level of care provided to AI/AN people more on par with care provided to the country's veterans by the VA.

Impact on Other Agencies: None

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**INDIAN HEALTH SERVICE**
**FY 2024 Performance Budget Submission to Congress**

## TABLE OF CONTENTS

### Self Determination

Page

*Self-Determination*
Self-Determination Program ....... 300
Self-Determination Tables ....... 301

## Indian Health Service

## Indian Self Determination

Indian Health Service Philosophy – The Indian Health Service (IHS) implements the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law (Pub. L. No.) 93-638, as amended, which recognizes the unique legal and political relationship between the United States and American Indian and Alaska Native peoples. Accordingly, the IHS supports Tribal sovereignty: (1) by assisting Tribes in exercising their right to administer the IHS health programs, or portions thereof, and (2) by continuing to directly provide services to Tribes that choose the IHS as their health care provider. A Tribal decision to enter or not enter into ISDEAA agreements are equal expressions of self-determination.

Title I Contracts and Title V Self-Governance Compacts – Titles I and V of the ISDEAA provide Tribes the option to exercise the right to self-determination by assuming control and management of programs previously administered by the federal government. Since 1975, the IHS has entered agreements with Tribes and Tribal organizations to plan, conduct, and administer programs authorized under Section 102 of the Act. Today, over $6.2 billion of the Agency's appropriation is transferred to Tribes and Tribal Organizations through Title I contracts and Title V compacts. Under Title I, there are 242 Tribes and Tribal Organizations operating 252 contracts and annual funding agreements. Under Title V, IHS is party to 109 compacts and 135 funding agreements; through which approximately $2.7 billion of the IHS budget is transferred to Tribes and Tribal organizations. Sixty-seven percent of federally recognized Tribes participate in Title V.

## Indian Health Service

## Self-Governance Funded Compacts FY 2022

**(Dollars in Thousands)**

| Compacts by State | IHS Services | IHS Facilities | Contract Support Costs (Direct) | Contract Support Costs (Indirect) | Total |
|---|---|---|---|---|---|
| **ALABAMA** | **4,543** | **363** | **166** | **431** | **5,504** |
| Poarch Band of Creek Indians | 4,543 | 363 | 166 | 431 | 5,504 |
| **ALASKA** | **614,350** | **56,364** | **57,370** | **181,364** | **909,448** |
| Alaska Native Tribal Health Consortium | 103,935 | 19,707 | 12,684 | 18,102 | 154,428 |
| Aleutian Pribilof Islands Association, Inc. | 1,692 | 32 | 190 | 1,364 | 3,277 |
| Arctic Slope Native Association, Ltd | 24,011 | 2,302 | 3,583 | 7,604 | 37,499 |
| Bristol Bay Area Health Corporation | 21,341 | 1,008 | 2,409 | 9,877 | 34,635 |
| Chickaloon Native Village | 60 | 1 | 16 | 13 | 91 |
| Chugachmiut | 3,774 | 61 | 244 | 1,949 | 6,027 |
| Copper River Native Association | 6,240 | 430 | 536 | 2,254 | 9,461 |
| Council of Athabascan Tribal Governments | 1,878 | 138 | 109 | 1,373 | 3,497 |
| Eastern Aleutian Tribes, Inc. | 3,279 | 31 | 194 | 1,926 | 5,430 |
| Kenaitze Indian Tribe, I.R.A. | 12,803 | 1,180 | 432 | 2,377 | 16,792 |
| Ketchikan Indian Community | 5,774 | 211 | 599 | 3,614 | 10,198 |
| Knik Tribal Council | 75 | 1 | 11 | 9 | 97 |
| Kodiak Area Native Association | 7,551 | 192 | 496 | 3,367 | 11,606 |
| Maniilaq Association | 28,422 | 1,067 | 3,074 | 14,882 | 47,446 |
| Metlakatla Indian Community | 6,511 | 1,049 | 518 | 1,342 | 9,420 |
| Mount Sanford Tribal Consortium | 389 | 0 | 43 | 157 | 590 |
| Native Village of Eklutna | 185 | 3 | 7 | 56 | 250 |
| Native Village of Eyak | 823 | 44 | 96 | 480 | 1,443 |
| Norton Sound Health Corporation | 45,495 | 4,129 | 4,728 | 11,601 | 65,952 |
| Seldovia Village Tribe | 1,913 | 11 | 95 | 922 | 2,941 |
| Southcentral Foundation | 93,339 | 4,379 | 10,931 | 33,643 | 142,293 |
| SouthEast Alaska Regional Health Consortium | 39,821 | 1,644 | 3,888 | 19,011 | 64,363 |
| Tanana Chiefs Conference | 64,472 | 4,309 | 6,177 | 16,872 | 91,830 |
| Yakutat Tlingit Tribe | 4,578 | 377 | 34 | 1,425 | 6,414 |
| Yukon-Kuskokwim Health Corporation | 135,989 | 14,057 | 6,278 | 27,143 | 183,466 |
| **ARIZONA** | **242,561** | **22,997** | **8,334** | **58,075** | **331,967** |
| Ak-Chin Indian Community | 458 | 0 | 7 | 22 | 488 |
| Gila River Indian Community | 76,991 | 9,688 | 1,927 | 27,800 | 116,405 |
| Pascua Yaqui Tribe | 15,881 | 553 | 200 | 3,753 | 20,386 |
| Salt River Pima-Maricopa Indian Community | 46,136 | 3,454 | 284 | 3,005 | 52,879 |
| Tohono O'Odham Nation | 36,421 | 3,778 | 2,644 | 4,200 | 47,043 |
| Tuba City Regional Health Care Corporation | 43,503 | 3,986 | 2,382 | 11,817 | 61,687 |
| Winslow Indian Health Care Center, Inc. | 23,172 | 1,538 | 890 | 7,479 | 33,079 |
| **CALIFORNIA** | **90,296** | **6,021** | **4,161** | **29,782** | **130,259** |
| Chapa-De Indian Health Program, Inc. | 6,994 | 455 | 193 | 3,155 | 10,798 |
| Consolidated Tribal Health Project, Inc. | 4,326 | 160 | 112 | 1,538 | 6,135 |
| Feather River Tribal Health, Inc. | 6,040 | 693 | 0 | 0 | 6,733 |
| Hoopa Valley Tribe | 5,216 | 420 | 286 | 0 | 5,922 |
| Indian Health Council, Inc. | 8,975 | 903 | 301 | 4,269 | 14,449 |
| Lake County Tribal Health Consortium, Inc | 6,807 | 1,138 | 181 | 728 | 8,854 |
| Karuk Tribe of California | 3,184 | 294 | 103 | 935 | 4,516 |
| Northern Valley Indian Health, Inc. | 4,412 | 796 | 122 | 1,366 | 6,697 |
| Pinoleville Pomo Nation | 93 | 94 | 3 | 6 | 195 |
| Pit River Health Services, Inc. | 2,046 | 130 | 67 | 697 | 2,941 |
| Redding Rancheria Tribe | 7,418 | 447 | 625 | 2,723 | 11,213 |
| Riverside-San Bernardino County Indian Health, Inc. | 22,466 | 257 | 945 | 9,312 | 32,980 |
| Rolling Hills Clinic | 549 | 29 | 1 | 257 | 836 |
| Round Valley Indian Health Center, Inc. | 2,219 | 136 | 100 | 528 | 2,985 |
| Santa Ynez Band of Chumash Mission Indians | 2,002 | 14 | 37 | 721 | 2,775 |
| Southern Indian Health Council, Inc. | 5,778 | 43 | 910 | 2,680 | 9,411 |
| Susanville Indian Rancheria | 1,771 | 12 | 172 | 865 | 2,820 |

## Indian Health Service

## Self-Governance Funded Compacts FY 2022

**(Dollars in Thousands)**

| Compacts by State | IHS Services | IHS Facilities | Contract Support Costs (Direct) | Contract Support Costs (Indirect) | Total |
|---|---|---|---|---|---|
| **CONNECTICUT** | **2,564** | **74** | **0** | **643** | **3,281** |
| Mohegan Tribe of Indians of Connecticut | 2,564 | 74 | 0 | 643 | 3,281 |
| **FLORIDA** | **7,956** | **378** | **1,058** | **2,051** | **11,444** |
| Seminole Tribe of Florida | 7,956 | 378 | 1,058 | 2,051 | 11,444 |
| **IDAHO** | **16,522** | **1,080** | **2,031** | **6,617** | **26,250** |
| Coeur D'Alene Tribe | 6,436 | 462 | 1,482 | 3,421 | 11,801 |
| Kootenai Tribe of Idaho | 678 | 37 | 82 | 138 | 936 |
| Nez Perce Tribe | 9,408 | 581 | 466 | 3,058 | 13,512 |
| **KANSAS** | **7,071** | **191** | **274** | **3,218** | **10,754** |
| Iowa Tribe of Kansas and Nebraska | 2,237 | 32 | 177 | 1,517 | 3,963 |
| Prairie Band Potawatomi Nation | 4,821 | 137 | 96 | 1,700 | 6,754 |
| Wichita & Affiliated Tribes | 14 | 23 | 0 | 0 | 37 |
| **LOUISANA** | **1,227** | **98** | **136** | **254** | **1,714** |
| Chitimacha Tribe of Louisiana | 1,227 | 98 | 136 | 254 | 1,714 |
| **MAINE** | **3,834** | **125** | **185** | **916** | **5,060** |
| Penobscot Indian Nation | 3,834 | 125 | 185 | 916 | 5,060 |
| **MASSACHUSETTS** | **733** | **41** | **238** | **0** | **1,013** |
| Wampanoag Tribe of Gay Head | 733 | 41 | 238 | 0 | 1,013 |
| **MICHIGAN** | **29,718** | **1,181** | **2,901** | **3,249** | **37,049** |
| Grand Traverse Band of Ottawa and Chippewa Indians | 2,972 | 69 | 335 | 418 | 3,793 |
| Keweenaw Bay Indian Community | 3,562 | 279 | 877 | 635 | 5,353 |
| Little River Band of Ottawa Indians | 2,138 | 10 | 270 | 335 | 2,754 |
| Match-E-Be-Nash-She-Wish Band of Pottawatomi | 1,219 | 3 | 239 | 346 | 1,806 |
| Nottawaseppi Huron Band Of The Potawatomi | 1,833 | 178 | 339 | 209 | 2,558 |
| Sault Ste. Marie Tribe of Chippewa Indians | 17,996 | 642 | 841 | 1,306 | 20,785 |
| **MINNESOTA** | **21,445** | **579** | **3,063** | **2,268** | **27,355** |
| Bois Forte Band of Chippewa Indians | 2,747 | 53 | 434 | 718 | 3,952 |
| Fond du Lac Band of Lake Superior Chippewa | 12,506 | 242 | 1,320 | 821 | 14,890 |
| Mille Lacs Band of Ojibwe | 4,366 | 269 | 1,291 | 399 | 6,326 |
| Shakopee Mdewakanton Sioux Community | 1,826 | 15 | 18 | 329 | 2,188 |
| **MISSISSIPPI** | **39,690** | **4,019** | **1,361** | **5,761** | **50,831** |
| Mississippi Band of Choctaw Indians | 39,690 | 4,019 | 1,361 | 5,761 | 50,831 |
| **MONTANA** | **34,201** | **1,279** | **3,329** | **3,810** | **42,619** |
| Chippewa Cree Tribe of the Rocky Boy's Reservation | 10,821 | 292 | 2,447 | 2,310 | 15,870 |
| Confederated Salish and Kootenai Tribes of the Flathead | 23,380 | 987 | 882 | 1,500 | 26,749 |
| **NEBRASKA** | **18,227** | **3,466** | **1,860** | **2,887** | **26,440** |
| Winnebago Tribe of Nebraska | 18,227 | 3,466 | 1,860 | 2,887 | 26,440 |
| **NEW MEXICO** | **13,133** | **237** | **1,452** | **2,238** | **17,060** |
| Pueblo of Jemez | 10,135 | 220 | 1,057 | 1,722 | 13,134 |
| Pueblo of Sandia | 2,039 | 0 | 165 | 248 | 2,452 |
| Taos Pueblo | 958 | 17 | 231 | 268 | 1,474 |
| **NEW YORK** | **8,299** | **520** | **351** | **2,064** | **11,233** |
| St. Regis Mohawk Tribe | 8,299 | 520 | 351 | 2,064 | 11,233 |
| **NEVADA** | **29,004** | **1,414** | **2,382** | **5,399** | **38,199** |
| Duck Valley Shoshone-Paiute Tribes | 6,965 | 521 | 844 | 1,358 | 9,688 |
| Duckwater Shoshone Tribe | 1,102 | 6 | 219 | 760 | 2,088 |
| Ely Shoshone Tribe | 1,330 | 29 | 69 | 481 | 1,909 |
| Fort McDermitt Paiute and Shoshone Tribe | 1,606 | 101 | 8 | 109 | 1,824 |
| Las Vegas Paiute Tribe | 3,485 | 86 | 131 | 283 | 3,985 |
| Reno-Sparks Indian Colony | 7,140 | 395 | 739 | 1,641 | 9,915 |
| Washoe Tribe of Nevada and California | 5,325 | 136 | 258 | 427 | 6,146 |
| Yerington Paiute Tribe of Nevada | 2,050 | 140 | 114 | 341 | 2,644 |
| **NORTH CAROLINA** | **20,572** | **1,106** | **1,091** | **8,326** | **31,096** |
| Eastern Band of Cherokee Indians | 20,572 | 1,106 | 1,091 | 8,326 | 31,096 |
| **NORTH DAKOTA** | **11,424** | **706** | **1,677** | **2,568** | **16,375** |
| Spirit Lake Tribe | 11,424 | 706 | 1,677 | 2,568 | 16,375 |

## Indian Health Service

## Self-Governance Funded Compacts FY 2022

**(Dollars in Thousands)**

| Compacts by State | IHS Services | IHS Facilities | Contract Support Costs (Direct) | Contract Support Costs (Indirect) | Total |
|---|---|---|---|---|---|
| **OKLAHOMA** | **582,311** | **59,004** | **44,994** | **122,676** | **808,985** |
| Absentee Shawnee Tribe of Oklahoma | 18,870 | 1,697 | 2,118 | 6,013 | 28,697 |
| Cherokee Nation | 248,580 | 23,778 | 15,053 | 37,529 | 324,939 |
| Chickasaw Nation | 88,900 | 15,832 | 11,094 | 23,144 | 138,970 |
| Choctaw Nation of Oklahoma | 91,114 | 9,999 | 6,974 | 31,797 | 139,884 |
| Citizen Potawatomi Nation | 22,903 | 1,773 | 1,798 | 9,239 | 35,714 |
| Kaw Nation of Oklahoma | 2,955 | 110 | 231 | 790 | 4,087 |
| Kickapoo Tribe of Oklahoma | 10,310 | 197 | 318 | 1,612 | 12,437 |
| Modoc Tribe of Oklahoma | 61 | 28 | 7 | 20 | 116 |
| Muscogee Creek Nation | 56,362 | 4,381 | 6,209 | 5,170 | 72,121 |
| Northeastern Tribal Health System | 7,761 | 123 | 168 | 1,380 | 9,433 |
| Osage Nation | 13,272 | 37 | 406 | 2,293 | 16,008 |
| Pawnee Nation of Oklahoma | 703 | 13 | 19 | 214 | 949 |
| Ponca Tribe of Oklahoma | 6,494 | 96 | 285 | 937 | 7,812 |
| Quapaw Tribe of Oklahoma | 232 | 0 | 37 | 157 | 426 |
| Sac and Fox Nation of Oklahoma | 10,192 | 80 | 182 | 1,456 | 11,911 |
| Seminole Nation of Oklahoma | 514 | 682 | 54 | 179 | 1,429 |
| Wyandotte Nation | 3,087 | 177 | 43 | 744 | 4,051 |
| **OREGON** | **30,752** | **1,279** | **3,049** | **11,495** | **46,574** |
| Confederated Tribes of Grand Ronde | 7,282 | 125 | 620 | 2,626 | 10,652 |
| Confederated Tribes of Siletz Indians of Oregon | 8,338 | 349 | 827 | 3,044 | 12,558 |
| Confederated Tribes of the Coos, Lower Umpqua & Sius | 1,899 | 81 | 323 | 521 | 2,825 |
| Confederated Tribes of the Umatilla Reservation | 7,102 | 334 | 811 | 1,922 | 10,169 |
| Coquille Indian Tribe | 2,243 | 141 | 256 | 2,586 | 5,227 |
| Cow Creek Band of Umpqua Tribe of Indians | 3,888 | 248 | 211 | 796 | 5,143 |
| **UTAH** | **10,601** | **100** | **2,228** | **3,987** | **16,916** |
| Utah Navajo Health System, Inc. | 8,231 | 66 | 1,961 | 3,425 | 13,683 |
| Paiute Indian Tribe of Utah | 2,370 | 34 | 267 | 562 | 3,233 |
| **WASHINGTON** | **62,673** | **3,489** | **3,187** | **16,508** | **85,858** |
| Cowlitz Indian Tribe | 7,116 | 61 | 26 | 1,488 | 8,690 |
| Jamestown S'Klallam Indian Tribe | 1,032 | 69 | 102 | 560 | 1,763 |
| Kalispel Tribe of Indians | 1,156 | 48 | 24 | 84 | 1,312 |
| Lower Elwha Klallam Tribe | 1,979 | 110 | 120 | 289 | 2,497 |
| Lummi Indian Nation | 8,505 | 598 | 297 | 1,799 | 11,199 |
| Makah Indian Tribe | 4,107 | 282 | 317 | 1,256 | 5,962 |
| Muckleshoot Tribe | 7,675 | 390 | 232 | 2,819 | 11,115 |
| Nisqually Indian Tribe | 2,438 | 187 | 128 | 446 | 3,199 |
| Port Gamble S'Klallam Tribe | 2,755 | 188 | 158 | 1,464 | 4,564 |
| Quinault Indian Nation | 5,899 | 535 | 254 | 1,423 | 8,110 |
| Samish Indian Nation | 1,185 | 8 | 105 | 499 | 1,796 |
| Shoalwater Bay Indian Tribe | 1,881 | 57 | 324 | 703 | 2,966 |
| Skokomish Indian Tribe | 2,178 | 99 | 129 | 456 | 2,862 |
| Squaxin Island Indian Tribe | 2,896 | 218 | 227 | 1,283 | 4,623 |
| Suquamish Tribe | 1,777 | 37 | 173 | 617 | 2,604 |
| Swinomish Indian Tribal Community | 2,373 | 119 | 205 | 541 | 3,239 |
| Tulalip Tribes of Washington | 7,722 | 485 | 368 | 781 | 9,356 |
| **WISCONSIN** | **37,319** | **1,243** | **4,429** | **4,956** | **47,947** |
| Forest County Potawatomi Community | 2,518 | 77 | 817 | 401 | 3,814 |
| Ho-Chunk Nation | 8,560 | 604 | 987 | 866 | 11,016 |
| Oneida Tribe of Indians of Wisconsin | 22,809 | 320 | 2,096 | 3,087 | 28,312 |
| Stockbridge-Munsee Community | 3,432 | 242 | 529 | 602 | 4,805 |
| **Grand Total** | **1,941,025** | **167,354** | **151,307** | **481,544** | **2,741,231** |

# Indian Health Service
# FY 2022 Self-Governance Funding Agreements
# By Area

**(Dollars in Thousands)**

| Area | Program Tribal Shares | Area Office Tribal Shares | Headquarters Tribal Shares | Contract Support Costs (Direct) | Contract Support Costs (Indirect) | Total |
|---|---|---|---|---|---|---|
| ALASKA | 647,749 | 13,452 | 9,512 | 57,370 | 181,364 | 909,448 |
| ALBUQUERQUE | 12,089 | 955 | 326 | 1,452 | 2,238 | 17,060 |
| BEMIDJI | 87,909 | 1,886 | 1,689 | 10,394 | 10,473 | 112,351 |
| BILLINGS | 32,718 | 1,866 | 897 | 3,329 | 3,810 | 42,619 |
| CALIFORNIA | 89,966 | 3,604 | 2,747 | 4,161 | 29,782 | 130,259 |
| GREAT PLAINS | 32,202 | 1,272 | 349 | 3,537 | 5,455 | 42,815 |
| NASHVILLE | 89,471 | 5,287 | 1,385 | 4,586 | 20,446 | 121,175 |
| NAVAJO | 75,869 | 2,572 | 2,054 | 5,233 | 22,721 | 108,449 |
| OKLAHOMA | 623,864 | 11,891 | 12,822 | 45,268 | 125,894 | 819,739 |
| PHOENIX | 165,882 | 2,048 | 1,618 | 4,867 | 36,788 | 211,204 |
| PORTLAND | 109,099 | 3,850 | 2,846 | 8,267 | 34,620 | 158,682 |
| TUCSON | 53,274 | 2,586 | 772 | 2,844 | 7,952 | 67,429 |
| **Total, IHS** | **2,020,092** | **51,269** | **37,018** | **151,307** | **481,544** | **2,741,231** |

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**INDIAN HEALTH SERVICE**
**FY 2024 Performance Budget Submission to Congress**

**TABLE OF CONTENTS**

**Nonrecurring Expenses Fund**

Page

Nonrecurring Expenses Fund.......................................................................................305

## Nonrecurring Expenses Fund
## Budget Summary

(Dollars in Thousands)

| | FY 2022[1] | FY 2023[2] | FY 2024[3] |
|---|---|---|---|
| **Information Technology** | $17,865 | $18,000 | $31,500 |
| **Facilities** | $62,345 | $96,788 | $80,873 |
| **Notification[4]** | $80,210 | $114,788 | $112,373 |

**Authorizing Legislation:**
Authorization…………Section 223 of Division G of the Consolidated Appropriations Act, 2008
Allocation Method…………………………..……………..Direct Federal, Competitive Contract

### Program Description and Accomplishments

The Nonrecurring Expenses Fund (NEF) permits HHS to transfer unobligated balances of expired discretionary funds from FY 2008 and subsequent years into the NEF account. Congress authorized use of the funds for capital acquisitions necessary for the operation of the Department, specifically information technology (IT) and facilities infrastructure acquisitions.

NEF resources have allowed IHS to address the Health Care Facilities Construction Priority List backlog and to modernize IHS' aging health IT systems. These investments will facilitate improved access to modern facilities and data systems for health care providers, support accurate clinical diagnosis, and effective therapeutic procedures to assure the best possible health outcomes. NEF funds have also allowed IHS to make numerous capital investments through the Health IT Systems and Support project, enabling targeted upgrades toward its quarterly release schedule for the IHS electronic health records system software applications. IHS has been able to replace over-age medical equipment. These funds were distributed to procure prioritized medical equipment across various IHS Area Offices, and have allowed replacement of a wide range of equipment including mobile mammography equipment, digital radiology, central patient monitoring systems, nurse call systems, x-rays, ultrasounds, fetal monitoring systems, medical pumps and dental equipment.

## IT Projects

### Budget Allocation FY 2024

IHS received $31.5 million from FY 2024 NEF for the following projects:

### Implement Zero Trust and Critical Cybersecurity Capabilities

OMB Memorandum M-22-09 requires agencies to achieve specific zero trust security goals by the end of Fiscal Year (FY) 2024. The IHS requires CapEx funding to develop a Federal zero trust architecture and implement the required capabilities in order to reinforce the Government's defenses against increasingly sophisticated and persistent threat campaigns. In order to implement the Zero Trust architecture mandate, the IHS will seek out and identify external partners and Subject Matter Experts (SME) via the contracting process to evaluate agency IT infrastructure and applications with the specific goal of implementing next-

[1] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on June 17, 2021.
[2] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on September 23, 2022
[3] HHS has not yet notified for FY 2024.

[4] Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use.

generation security protocols and processes. The IHS does not have in-house expertise nor the staffing required to implement a complex, next-generation IT architecture. Once an agency-wide current state IT assessment is completed utilizing external contracted partners, this initiative will next focus on identifying the tools, applications, IT hardware, and processes necessary to implement the zero trust goals. It must be noted that the impact of implementing a Zero Trust IT architecture is enormous and the IHS is severely constrained in harnessing and leveraging in-house resources that are currently non-existent. This initiative will also require developing pilot projects which require additional resources in the form of increased staffing, new tools and applications as well as the expertise necessary to develop, test, and implement a Zero Trust IT environment. Where applicable, the IHS will comply with all FISMA and HHS cybersecurity/privacy requirements.

**Modernize the Indian Health Service Network**

OMB Memorandum M-21-07 requires all federal agencies to have at least 80 percent of IP-enabled IT assets operating in IPv6-only environment by FY 2025. IPv6 is the next-generation Internet protocol, designed to replace version 4 (IPv4) that has been in use since 1983. In order to implement OMB mandate M-21-07, the IHS will need to identify external partners and SMEs via the contracting process to evaluate agency IT infrastructure and applications with the specific goal of transitioning the agency to next-generation internet communication protocols. Once external partners are identified and contracted, the next phase of this initiative will be to identify a path forward to migrate to an Ipv6-only infrastructure. The plan includes performing a current-state assessment, the identification and procurement of tools, applications, and hardware necessary to migrate to an IPv6 environment. The IHS does not have in-house expertise, nor does the IHS have the staffing required to implement a complex, next-generation internet communication protocol that is mandated. This initiative will also require developing pilot projects which require additional resources in the form of increased staffing, new tools and applications as well as the expertise necessary to develop, test, and implement an IPv6-only environment.

**Modernize Enterprise IT and Cloud Services**

The primary objective of this project is to leverage cloud computing capabilities and modernize IHS IT enterprise services, support HIT modernization efforts, and accelerate existing IHS IT initiatives to create a unified, automated, and optimized computing environment by adapting a "Cloud Smart" strategy. OMB expects all new agency applications to use virtualization or containerization whenever possible and appropriate Cloud computing benefits and advantages are readily accessible and will enable the IHS to enhance the mission of the agency. Further, the implementation of cloud-computing capabilities will support and accelerate existing IT initiatives including IHS HIT modernization, data center consolidation, shared IT services, and enhance the cybersecurity posture of the IHS network. Utilizing cloud computing capabilities and services is a high priority requirement that is integral to the modernization of the IHS HIT infrastructure. In order to modernize IHS IT enterprise services, the IHS will seek out and identify external partners and SMEs via the contracting process to evaluate agency IT infrastructure and applications with the specific goal to leverage cloud-computing capabilities to modernize and optimize the IHS network. The IHS does not have in-house cloud-computing expertise nor the staffing required to assess, develop, and implement a plan to migrate to a fully modernized IT environment that utilizes cloud-computing resources. Once an initial assessment is completed, the initiative will focus on identifying the tools, applications, hardware, and processes necessary to fully modernize the IHS network and leverage cloud-computing resources. It must be noted that the impact of migrating to a fully modernized IT environment while leveraging cloud-computing resources are enormous and the IHS is severely constrained in harnessing and leveraging in-house resources that are currently non-existent. It is anticipated that this initiative will also require developing pilot projects that will require additional resources in the form of increased staffing, new tools, and applications as well as the expertise necessary to develop, test, and implement a modernized IT environment that leverages cloud-computing resources. With regards to acquisition, the IHS will insure that all applicable contract language and contract clauses will be consistent with the HHS Policy for IT Procurements – Security and Privacy Language policy.

**IT Service Management Enhancements**

Information Technology Service Management (ITSM) is the process of designing, delivering, managing, and improving the IT services an organization provides to its end users. The IHS objective is to focus on aligning IT processes and services with business objectives to help the IHS provide improved IT services that directly support direct patient care services. The strategic intent is for the IHS is to drive down IT costs and enhance IT Service Management efficiencies by maturing its IT Service Management capabilities by improving the capabilities of its ITSM tool. In 2018, the IHS contracted with the research firm Gartner to develop a detailed ITSM Maturity Improvement Roadmap. This project builds upon several years of work and will implement important capabilities to improve the ITSM maturity within IHS, reduce costs, enhance managerial oversight, and increase cybersecurity capabilities in IHS. The project requires contract labor for integration support, hardware, and increased software licenses. Funding will be used to implement new cloud capabilities in the ITSM tool (ServiceNow cloud platform) to improve IT and HIT services used to directly support direct patient care services. IHS lacks the ability to centrally manage IT service events such as service outages and performance degradation. This project consolidates multiple data sources for configuration items into a single IHS ServiceNow Configuration Management Database dashboard. This project also implements Service Level Management capabilities in the ITSM tool to document and track all service commitments between IT, service providers, and customers. This project centralizes these functions and provides IHS with tools and processes to improve IT services across the Agency.

**Advancing Interoperability of Health Information**

The Interoperability project objective is to develop strategies, including the development and/or acquisition of solutions in response to support the HHS requirements of the 21st Century Cures Act, as well as position IHS for further interoperability in preparation for future data migration/archiving needs. While the IHS and HHS are beginning the selection and implementation of the modernized Electronic Health Record, the IHS agency is required to comply with HHS mandates for Certified Health Information Technology. This new development is necessary as prescribed by the Cures Act so as not to compromise quality of care. In addition, should IHS not comply with Cures Act standards, I/T/U sites, hospitals, clinics, and health stations where direct patient care is delivered will be subject to reductions in billable services to CMS further impacting resources at the point of care provided through revenue generation. Primary activities include analyzing and developing requirements to meet the Trusted Exchange Framework, meeting the minimum required terms and conditions for the Trust Exchange, and participating in a Qualified Health Information Network. Components impacted by the Cures Act include, but are not limited to, systems and processes supporting Health Information Exchange, Personal Health Record, Master Patient Index, standardization of application programming interfaces (APIs), analytics supporting quality measure development and reporting, user authentication, patient-initiated health data requests, and data segmentation and privacy policies.

**Clinical Quality Measure Development and Training**

Activities include new quality measure analysis, existing logic reviews to identify changes needed to meet new measure requirements, updating measures to the current version logic, developing new measures as identified, preparing tests to verify the measures return the intended data, and developing all required workflow reporting processes that must be performed either individually at the site level or through central reporting mechanisms. Additional activities require the identification and creation of new data elements to capture new codes, tests, results, and other applicable information related to the public health emergency and associated workforce training activities to support the response to the pandemic information tracking.

This project delivers update work needed to prepare the electronic Clinical Quality Measures eCQM for the 2024 CMS Reporting Period (January 1-December 31, 2024) and support local quality performance improvement activities by updating the product to the most current version standards and maintaining

ONC Maintenance Certification. We anticipate that eCQM will need to recertify with the ACB (Authorized Certification Body).

**Budget Allocation FY 2023**

In FY 2023, IHS received $18 million in resources for the following projects:

1. **Modernize Enterprise IT Services ($5.5M)**
   The project will support the acquisition and implementation of cloud capabilities for the IHS enterprise infrastructure that will support the IHS HIT modernization initiative. Leveraging cloud computing capabilities will enable the IHS to leverage five essential characteristics of cloud computing: on-demand IT services, broad network access, resource pooling, rapid elasticity, and measured services.

2. **IPv6 Cybersecurity Remediation ($5M)**
   The project upgrades the IHS Wide Area Network (WAN) to support the migration to an Internet Protocol IPv6 capable network. This upgrade is critical to support Health IT services and will provide the network hardware, tools and migration support services to enable the IHS WAN to migrate to next-generation networking capabilities and increase the overall security posture of the IHS network.

3. **Quality Measures Development and Reporting ($7.5M)**
   The project develops new data capture capabilities, measure logic, and business intelligence development to respond to mandated requirements from various quality initiative programs and public health emergency management reporting. Activities include updating measures to the current version logic, developing new measures as identified, and developing all required reporting processes that must be performed either individually at the site level or through central reporting mechanisms, such as the Association of Public Health Laboratories (APHL) Information Messaging Services (AIMS) system.

**Budget Allocation FY 2022**

1. **Improve IT Service Management Maturity**
   This project will mature the cloud capabilities of IHS HIT systems and improve IT services that support direct patient care.

2. **Lifecycle Replacement of Critical Hardware**
   This project continues replacing end of life network and data center hardware critical to HIT services that support medical providers. IHS has thousands of devices operating beyond the lifecycle that are not covered by warranties or service agreements and cannot be updated against cybersecurity threats. This project is part of a multi-year strategy to improve lifecycle management of all IHS hardware.

3. **Cybersecurity Operations Center**
   This project creates a dedicated lab space with specific tools and equipment needed to perform several mission essential functions that aid in HHS and OIG investigations. Some of these functions include malware analysis, eDiscovery and research. This facility will give the incident responders the ability to correlate data from various sources and determine if a critical system has been impacted; provide remediation efforts and support system owners in data/system recovery.

4. **Advancing Interoperability of Health Information**

This project will continue work toward expanding capacity and capability of the interoperability framework and meeting the certification requirements of the 21CCA. The upcoming objectives include the performance of Real World Testing of the current released certified criteria in production settings, completion of the coding necessary to transition to the US Core Data for Interoperability (USCDI) v2.0 data requirements, development to meet the certification criteria for Transitions of Care, Clinical Information Reconciliation, Security Tagging, Standardized APIs, and self-declaration criteria supporting auditing requirements. In addition, work continues to complete the necessary documentation to obtain the Authority to Operate for the Four Directions Hub system providing the interoperability framework.

5. **Developing and implementing supporting technology standardization through a planned Enterprise Architecture**
   Plans for the FY2022 in support of the technology standardization include the efforts to implement the USCDI v2.0, as well as the implementation of the certified software in scheduled phases for 21CCA. Providing a common data set, software configuration, security orchestration, and standardized API configuration that are the industry standards for interoperability. These efforts will prepare the IHS for the solutions to standardize HIT in use at IHS now and in the future.

## Facilities

**Budget Allocation FY 2024**

IHS received $80.873 million from FY 2024 NEF for the following projects:

**Design of the Southern Bands Health Center (SBHC), Elko Nevada**
This request will complete the design of the new Southern Bands Health Center. The proposed 68,500 BGSF healthcare facility has been planned for the approved User Population of 2,400. New planned services include eye care, social services, visiting specialties (endodontics, cardiology, and podiatry), general radiography, physical therapy, facility management, property and supply, housekeeping, public health nutrition, and a wellness center.

**Red Lake Hospital, Red Lake, MN**
This project proposes 900 SF of environmental services, 400 SF Audiology, 4,240 SF Pharmacy renovation, loading dock addition, property and supply renovation, a new helipad, and 3,000 SF behavioral health renovation.

**NYRTC - Sacred Oaks Healing Center Stormwater, Davis, CA**
This project installs stormwater chambers as flood protection structures and complete landscaping improvements above these chambers.

**Chinle Comprehensive Health Care Facility Phases 1-4, Chinle, AZ**
This project improvements included in Track 2 are the Primary Care, Specialty Care, and Pharmacy Addition. Specifically building an addition for Primary Care expansion, building an addition for Outpatient Pharmacy relocation, and expansion with a drive-thru window. Renovate vacated Outpatient pharmacy for Specialty Care expansion and relocated provider offices, and Nursing Administration Expansion.

**Parker Quarters Project, 25 units, Parker, AZ**
This project will construct 25 quarters units at the Parker Indian Health Center to provide additional housing for staff that works at the healthcare facility.

**Indian Health Service - Medical Equipment**
Medical equipment at some IHS and Tribal healthcare sites is old, out of date or obsolete especially at sites with high volumes of patients and limited third-party collections. The NEF resources will be used to mitigate some of the most pressing needs at these sites.

**Inscription House Health Care Quarters Renovation, Shonto, AZ**
The Inscription House Health Care Facility Quarters Renovation (IHHCQ) is an approximately 19,550 SF health facility located in the northern boundary of Arizona. The IHHC was built in 1983. The quarters are to house medical and support staff for the health facility. In a recent review of the quarters, it was determined these quarters need renovation and updating. The renovations of the quarters will help in the recruitment and retention of health care providers and support staff.

**Browning Hospital Mechanical Equipment Phase I, Browning, MT**
The proposed renovation project of the Browning Hospital Mechanical Equipment in Browning, MT is needed to ensure quality and comprehensive healthcare is accessible to the American Indian and Alaska Native people of the area. The patient Centered model is followed to provide care for 108,481 outpatient visits per year to an ever-growing user population that is projected to be 20,736 in 2025. In 2021 a Facilities Condition Assessment was prepared by KF Davis Engineering that identified almost all major mechanical is at or past the end of their useful life in the Browning Hospital.

**Budget Allocation FY 2023**

In FY 2023, IHS received $96.788 million in resources for the following projects:

**Fort Duchesne Health Center Modernization, Ft. Duchesne, UT**
The Fort Duchesne PHS Indian Health Center Renovations project modernized the building's mechanical, electrical, plumbing, security, and IT systems and reconfigure the space allocation within the healthcare facility to address current healthcare needs.

**Rapid City Health Center Priority Project, Rapid City, SD**
The funding was used to equip the healthcare facility to replace the Sioux San Hospital with a new 137,391 SF ambulatory care center. This facility will improve access to medical care as well as improve the collaboration and partnership between the Great Plains Tribes and the IHS. The new healthcare facility provides an expanded outpatient department, community health department, and a full array of ancillary and support services. This facility began construction in September 2019.

**Desert Sage Youth Wellness Center Best Road, Hemet, CA**
The funds will acquire, from willing sellers, the land in Hemet, California, upon which is located a dirt road known as ``Best Road' 'and construct a reliable and safe all-weather access road between Sage Road (a Riverside County paved road), to the DSC paved entrance. The newly paved all-weather access road is approximately 0.51 of a mile long and 24' wide. It will be constructed along the same alignment as the current Best Road which is currently an unimproved dirt road that traverses across two parcels of private property that will need to be purchased.

**Crow 18-Unit Apartment Building, Crow Agency, MT**
The NEF funds will be used to construct an 18-Unit apartment building in Crow Agency, Montana. The Program Justification Document for Quarters identifies the shortage of living quarters within the area and that shortage limits IHS' ability to hire and retain staff. The project will expand the availability of living quarters at the remote location, which enables the Service Unit to hire and house the needed staff for delivering adequate health care.

**FBSU Hospital Expansion and Renovation, Harlem, MT**

This project consists of expanding and renovating the Emergency, Inpatient, Pharmacy and Laboratory Departments at the Fort Belknap Hospital. This will allow the hospital to improve general safety, patient care, COVID response, staff performance and overall hospital efficiency.

**Pryor Clinic Expansion and Renovation, Pryor, MT**

This project will fund the first phase of capital improvements is anticipated which is to renovate and expand the Pryor Clinic. The renovation and expansion will optimize workflow, and expand services to a remote population base at the service unit. The expanded services will include behavior health, physical therapy, radiology, optometry, and create telehealth capabilities. This investment of NEF funds will notably improve patient care and efficiency, increase patient's access to care, and update the facility for treating patients with COVID-19 and other infectious diseases.

**Cass Lake Hospital 2023 Expansion and Remodel, Cass Lake, MN**

The NEF funds will be used to complete Phases 2.3 and 2.4: remodel of Administrative and Inpatient space, Rooftop Helipad and Medical Office Space Remodel; FFE and Medical Equipment needed for Phases 2.2, 2.3, and 2.4; and facility remodel needed for a pharmacy drive-up window.

**Lower Brule Dental Building, Lower Brule, SD**

The NEF funds will be used to construct a new dental building on the Lower Brule Service Unit campus. Moving the dental department to the new building will provide space to renovate and expand the existing primary care department.

**Rosebud Emergency Department Expansion, Rosebud, SD**

This project funding will be used for the expansion and renovation of existing space at the Rosebud Healthcare Center Emergency Department. The current area is under-sized for the high volume of patients and needs to be expanded, with a more functional floorplan, to adequately serve the patient load. The 3,000 SF ED space will be expanded to approximately 11,000 SF. The space needs include ligature free exam rooms, two procedure rooms, an isolation room and restroom, birthing room, low acuity exam rooms, a second trauma room, and support space for staff and supplies

**Great Plains Area Clinic Pharmacy USP Renovations, Great Plains Area**

The funding will be used to redesign, construct, and equip six-Service Unit clinic pharmacies so they will meet the current United States Pharmacopeia (USP) 795, 797, and 800 standards. Site assessments have been completed by a USP consultant

**Nationwide Quarters New and Replacement**

The NEF funds will be used to design, construct, and equip new and replacement staff quarters. Many locations need to replace existing staff quarters due to deterioration. Staffing health centers in remote locations is difficult when quarters are limited. The shortage of staff limits IHS' ability to provide healthcare.

**Budget Allocation FY 2022**

In FY 2022, IHS received $62.345 million in resources for the following projects:

**Generators for California Area Tribal Health Programs**

The NEF funds will be used to support the purchase of emergency generators for California Area Tribal Health programs impacted by public safety power shutoffs in California.

**IHS Chemawa Indian Health Center, Salem, OR**

The NEF funding will be used to construct a new student wellness building on the Western Oregon Service Unit campus. The construction work aligns with other agency strategic initiatives specific to youth behavioral health needs.

**Yakama Dental Building and Modern Primary Care Department**
The funds will be used to construct a new dental and optometry building on the Yakama Service Unit campus. An updated site survey for the campus has been completed and is currently being recorded with the Yakama Nation's BIA Realty office and at the US Title Plant. Moving the dental and optometry departments to the new building will provide space to renovate and expand the existing primary care department.

**White Earth Health Center Phase II Renovation**
This project funding will be used for the renovation of the White Earth Health Center in Ogema, MN, which is needed to meet the demand for health services from the increase in user populations. The 35,800 SF renovation, increases space for Radiology Diagnostics, Behavioral Health, Lab, Optometry, Primary Care, Employee Facilities, Health Information Management and Administration.

**Fort Duchesne Health Center Modernization**
The Fort Duchesne PHS Indian Health Center Renovations project is intended to modernize the building's mechanical, electrical, plumbing, security and IT systems, and reconfigure the space allocation within the healthcare facility to address current healthcare needs.

**Nationwide Quarters New and Replacement**
The NEF funds will be used to design, construct, and equip new and replacement staff quarters. Many locations need to replace existing staff quarters due to deterioration. Staffing health centers in remote locations is difficult when quarters are limited. The shortage of staff limits IHS' ability to provide healthcare.

**Sells Health Center Replacement Facility**
The NEF Funds will augment the FY 2022 HHSJ funding requested for the Sells Health Center Replacement Facility for initial infrastructure and construction.