U.S. Department of Health and Human Services

National Tribal Budget Recommendations for the Indian Health Service

Fiscal Year 2013 Budget

Fulfilling U.S. Treaty and Constitutional Obligations: Honoring Promises of Justice, Health and Prosperity

"We know that Native Americans die of illnesses like diabetes, pneumonia, flu – even tuberculosis – at far higher rates than the rest of the population…And closing these gaps is not just a question of policy, it's a question of our values – it's a test of who we are as a Nation."

President Barack Obama, December 16, 2010

"We urge Congress to sustain investments in tribal nations by holding Indian programs harmless … now is not the time to step back from investments in tribal communities that hold promise for our entire nation."

Jefferson Keel, President, National Congress of American Indians, January 27, 2011

"The provision of health care services to American Indians and Alaska Natives is a key component of the federal government's trust responsibility, and the updating and permanent authorization of the IHCIA helps to fulfill this responsibility."

Yvette Roubideaux, M.D., M.P.H., Director, Indian Health Service, March 26, 2010

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Executive Summary

Introduction

"This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding."

- The Constitution of the United States, Article VI

The federal budget is a moral, as well as a fiscal document. The nation's budget priorities are a demonstration of its core values and, in the case of the Indian Health Service, of its commitment to addressing the health needs of American Indian and Alaska Native people. The budget request for IHS reflects the extent to which the United States honors its promises of justice, health and prosperity to Indian people. The provision of federal health services to American Indians and Alaska Natives (AI/ANs) is the direct result of treaties and executive orders that were made between the United States and Indian Tribes, and of two centuries of Supreme Court case law developed in the wake of those treaties. Through the cession of lands and the execution of treaties, the federal government took on a trust responsibility to provide for the health and welfare of Indian peoples. It is this federal trust responsibility that is the foundation for the provision of federally funded health care to all enrolled members of the 565 federally recognized Indian Tribes, bands, and Alaska Native villages in the United States. The Snyder Act of 1921 provides the basic authority for health services provided by the federal government to American Indian and Alaska Natives. The Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450 *et. seq.*) allows Tribes to assume the administrative and program direction responsibilities that were previously carried out solely by the federal government. The Indian Health Care Improvement Act of 1976 (IHCIA) (25 U.S.C. §1601, *et. seq.*), the statutory basis of the Indian health care delivery, was permanently reauthorized in Title X of the Patient Protection and Affordable Care Act (Affordable Care Act)(Pub. L. 111-148), granting new authorities to Indian Health Service (IHS) and the Tribes.

Foundation for National Tribal Budget Recommendations

- U.S. treaties and laws requiring the U.S. government to provide health services to Indian people are grounded in the U.S. Constitution. The federal government has a constitutional obligation to fulfill this trust responsibility.

- Because of this trust responsibility, federal spending for the Indian Health Service is mandatory, not discretionary, spending. The Indian Health Service, like the Veteran's Administration, should be exempt from broad-based cuts in discretionary spending and budget rescissions.

- Although significant improvements in mortality and morbidity rates for AI/ANs have been and continue to be made by IHS, Tribal and Urban Indian health programs (I/T/Us or collectively, the "Indian health system"), serious health disparities persist between AI/ANs and the general U.S. population, and in many areas of health the disparity gap is growing wider.

- In addition to significant health disparities, the Indian health system also faces significant funding disparities, both in per capita spending between IHS and other federal health care programs and within IHS, as reflected by differences in the Level of Need Funded (LNF) among IHS Areas and among sites within IHS Areas.

FY 2013 Budget Priorities & Recommendations

"Our native communities face problems that are serious, severe, and sometimes chronic… I intend to continue the long tradition of working together on this committee in a bipartisan manner to find solutions that will improve the lives and strengthen the futures of America's native people."

Senator Daniel Akaka (D-HI), Chairman

Senate Indian Affairs Committee, February 7, 2011

The National Tribal Budget Formulation Workgroup offers the following budget recommendations for FY 2013:

Top Budget Priorities

- Hold Indian health programs harmless and **protect prior year and proposed FY11 and FY12 increases** from budget roll-backs, freezes and rescissions. We have been encouraged by the increased investments made in Indian health in Fiscal Years 2008, 2009 and 2010 and greatly appreciate President Obama's proposed increases for FY 2011 and 2012, but are equally concerned that efforts by Congress and the Administration to reduce the overall size of the federal budget may jeopardize the progress made in recent years to address severe and chronic health and funding disparities in Indian country.

- Make a commitment to a multi-year funding agreement to **fully fund the IHS Total Need of $22.1 billion over the next 10 years**. It will take an additional $1.6 billion per year over the next ten years for the IHS budget to grow sufficiently to meet the total $22.1 billion health care need in Indian country. Developing and implementing a plan to achieve funding parity is critical to the future of Indian health and to fulfilling the United States' trust responsibility to AI/AN people. See "AI/AN Needs Based Funding Aggregate Cost Estimate" table and "Percent of Increase Required to Achieve Full Funding in 10 Years - $22.1 Billion" chart included in the Appendix.

- Increase the IHS budget for FY 2013 by **$1.431 billion in "must have" spending** over the FY 2012 President's Budget Request to a **total of $6.054 billion**.

- **Fully fund Current Services** (Federal & Tribal Pay Costs, Medical & Non-Medical Inflation and Population Growth) at +$136.795 million **and other Binding Obligations** (New Staffing for New/Replacement Facilities, Contract Support Cost - Shortfall and Health Care Facilities Construction 5-Year Plan) at +$606.188 million for a total of +$742.983 million.

- Increase funding for Hospitals & Clinics by $219.17 million over the FY 2012 President's Budget Request to a total of $2.18 billion.

- Increase funding for Contract Health Services by $200 million over the FY 2012 President's Budget Request, plus an additional +$30 million for the Catastrophic Health Emergency Fund (CHEF) for a total of $1.17 billion.

Other Budget Priorities

- Services Increases of $621.230 million to include:
    - $200 million for Contract Health Services and $30 million for CHEF
    - $80 million for Behavioral Health (Mental Health $40 million & Alcohol and Substance Abuse $40 million, with 50% of new Alcohol and Substance Abuse funding targeted to youth)
    - $75 million in Hospitals & Clinics (H&C) funding for New/Expanded programs
    - $45 million in Hospitals & Clinics funding for the Indian Health Care Improvement Fund (IHCIF)
    - $32 million in Hospitals & Clinics funding for Chronic Diseases (Diabetes, Cancer, Cardiovascular Disease)
    - $30 million in Hospitals & Clinics funding for Health Promotion and Disease Prevention
    - $30 million in Hospitals & Clinics funding for Information Technology

- Facilities Increases of $66.800 million to include:
    - $20.0 million for Health Facilities & Environmental Support
    - $18.2 million for Health Care Facilities Construction
    - $11.5 million for Maintenance & Improvement
    - $10.7 million for Sanitation Facilities Construction

These increases are needed to address funding disparities between the Indian Health Service and other federal health programs as illustrated below and in the "2010 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita" chart included in the Appendix to these National Tribal Budget Recommendations:

Medicare spending per beneficiary	$11,018	(2009)
Veterans medical spending per user	$7,154	(2010)
National Health Expenditures per capita	$6,909	(2010)
Medicaid spending per enrollee	$5,841	(2008)
Federal Employee Health Benefits per enrollee	$4,817	(2009)
Indian Health Service spending per user - all	**$3,348**	**(2010)**
Indian Health Service spending per user – medical care	$2,741	(2010)

These increases are necessary to address funding disparities within the Indian Health Service, as the Level of Need Funded (LNF) varies widely across and among IHS sites. The Area LNF funded ranged from 50.0% for the Bemidji Area to 62.2% for the Alaska Area for FY 2010. Among all IHS sites, the LNF ranged from a low of 44.7% to a high of 100%, with an average LNF of 56.5%. In December 2010, IHS estimated that it would cost $217 million to raise all IHS sites to a minimum LNF of 55% and $394 million to reach a minimum of 65%. See "Average LNF Score for IHS Areas – FY 2010" chart in the Appendix. The chart shows average Level of Need Funded (LNF) scores by Area. It is important to note that the national IHCIF formula applies to LNF scores of individual sites. Area average scores have no impact on IHCIF allocations, and are included here simply to illustrate that we are a long way from 100% LNF.

These increases are also needed to address the erosion of health care funding by population growth and inflation, particularly the diminished purchasing power resulting from medical inflation rates for CHS (estimated at 11%-12% in 2010), pharmaceuticals and other health services that far exceed standard non-medical inflation rates (1.5% in 2010) and general other medical inflation (3.6% in 2010). See "Diminished Purchasing Power" chart included in the Appendix.

"The federal Indian programs that we fight hardest to fund were created to fulfill the trust responsibility between this Nation and its first people. Authority to fund these programs derives from three distinct provisions of the Constitution – the Indian Commerce Clause, the Treaty Clause and the Property Clause. This is not "nice to have" spending. That is "must have" spending to fulfill the trust responsibility founded in the Constitution."

Senator Lisa Murkowski (R-AK), Ranking Member

Subcommittee on Interior and the Environment

Senate Committee on Appropriations, January 27, 2011

FY 2013 National Tribal Budget Recommendation Table

		Recommendation
PLANNING BASE - FY 2012 President's Budget		**$4,623,808,000**
Total increase to be spread		**$1,431,013,000**
Current Services & Binding Obligations	**Subtotal**	**$742,983,000**
Current Services	**Subtotal**	**$136,795,000**
Federal Pay Costs [1]		$10,935,000
Tribal Pay Costs		$13,417,000
Inflation (medical & non-medical)		$59,977,000
Population Growth		$52,466,000
Binding Obligations	**Subtotal**	**$606,188,000**
Staffing New/Replacement Facilities [2]		$50,000,000
Contract Support Costs - Shortfall		$212,592,000
Health Care Facilities Construction 5-Year Plan		$343,596,000
Program Expansion Increases - Services	**Subtotal**	**$621,230,000**
Hospitals & Clinics	Subtotal	$219,170,000
Indian Health Care Improvement Fund		$45,000,000
Health Information Technology[3]		$30,000,000
Maternal Child Health		$6,500,000
Health Promotion/Disease Prevention		$30,000,000
Diabetes, Cancer, Heart Disease		$32,000,000
Hospitals & Clinics - New/Expanded		$75,670,000
Dental Services		$21,000,000
Mental Health		$40,000,000
Alcohol & Substance Abuse		$40,000,000
Contract Health Services		$200,000,000
Catastrophic Health Emergency Fund (CHEF)		$30,000,000
Public Health Nursing		$12,600,000
Health Education		$11,400,000
Community Health Representatives		$15,400,000
Urban Health		$7,500,000
Indian Health Professions		$3,300,000
Tribal Management Grant		$660,000
Direct Operations[5]		$8,200,000
Contract Support Costs - New/Expanded		$12,000,000
Program Expansion Increases - Facilities	**Subtotal**	**$66,800,000**
Maintenance & Improvements		$11,500,000
Sanitation Facilities Construction [6]		$10,700,000
Heath Care Facilities Construction (HCFC) Authorities		$10,400,000
Small Ambulatory		$4,500,000
Youth Regional Treatment Centers		$3,300,000
Facilities & Environmental Support		$20,000,000
Injury Prevention		$2,600,000
Equipment		$1,800,000
Ambulance		$2,000,000
TOTAL		**$6,054,821,000**

[1] Federal Pay Costs - to be adjusted if pay freeze is extended

[2] Staffing New Facilities - to be adjusted to cover total requirement

[3] Health IT - increase distributed first to tribes to assist in meeting Meaningful Use and ICD-10

[4] H&C New/Expanded - to address the health priorities established by each Area

[5] Direct Operations - placeholder to establish Nevada Area Office, if approved

[6] Sanitation Facilities Construction - increase on this line is over FY 2011 President's Budget

Budget Narrative

FY 2013 Tribal Health Priorities

Ranked Health Priorities	
1	Behavioral Health /Mental Health /Alcohol and Substance Abuse/ Family Violence
2	Diabetes/Chronic Disease
3	Cancer
4	Health Promotion / Disease Prevention / Obesity
5	Heart Disease / Stroke / Cardiovascular
6	Maternal Child Health/Child Adolescent Health
7	Dental
8	Injuries / Injury Prevention
9	Elder Health
10	Long Term Care

The Indian Health Service has made significant progress in improving the health status of AI/AN people since it was established in 1955. There have been significant decreases in mortality rates; for example, since 1973, mortality rates have decreased about 89 percent for tuberculosis, 79 percent for cervical cancer, 38 percent for maternal deaths, 56 percent for accidental deaths, and 66 percent for infant deaths. IHS has also achieved accomplishments in improving the quality of care over time. For example, the percent of patients with diabetes with ideal A1C (or glycemic) control has increased from 25% in FY 2002 to 32% in FY 2008.[1] These types of improvements have been shown to result in reduced complications of diabetes.

However, health disparities continue to persist for AI/ANs compared to other populations. AI/AN communities face many health challenges including higher mortality rates from tuberculosis, chronic liver disease and cirrhosis, accidents, diabetes, pneumonia, suicide, and homicide, compared with other racial and ethnic groups.[2] For example, diabetes mortality rates are still nearly three times higher for AI/ANs than for the general U.S. population, and suicide rates are nearly twice as great. The AI/AN population has a life expectancy at birth that is 5.2 years less than that of all U.S. populations combined.[3]

The following narrative provides additional information regarding the tribal health priorities listed above, the severity of these health problems in Indian country, health disparities as compared to other population groups and budget and program recommendations to improve Indian health status.

1. Behavioral Health

These recommendations correspond to the following new or amended sections of the IHCIA:
Section 217. American Indians into Psychology Program
Section 702. Behavioral Health Prevention and Treatment Services
Section 704. Comprehensive Behavioral Health Prevention and Treatment Programs
Section 705. Mental Health Technician Program
Section 707. Indian Women Treatment Programs
Section 708. Indian Youth Program
Section 709. Inpatient and Community Based Mental Health Facilities
Section 711. Behavioral Health Program
Section 712. Fetal Alcohol Spectrum Disorders Programs
Section 713. Child Sexual Abuse Prevention and Treatment Programs
Section 714. Domestic and Sexual Violence Prevention and Treatment
Section 715. Behavioral Health Research
Section 723. Indian Youth Telemental Health Demonstration Project
Section 724. Substance Abuse and Mental Health Services and Administration Grants
Section 725. Use of Predoctoral Psychology and Psychiatry Interns
Section 726. Indian Youth Life Skills Development Demonstration Program

Behavioral health is the top tribal health priority for FY 2013. This priority includes mental health; alcohol and substance abuse; and family violence, including domestic/intimate partner violence and child abuse and child sexual abuse. The high incidence of mental health disorders, suicide, violence, substance abuse and behavior-related chronic disease in Indian country is well-documented. In December 2010, the IHS National Tribal Leaders Advisory Committee on Behavioral Health completed work on the IHS Behavioral Health Strategic Plan and the Suicide Prevention Plan. Additional financial resources, service integration, and coordination with other HHS partners are needed to effectively implement these plans.

Mental Health

AI/AN represent 1.1% of all suicides in the United States and have the highest rates of suicide for any racial/ethnic group (2 times higher)[4]. Between 1999 and 2007 the suicide rate for AI/AN people ages 10-44 was nearly sixteen percent, representing 88,657 years of potential life lost (IHS, 2010). Youth are being impacted by suicide at much higher rates. Of all suicides in Indian Country, AI/AN youth and young adults (ages 15-34) make up 64% of all completed cases.[5] It is estimated that over 90% of people who die by suicide have a mental illness (most common, clinical depression), substance addiction, or both.[6]

AI/ANs are at higher risk for certain mental health disorders, such as psychological distress and suicide, than other racial/ethnic groups. Indian people are also overrepresented among high-need populations requiring mental health services, such as those who are homeless, incarcerated, drug and alcohol abusers, those exposed to trauma and children in foster care. Available data suggest that approximately 21% of the AI/AN population suffers from mental illness, mental dysfunction and/or self-destructive behavior, at an estimated annual cost of $1.07 billion.[7] In Indian Country, the severe underfunding for these mental health services exacerbates the lack of treatment for behavioral health conditions. A total of $267 million dollars in the IHS FY2010 budget was allocated to support behavioral health services (which includes both mental health and substance abuse), representing only 6.7 percent of the entire IHS budget to serve the AI/AN population.

Culturally relevant, community-based psychological services are necessary to improve outreach, education, appropriate intervention and treatment for depression, unresolved childhood trauma, and other risk factors contributing to suicide, violence and other mental health disorders. The Navajo Nation provides us with one example of a successful community-based suicide intervention.

This year, the Navajo Nation reported that suicide clusters were evident in several Service Units in the New Mexico and Arizona portions of the Navajo Nation. The Tribal Council approved a declaration of emergency to address the situation. In the Crownpoint Service Unit, a unified command system was instituted to address suicide attempts and suicides and to foster cooperation among community leaders, the Navajo Nation, public and private schools, law enforcement, and health care agencies including the States, NAIHS, and the Navajo Nation. A crisis center was established in Thoreau, New Mexico, with a telephone hotline for community residents to call in for information and counseling. Other activities included realigning funding to address program needs with a focus on developing youth activities, and deployment of Commissioned Corps personnel to the Navajo Nation to assist in the effort.

The National Tribal Budget Formulation Workgroup recommends continued and increased funding for the IHS Methamphetamine and Suicide Prevention Initiative, and expanded use of TeenScreen and other depression screening tools for assessing suicide risk among AI/AN youth and adults in primary care settings. We urge support for the prompt implementation of Sections 217, 702, 704, 705, 707, 709, 711, 715, 723, 724 and 725 of the Indian Health Care Improvement Act (IHCIA) which will expand training for psychiatrists, psychologists and mental health technicians, mental health prevention and treatment services, mental health facilities, behavioral health research, the use of tele-behavioral health services, and mental health grant opportunities.

Alcohol and Substance Abuse

AI/AN populations have major health disparities in rates of alcohol/substance abuse and addiction, but the use of alcohol and substances often go hand in hand with other mental health conditions and high risk behaviors in Indian Country including suicide, depression, PTSD, HIV transmission, domestic violence and incarceration, among others. The National Institute on Drug Abuse estimates that 60% of all people

with a substance abuse disorder also suffer from a mental illness. However, treatment of substance abuse and mental illness are typically funded and treated separately.

As with the mental health conditions, alcohol and substance abuse are affecting AI/AN young people at alarming rates. A study of both reservation and urban youth found that more than 60% had a family history of substance abuse or dependence[8] and Native youth are more likely to have an alcohol use disorder, consume more alcohol and have higher rates of any illicit drug use than other racial/ethnic groups.[9]

Among AI/AN adults, rates of past year use disorders were higher than other racial/ethnic groups for alcohol, illicit drug use, marijuana, cocaine, and hallucinogen use disorders.[10] A recently released CDC report indicates that AI/AN people have the largest average number of drinks consumed through binging (8.4 drinks in one setting). This means that AI/AN people have more intense binge drinking sessions than do any other racial/ethnic group. Methamphetamine abuse rates among AI/ANs are substantially higher than other racial/ethnic groups with an overall use rate of 1.7 percent of the entire AI/AN population (compared to 0.7 percent use among whites, 0.5 percent use among Hispanics, 0.2 percent use among Asians, and 0.1 percent use by African Americans).[11] This represents a rate that is more than three times higher than the general U.S. population. On a more optimistic note, about one-fifth of AI/AN adults (21.8%) were former drinkers. Where treatment services are available, we can have a positive effect on alcohol and drug use.

Tribal leaders are especially concerned about the negative impact of alcohol and substance abuse on Indian children and recommend that at least half of all new A/SA dollars be targeted to youth prevention, intervention and treatment. They also recommend that IHS make a greater effort to support and coordinate substance abuse and maternal and child health programs to reduce the incidence of fetal alcohol spectrum disorders (FASDs), which are 100% preventable when women abstain from drinking alcohol during pregnancy.

We urge support for the prompt implementation of Sections 707, 708, 712 and 724 of the Indian Health Care Improvement Act (IHCIA) which will increase the availability of treatment programs for Indian women and substance abuse grants.

Family Violence

AI/AN children have the second highest maltreatment rate nationally.[12] According to the U.S. Department of Justice, AI/AN women are 2.5 times more likely than U.S. women in general to be raped or sexually assaulted and 1 in 3 AI/AN women will be raped at some point in her life.[13] Further, eighty-six percent of all violence against AI/AN women is perpetrated by non-Indian men.[14]

To help victims of violence, I/T/Us provide direct services, referrals to community agencies, advocacy, and collaboration with other agencies. A survey of IHS facilities found that 44% lacked personnel trained to provide emergency services in the event of a sexual assault. Sexual assault nurse examiners (SANEs)

are registered nurses with advanced education and clinical preparation in forensic examination of victims of sexual violence, but there are few such professionals working in Indian country.

We urge support for the prompt implementation of Sections 707, 713 and 714 of the Indian Health Care Improvement Act (IHCIA) which will increase the availability of treatment programs for Indian women, child sexual abuse prevention and treatment, and the prevention and treatment of domestic and sexual violence.

GPRA Clinical Measures	2012 IHS Target	2010 IHS Result	2010 Area Range
BH-Depression Screening	51.9%	52%	39% - 71%
Alcohol Screening (FAS)	56.1%	55%	38% - 72%
DV/IPV Screening	57.3%	53%	34% - 68%

2. Diabetes

These recommendations correspond to the following new or amended sections of the IHCIA:
Section 204. Diabetes Prevention, Treatment and Control
Section 213. Patient Travel Costs
Section 214. Epidemiology Centers

Combating diabetes and its resultant complications remains a top health priority in Indian country. The rates of diabetes for AI/ANs are the highest in the U.S., with diabetes rates reaching 60% of the adult population in some tribal communities.[15] The consequences of uncontrolled diabetes include heart disease, stroke, kidney failure, blindness and amputations. Once exclusively a disease of adults, type 2 diabetes in increasingly common among AI/AN young adults and youth, threatening the future of AI/AN communities. Between 1990-2009, there was a 161% increase in diabetes in AI/AN young people aged 25-34 years and a 110% increase in diabetes in AI/AN youth aged 15-19 years.[16] The IHS Special Diabetes Program for Indians (SDPI) has resulted in significant improvements in diabetes clinical care and community services. In addition to continued funding for the SDPI, investments in Hospitals & Clinics, Contract Health Services, Behavioral Health and Health Promotion and Disease Prevention are needed to develop diabetes systems of care, manage care effectively, support diabetes self-management education, screen for pre-diabetes and conduct patient and public education and community activities to reduce diabetes risk-factors.

We also urge support for the prompt implementation of the Section 204 - Diabetes Prevention, Treatment and Control - of the Indian Health Care Improvement Act (IHCIA), which expands IHS program authority to offer dialysis programs. Tribal leaders identified this is a top priority for IHCIA implementation.

GPRA Clinical Measure	2012 IHS Target	2010 IHS Result	2010 Area Range
Poor Glycemic Control (lower is better)	18.9%	18%	25% - 9%
Ideal Glycemic Control	31.0%	32%	26% - 43%
Controlled Blood Pressure	36.8%	38%	35% - 44%
LDL Assessed	64.9%	67%	57% - 77%
Nephropathy Assessed	53.2%	55%	32% - 71%
Retinopathy Assessed	51.4%	53%	43% - 63%

3. Cancer

These recommendations correspond to the following new or amended sections of the IHCIA:
Section 212. Cancer Screenings
Section 213. Patient Travel Costs

Cancer is now the second leading cause of death among AI/ANs.[17] The rate of cancer deaths has been declining since 1990 among the U.S. All Races, but it has been increasing among American Indians/Alaska Natives.[18] AI/ANs have higher mortality rates than the general population from specific cancers and have more devastating outcomes after diagnosis.[19]

Limited access to cancer screening and lack of specialized care contribute to the increasing cancer mortality rate. The standard of care for four cancers (cervical, breast, prostate and colorectal), accounting for about 50% of all cancers, includes prevention, screenings and early diagnosis. However, access to preventive services, such as mammograms and pap smears, is a major impediment to early diagnosis and successful treatment of cancer in Indian Country. Another major contributor for the increased cancer mortality among AI/ANs is the lack of resources to assist patients in navigating the health care delivery system and to provide access to specialized cancer treatments and technology.

Tribal communities should be afforded the opportunity to improve prevention and care services. One example of the difference that screening can make in the prevention and treatment of colorectal cancer was shared by the Cherokee Indian Hospital in the Nashville Area.

Cherokee Indian Hospital conducted a 4-month colorectal cancer screening initiative July 2010 - October 2010. A total of 262 male outpatient clinic patients were given fecal occult blood cards to take home and offered a small incentive, a $5 discount store gift card, to return a stool sample to the clinic. The initiative resulted in 213 negative occult stool screens and 25 positive screens. Among those 25 patients there were 7 positive screens followed by negative endoscopies, 8 positives pending further workup, 5 patients with diverticulosis, erosive gastritis and/or arteriovenous malformation, 3 with sigmoid polyps and 2 with colorectal cancer. This inexpensive targeted preventive services

initiative provided 213 male patients with the good news that their fecal occult blood tests were negative and reinforcement regarding the importance of self-care and the benefits of preventive screening. The 25 patients with positive screens received additional testing and treatment as appropriate. The two patients diagnosed with colorectal cancer may not have learned of their condition or received recommended care and treatment for their cancer if they had not participated in the screening program.

Additional funding is needed for Health Education, Hospitals & Clinics, Contract Health Services, medical equipment, medications and Preventive Services.

We also urge support for the prompt implementation of Sections 212 and 213 of the Indian Health Care Improvement Act (IHCIA), which will provide increased coverage for screening mammography, other types of cancer screening and patient travel costs.

GPRA Clinical Measure	2012 IHS Target	2010 IHS Result	2010 Area Range
Mammography Screening	48.8%	48%	38% - 60%
Colorectal Screening	38.2%	37%	24% - 55%
Tobacco Cessation	24.3%	25%	14% - 37%

4. Health Promotion and Disease Prevention

These recommendations correspond to the following new or amended sections of the IHCIA:
Section 123. Health Professional Chronic Shortage Demonstration Program
Section 204. Diabetes Prevention, Treatment and Control
Section 212. Cancer Screenings
Section 214. Epidemiology Centers

Across Indian country, AI/AN people are struggling, as never before, with chronic health conditions and challenges. The burden of chronic diseases remains disproportionately high among AI/ANs, contributing to increased rates of disability, a reduction in life expectancy, spiraling costs, and personal and community suffering. As noted here, Tribal leaders have clearly identified diabetes, cancer, heart disease and stroke as national tribal health priorities. However, there are common modifiable risk-factors are associated with these diseases: the common risk factors are: 1) unhealthy diet, 2) physical inactivity, and 3) tobacco use. These behavioral or lifestyle risk factors are linked with the intermediate clinical risk factors: 1) raised blood pressure, 2) raised blood glucose, 3) abnormal blood lipids, and 4) overweight/obesity.

Health Promotion and Disease Prevention (HPDP) activities aimed at improving nutrition, increasing physical activity and reducing tobacco use offer the greatest opportunities to reduce the burden of chronic disease on AI/AN communities and the Indian health system. Consequently, Tribal leaders feel that HPDP must be a top IHS health priority. Historically, the majority of IHS funding has been focused

on crisis intervention treatment of illness and very little funding has been allocated to health promotion and disease prevention. Equal funding must be focused on prevention and health promotion activities.

Additional funding would be used to adequately provide health care while fully supporting and enhancing prevention programs that target preventing the on-set of chronic debilitating diseases. Cross-cutting HPDP approaches aimed at reducing smoking, obesity and sedentary lifestyles hold the most promise and offer the best hope of improving disease-related AI/AN mortality and morbidity. This strategic approach to HPDP will require investments in Hospitals & Clinics, Health IT, Tribal Epidemiology Centers, Public Health Nursing, Health Education, and the Community Health Representatives program.

While there is no specific clinical measure for HPDP, all 17 national GPRA clinical measures relate to health promotion and disease prevention.

5. Heart Disease / Stroke / Cardiovascular

These recommendations correspond to the following new or amended sections of the IHCIA:
Section 204. Diabetes Prevention, Treatment and Control
Section 214. Epidemiology Centers
Section 409. Access to Federal Insurance

Diseases of the cardiovascular system are responsible for over 40% of deaths in the general American population and low income and minority populations suffer a disproportionally high burden from such disease.[20] Cardiovascular disease (CVD) is the leading cause of death in AI/AN adults. CVD rates are on the rise among Indian people, compared to a decline in the rest of the U.S. population. The prevalence of CVD risk factors (hypertension, current cigarette smoking, high cholesterol, obesity, and diabetes) among AI/AN is significant, with 63.7% of AI/AN men and 61.4% of AI/AN women having one or more CVD risk factors.[21] The sharp rise in diabetes prevalence in Indian country unquestionably plays an important role in the increasing levels of heart and other cardiovascular diseases, due to blood vessel damage and the close relationship between diabetes and obesity, high blood pressure and poorly controlled blood cholesterol levels. Two-thirds of the AI/AN population who have CVD also have diabetes.[22]

There is need for increased funding for treatment of CVD and stroke, as well as for primary and secondary prevention. HPDP activities aimed at reducing obesity and other risk factors could greatly assist in reducing the incidence of heart disease and stroke. Primary prevention efforts should focus on educating Indian people about the health risks that can lead to heart disease and stroke. Secondary prevention activities should focus on access to hypertension management, and prevention of a second heart attack or stroke.

These efforts will require investments in Hospitals & Clinics, Contract Health Services, medications, and Preventive Services.

GPRA Clinical Measure	2012 IHS Target	2010 IHS Result	2010 Area Range
CVD Prevention	33.8%	35%	20% - 51%

6. Maternal and Child Health

These recommendations correspond to the following new or amended sections of the IHCIA:
Section 204. Diabetes Prevention, Treatment and Control
Section 710. Training and Community Education
Section 711. Behavioral Health Program
Section 712. Fetal Alcohol Spectrum Disorders Programs

Tribal leaders recognize that Maternal and Child Health (MCH) is the cornerstone of any healthy community and it is a top health priority. Providing access to early and regular comprehensive prenatal care and education is vital to reducing low birth weight, premature birth, and infant mortality and improving pregnancy outcomes. It is well documented that efforts in the first years of life to improve breastfeeding rates, fully immunize, maintain healthy nutrition for toddlers and school age children pays dividends in later years. Avoiding tobacco and alcohol, maintaining a healthy weight and an active physical lifestyle, support for literacy and academic success, and graduation rates are important predictors of future health for children and youth. Unfortunately, great disparities exist between AI/AN youth and other youth in many of these areas. These disparities in childhood and adolescence can lead to compromised health in adulthood and even premature death.

Additional funding is needed to develop, implement and evaluate culturally appropriate strategies to assist community members, health care providers and school and child care providers to improve preconception, perinatal, and well-child care to detect, treat, and help parents modify behaviors, health conditions, and risk factors that contribute to adverse effects on AI/AN children. The impact of alcohol and substance abuse on children is a major concern. Childhood obesity must also be addressed through educational and practical wellness efforts in tribal communities. Breastfeeding has been shown to improve both the health of the mother and the infant, by reducing the risks of obesity, diabetes, and some types of cancers. [23,24]

GPRA Clinical Measure	2012 IHS Target	2010 IHS Result	2010 Area Range
Childhood Immunizations	76.5%	79%	70% - 92%
Alcohol Screening (FAS)	52.6%	55%	38% - 72%

7. Dental

These recommendations correspond to the following new or amended sections of the IHCIA:
Section 119. Community Health Aide Program
Section 123. Health Professional Chronic Shortage Demonstration Program

The rate of periodontal disease is 2.5 times greater among AI/AN adults than in the general population.[25] Dental decay among Indian children is even more significant, with children between the ages of 2 and 4 suffering tooth decay rates that are 5 times the national average.[26] Overall, 68% of AI/AN children have untreated dental caries, 33% of school children report missing school because of dental pain, and 25% report avoiding laughing or smiling because of the way their teeth look.[27]

Additional funding is needed to decrease the disparity in the oral status of AI/AN's. The funding is needed to increase access to care and to provide treatment. Overcoming barriers to dental access will require filling dental vacancies and expanding workforce options to include as a part of the dental team expanded function dental assistants, hygienists and dental health therapists. Increased and varied methods to prevent tooth decay in children are also needed. These include fluoride varnishes and other sealants, aggressive educational programs (e.g. reducing consumption of sugared beverages), and the use of new protocols to prevent periodontal disease (such as use of antibiotics and home oral hygiene regimens). One core preventive dental health measure is fluoridation of tribal water systems, an activity that requires coordination with Tribal, IHS, EPA and other governmental agencies and jurisdiction.

GPRA Clinical Measure	2012 IHS Target	2010 IHS Result	2010 Area Range
Dental Access	23.0%	27%	NA
Dental Sealants	257,261	275,459	NA

8. Injuries

These recommendations correspond to the following new or amended sections of the IHCIA:
Section 708. Indian Youth Program
Section 710. Training and Community Education

Injuries are the leading cause of death for AI/ANs from ages 1-44 years, and the third leading cause of death overall.[28] Unintentional injury mortality rates for Indian people are approximately three times higher than the combined all-US. races. [29] IHS spends $350 million each year for injury related health care costs, but only $1.5 million is spent on injury prevention.

While injury mortality rates for American Indian and Alaska Native children have decreased during the past quarter century, it still remains almost double the rate for all children in America.[30, 31] Fatality rates

for motor vehicle occupant injuries are 3 times higher for American Indian and Alaska Native children than for Caucasian and African American children.[32] Among all age groups, American Indians and Alaska Natives have an injury rate nearly twice that of all races, with motor vehicle crashes causing the greatest number of injury deaths.[33,34]

Critical and recognized risk factors for unintentional injury mortality among AI/AN children include poverty, alcohol abuse, substandard housing, and limited access to emergency medical services, rural residence, and low rate of seatbelt use. The high rates of injury-related death and disability make it especially important to emphasize and intensify injury prevention efforts within this population. This alarming data suggests the need for comprehensive and collaborative efforts involving Tribes, IHS, and other DHHS agencies, the Bureau of Indian Affairs, the Department of Justice, and state, county and local public health and law enforcement agencies.

Additional funding would be used to support prevention programs in tribal communities that will decrease the number of injuries that occur annually, thereby decreasing the cost of treatment. The number of injury prevention grants offered by the IHS must be increased and tribes must be afforded flexibility to develop new ways to assist the populations most impacted, such as young adults.

9. Elder Health

These recommendations correspond to the following new or amended sections of the IHCIA:
Section 205. Other Authority for Provision of Services
Section 307. Indian Health Care Delivery Demonstration Projects
Section 312. Indian Country Modular Component Facilities Demonstration Program
Section 313. Mobile Health Stations Demonstration Program
Section 822. Shared Services for Long Term Care

As more American Indians and Alaska Natives live to adulthood and old age, the elderly population aged 55 and older is projected to increase from 5.5% of the total U.S. AI/AN population in 1990 to 12.6% in 2050.[35] The shifting demographic profile of the population calls for focused attention on the health status of AI/AN elders.

Tribal leaders are looking forward to the implementation of the new authorities provided in the reauthorized IHCIA pertaining to elder health, as this is one of the highest priorities of the Tribes in the FY 2013 IHS budget formulation process. The recommended funding in FY 2013 for this health priority has been stated in a previous section of this document under Program Increases.

Many Tribes are developing plans for elder health care programs and they are seeking funds to initiate best practices for the care of their elders. It is recommended that priority consideration in the rollout of Section 124 necessitates that the IHS; 1) establish elder health care protocols within its scope of services; 2) fully implement the IHS chronic care and Improving Patient Care (IPC) initiative; and 3) collaborate with Tribes to develop tribally and culturally based home health care services that utilize the IHS pharmacy and contract services and available Medicare and Medicaid reimbursement. The IHS Long

Term Care in Indian Country conference in November 2010 provided an opportunity for Tribes to discuss the work ahead to institute these new provisions. Continued discussion needs to occur as the services are developed and the regulations process gets underway.

Chronic health problems such as heart disease, diabetes, Alzheimer's disease, and high blood pressure are particularly impacting AI/AN elders when compared to the general public.[36] Contributing to the high chronic illness rates has been the lack of transportation for preventative care and minimal specialized geriatric care in the IHS system. The new authorities granted by the Indian Health Care Improvement Act will help address the need for providing care in the home and within the community.

GPRA Clinical Measure	2012 IHS Target	2010 IHS Result	2010 Area Range
Influenza 65+	59.9%	62%	48% - 68%
Pneumovax 65+	81.3%	84%	77% - 96%

10. Long Term Care

These recommendations correspond to the following new or amended sections of the IHCIA:
Section 205. Other Authority for Provision of Services
Section 312. Indian Country Modular Component Facilities Demonstration Program
Section 313. Mobile Health Stations Demonstration Program
Section 822. Shared Services for Long Term Care

Tribal Leaders agree that long term care is an important need in Indian Country. While primarily focused on the needs of the elderly, these services also benefit younger people, such as victims of traumatic brain injury, in need of specialized long term care. These services include residential care, such as nursing homes and assisted living facilities; home and community-based services (HCBS), caregiver services, case management and respite care. Tribes envision a system in which long term care services are effectively delivered in rural and isolated community settings in the least restrictive setting possible.

Some Tribes and tribal organizations have already begun this important work with support from the IHS Long Term Care grant program. The Hopi Tribe, for example, recently engaged in planning efforts to assess the long term care needs of their community, identifying the enhancement of existing home and community-based services, such as caregiver training and respite services, as top priorities for program development. The Hopi, like many other Tribes, are looking for new ways to integrate evidenced-based programs that improve the lives of elders by increasing their independence into existing senior center programs. These best practices include fitness programs, such as EnhanceFitness, Matter of Balance and Chronic Disease Management Program workshops.

The final report of the IHS "Long Term Care in Indian Country" conference provides specific recommendations regarding tribal compacting and contracting of long term care services, the provision of direct services, cultural competency, family involvement and support, training, regulations development and funding. Tribal leaders, IHS staff and representatives of other federal agencies participating in the meeting recognized the need for inter-agency cooperation to assure that design and delivery of long term care and enhanced geriatric services are tailored to meet the unique needs of tribal communities and the AI/ANs individuals served.

See "National and Area GPRA Targets and Results" table in the Appendix for 2010 results by Area.

FY 2013 Tribal Budget Priorities

"I believe very strongly that if you read the Constitution and our agreement with the American Indians and Alaska Natives, we have an obligation…And I don't want to see us balancing the budget on the backs of those we have an obligation to."

Representative Don Young (R-AK), Chairman
Subcommittee on Indian and Alaska Native Affairs
House Committee on Natural Resources
January 29, 2011

Current Services & Binding Obligations

Federal and Tribal Pay Costs - The budget request includes an increase of $24.3 million for Pay Costs based on the fixed cost projections for FY 2012 used in the FY 2013 budget formulation process which included a 1.4% increase for both Federal and Tribal employee pay costs. The members of the National Tribal Budget Formulation Workgroup feel strongly that not only Commissioner Corps Officers, but all Tribal and Federal IHS employees should be exempted from any federal employee pay freeze that may be imposed in FY 2011, 2012 or 2013.

Inflation (medical & non-medical) - Funding for IHS programs has not kept pace with inflation, while Medicaid and Medicare have accrued annual increases of 5% - 10%. The $59.9 million requested is needed to address the rising cost of providing health care and is based on the 1.5% non-medical inflation rate and 3.3% medical inflation rate identified by OMB. However, the actual inflation rate for different components of the IHS health delivery system is much greater. As a component of the Consumer Price Index (CPI), inpatient hospital care is currently at 9% and outpatient hospital care is at 5%. The National Tribal Budget Workgroup feels that the rates of inflation applied to Hospitals & Clinics, Dental Health, Mental Health and Contract Health Services in developing the IHS budget should correspond to the appropriate components in the CPI, and that there should be parity in the calculation of inflation among HHS operating divisions.

Population Growth - The request for $52.4 million will address the increased service need arising from the growth in the AI/AN population, which is increasing at an average rate of 1.3%.

Reasons for Breaking Out Binding Obligations - Current services estimates calculate mandatory costs increases necessary to maintain the current level of care. These “mandatories” are unavoidable and include medical and general inflation, pay costs, staff for recently constructed facilities, Contract Support Costs, and population growth. The costs associated with funding Contract Support Costs (CSC) and staffing for new and replacement facilities are presented as a subset of current services to emphasize the importance of funding these items. These binding obligations represent commitments

previously made by IHS, and must be funded in order to honor commitments made by the federal government.

Staffing for New/Replacement Facilities - $50 million is recommended as a placeholder to fund staffing and operating costs for new facilities in FY 2013. IHS construction funds are targeted to expand service at sites experiencing overcrowding by building new and renovating existing facilities. Additional funding is included in the budget to support staffing and operating costs for new and expanded facilities. Uncertainty regarding the level of funding for IHS Facilities programs in FY 2011 and FY 2012 makes it difficult to predict true staffing needs at this time. This figure may need to be adjusted to cover the total staffing requirement.

Contract Support Costs – Shortfall - The National Tribal Budget Formulation Workgroup recommends a $212 million increase to fully fund Contract Support Costs (CSC) in FY 2013. The tribal self-determination and self-governance initiatives have been widely recognized as the single greatest contributor to improved heath care in American Indian and Alaska Native communities. The choice of Tribes to operate their own health care systems and their ability to be successful in this endeavor depend upon the availability of CSC funding to cover fixed costs. Absent full funding, Tribes are forced to reduce direct services in order to cover the government's CSC shortfall. Adequate CSC funding assures that Tribes, under the authority of their contracts and compacts with IHS, have the resources necessary to administer and deliver the highest quality healthcare services to their members without sacrificing program services and funding.

Health Care Facilities Construction 5-Year Plan - $343 million is requested for previously approved health facility construction projects in accordance with the IHS Health Care Facilities FY 2012 Planned Construction Budget, referred to as the 5-Year Plan. As with Staffing for New/Replacement Facilities, this figure may need to be adjusted. Additional funding for new Facilities projects has been included in the budget under Program Increases.

Program Increases

SERVICES - + $621.230 million

Hospital & Clinics - $219.17 million – Funding for Hospitals & Clinics (H&C) is a top tribal budget priority, as more than half of the IHS H&C budget is transferred under P.L. 93-638 contracts or compacts to the Tribes , who are responsible for approximately 58% of the IHS outpatient workload and 50% of the inpatient workload. H&C funding supports essential personal health services including inpatient care, routine and emergency ambulatory care, and medical support services including laboratory, pharmacy, nutrition, diagnostic imaging, medical records, physical therapy and other services. H&C funds also supports community health initiatives targeting health conditions disproportionately affecting AI/ANs, such as specialized programs for diabetes, maternal and child health, women's health, elder health and disease surveillance.

Indian Health Care Improvement Fund – $45 million – Funding for the Indian Health Care Improvement Fund (IHCIF) is a top tribal budget priority. The purpose of IHCIF is to address deficiencies in health status and resources within the Indian health system and to promote greater equity in health services among Indian Tribes. The IHCIF directs funding through the Federal Disparity Index to the lowest funded operating units. The impact of the FY 2010 $45 million appropriation brought all operating units within the IHS to 45% Level Need Funded (LNF). The average Federal Disparity Index level among all IHS operating units is 55%. In December 2010, IHS estimated that it would cost $217 million to raise all IHS sites to a minimum Level of Need Funded of 55% and $394 million to reach a minimum of 65%.

Information Technology - +$30 million – Indian Health Service Information Technology (IT) investments include the Resource and Patient Management System (RPMS), including the RPMS Electronic Health Record (EHR), the IHS IT infrastructure, and the National Patient Information and Reporting System (NPIRS). Current national IHS Information Systems Advisory Council (ISAC) priorities include practice management, interoperability, EHR, infrastructure and architecture, clinical decision support, and Meaningful Use.

Health IT costs associated with the HITECH Act and new regulations will continue to increase as ICD-10 is implemented and enhanced certification, interoperability, and quality and outcome measures are required for the Medicare and Medicaid EHR incentive program. Tribal consultation about information technology is ongoing with listening sessions starting in March 2011 related to IT Shares as well as ongoing efforts to identify the true IT needs of Indian Country. ICD-10 is a complex and enterprise-wide initiative that will affect all of Indian Country. The transition from ICD-9 to ICD-10 must be completed by October 1, 2013. There has been no allocation to Indian Health Service to support this transition. Furthermore, meaningful use and certification requirements will increase in the second stage of the program in 2013, requiring increased interoperability capability, significant changes to the RPMS and other EHR systems used in Indian Country, as well as interfaces among IHS and Tribal systems. Practice management applications must increase in functionality to meet HIPAA, Meaningful Use, and other CMS requirements.

Maternal Child Health - +$6.5 million – Maternal and child health is a top tribal health priority. Funding for Maternal and Child Health (MCH) supports family planning, prenatal care, breastfeeding, infant and child health, and women's health care and education, including programs to address violence against women. The National Tribal Budget Workgroup recommends that MCH increases be focused on multi-disciplinary and collaborative efforts linking clinic, home and community-based MCH services with public health, behavioral health and public safety programs to address health and safety issues in pregnancy and childhood that have long-term effects on women, children and the strength of tribal communities.

Health Promotion and Disease Prevention - +$30 million - Health Promotion and Disease Prevention (HPDP) is a top tribal health priority. The goal of the HPDP program is to create healthier American Indian and Alaska Native communities by developing, coordinating, implementing, and disseminating effective health promotion and chronic disease prevention programs through collaboration with key stakeholders and by building on individual, family, and community strengths and assets. These funds are needed to support HPDP programs focused on diabetes, nutrition, obesity, physical activity and exercise, smoking cessation, access to healthcare, cardiovascular disease, environmental quality, immunization, injury and violence, mental health, oral health, substance abuse and traditional healing. The goal of the HPDP program is to help Indian people live well and stay well. Focusing on cross-cutting issues such as smoking and obesity maximizes the benefits of HPDP programs by simultaneously reducing health risks for multiple diseases and conditions.

Chronic Diseases - +$32 million – Diabetes, Cancer and Heart Disease are all top tribal health priorities. Increasing chronic disease burdens challenge the Indian health system, while devastating Indian families and communities. One of the ways that IHS is responding to this challenge is through the Improving Patient Care (IPC) initiative. The IPC began as a way to expand implementation of the Chronic Care Model, which has been found to be effective in preventing and treating chronic diseases by better integrating all of the health programs available to patients and by putting patients and families at the center of care. The program has grown in just a few short years to include a nationwide learning collaborative of 100 I/T/U sites. These sites are using health data to improve the quality of Indian health care by providing better preventive care, improving the management of chronic conditions, producing a better care experience for patients, families and communities, and maintaining financial viability in a health system with limited resources. IPC is just one example of the innovative ways that IHS sites are working to prevent and treat diabetes, cancer and cardiovascular disease. Increased H&C funding for **Diabetes (+$12 million)**, **Cancer (+$10 million)** and **Cardiovascular Disease (+$10 million)** will not only expand services at IHS hospitals and clinics but provide opportunities for other innovative programs and initiatives to prevent and manage chronic disease.

Hospitals & Clinics – New/Expanded - +$75.67 million – Additional funding is required to support the implementation of the Indian Health Care Improvement Act (IHCIA) and to address the wide range of health issues identified by tribal leaders through the budget formulation process, tribal consultation sessions, tribal community health assessments and Indian consumer and provider conferences. Funding is needed for targeted initiatives related to community, Area and national health concerns and for demonstration and planning projects related to the new authorities granted to IHS in the IHCIA reauthorization.

Dental - +$21 million - Dental health is a top tribal health priority. The IHS Dental program supports the provision of dental care through clinic-based treatment and prevention services and oral health promotion and disease prevention activities, including topical fluoride application and dental sealants. The demand for dental treatment remains high due to the high dental caries rate among AI/AN children.

Funds are used for staff salaries and benefits, contracts to support dental services, dental lab services, training, supplies and equipment. These funds are needed primarily to provide preventive and basic dental care services as over 90% of the dental services provided by I/T/Us are basic and emergency care services. More complex rehabilitative care (root canals, crown and bridge, dentures, surgical extractions) are extremely limited, but may be provided where resources allow.

Mental Health - +$40 million – Behavioral Health, including Mental Health, is a top tribal health priority. The high incidence of mental health disorders, suicide, violence, substance abuse and behavior-related chronic diseases is well documented. Each of these serious behavioral health issues has a profound impact on the health of individuals and community health, both on and off reservation. Mental Health program funding supports community-based clinical and preventive mental health services including outpatient counseling, crisis response and triage, case management services, community-based prevention programming, outreach and health education activities. After-hours and emergency services are generally provided through local hospital emergency rooms. Inpatient services are generally purchased from non-IHS facilities or provided by state or county mental health hospitals. Group homes, transitional living services and intensive case management are sometimes available, but generally not as IHS programs. The IHS Mental Health Program is currently focused on the integration of primary care and behavioral health services, suicide prevention, child and family protection programs, tele-behavioral health, and development and use of the RPMS Behavioral Health Management Information System.

Alcohol and Substance Abuse - +$40 million - Behavioral Health, including Alcohol and Substance Abuse, is a top tribal health priority. The Alcohol and Substance Abuse Program (ASAP) exists as part of an integrated Behavioral Health program to reduce the incidence of alcohol and substance abuse in AI/AN communities and to address the special needs of AI/ANs dually-diagnosed with both mental illness and drug dependency. The ASAP provides prevention, education and treatment services at both the clinic and community levels. Services are provided in both rural and urban community settings, with a focus on holistic and culturally-based approaches. Youth Regional Treatment Center (YRTC) operations are also funded by this line item. In FY 2010, the majority of ASAP services were tribally-managed. The IHS Alcohol and Substance Abuse Program is currently focused on the integration of primary care and behavioral health services, YRTCs, Fetal Alcohol Spectrum Disorders (FASD), the Methamphetamine and Suicide Prevention (MSPI), tele-behavioral health, development and use of the RPMS Behavioral Health Management Information System, and partnerships with consumers and their families, Tribes and tribal organizations, and federal, state and local agencies and organizations.

Contract Health Services - +$200 million – Contract Health Services (CHS) funding is a top tribal budget priority. IHS purchases health care from outside providers when no IHS-funded direct care facility exists, the direct care facility cannot provide the required emergency or specialty services, or the facility has more demand for services than it can meet. CHS funds are used to purchase essential health care services, including inpatient and outpatient care, routine emergency ambulatory care, transportation and medical support services, such as diagnostic imaging, physical therapy, laboratory, nutrition and pharmacy services. These funds are critical to securing the care needed to treat injuries, heart disease, digestive diseases, and cancer, which are among the leading causes of death for AI/ANs. New CHS funds

are distributed using a formula based on active user population, cost of purchasing health care services within a geographic area, and access to care, such as lack of availability of inpatient care. Tribes currently manage 54% of the CHS budget. At current funding levels, most IHS and tribal CHS programs are approving only medical emergent referrals (to preserve life and limb), and less urgent, routine and/or preventive care must be deferred or denied pending additional appropriations. The proposed $200 million increase would enable the purchase of an additional 9,657 inpatient services, 367,356 outpatient services, and 13,359 additional one-way transports for care.

Catastrophic Health Emergency Fund - +$30 million – The Contract Health Service program also includes the Catastrophic Health Emergency Fund (CHEF), which provides funding for high cost cases, such as burn victims, motor vehicle accidents, high risk obstetrics, and cardiology, after the expense associated with a case exceeds the established threshold. The top three diagnostic categories for FY 2010 CHEF cases were injuries, cancer and heart disease. The CHEF program is centrally managed at IHS Headquarters and is available to both IHS and tribally-managed CHS programs. As in prior years, FY 2010 CHEF funds were depleted prior to the end of the fiscal year. IHS is currently considering lowering the CHEF threshold, which will make more cases eligible for CHEF support, and will likely increase the number of cases submitted.

Public Health Nursing - +$12.6 million – Public Health Nursing (PHN) is a community health nursing program that focusing on promoting health and quality of life, and preventing disease and disability. The PHN programs provides quality, culturally sensitive primary, secondary and tertiary health promotion and disease prevention nursing services to individuals, families and community groups. Home-based services are most often related to chronic disease management, safety and health maintenance care for elders, investigation and treatment of communicable disease, breastfeeding promotion, parenting education, and screening for early diagnosis of developmental problems.

Health Education - +$11.4 million – The Health Education program supports the provision of community, school and worksite health promotion, patient and professional education, and the development of educational materials for staff, patients, families and communities. Current focus areas include health literacy, patient-provider communications, and the use of electronic health information by and for patients. The National Tribal Budget Workgroup identified several priority areas that involve the need for health education activities.

Community Health Representatives - +$15.4 million – The Community Health Representative (CHR) program helps to bridge the gap between AI/AN individuals and health care resources through outreach by specially trained members of the tribal community. CHRs integrate basic medical knowledge about health promotion and disease prevention with local community knowledge. They often play a key role in follow-up care and patient education.

Urban Indian Health - +$7.5 million – The Urban Indian Health program supports contracts and grants to 34 urban Indian 501 c (3) non-profit organizations to provide services at 41 sites, including 21 full ambulatory facilities, 6 limited ambulatory programs, and 7 outreach and referral programs. Urban

Indian Health Organizations provide affordable, culturally competent primary medical care and public health case management and wrap-around services for urban AI/ANs who do not have access to the resources offered through IHS and tribally operated health care facilities. Tribal leadership consistently demonstrates its support for funding Urban Indian Health programs to serve their members who reside away from their communities.

Indian Health Professions - +$3.3 million – The Indian Health Professions program manages the IHS Scholarship and Loan Repayment programs, health professions training related grants, and recruitment and retention activities for IHS. The program enables AI/ANs to enter health care professions through a system of preparatory, professional and continuing educational assistance programs; serves as a catalyst for community development by enabling AI/AN health care professionals to further Indian self-determination through the delivery of health care; and assist in the recruitment and retention of qualified health and mental health professionals to work in the Indian health system.

Tribal Management Grant - +$660 thousand – The Tribal Management Grant program provides discretionary competitive grants to Tribes and tribal organizations to establish goals and performance measures for current health programs, assess current management capacity to determine if new components are appropriate, analyze programs to determine if management by a Tribe or tribal organization is practicable, and to develop infrastructure systems to manage and organize programs, services, functions or activities. All federally-recognized Tribes and tribal organizations are eligible to apply for tribal management grants. Priority is given to newly-recognized Tribes, and Tribes and tribal organizations addressing audit material weaknesses.

Direct Operations - +$8.2 million – The Direct Operations budget supports the leadership and overall management of the Indian Health Service. This includes oversight of financial, employee, facilities, information and support resources and systems. Funding is allocated to IHS Headquarters, Area Offices and Tribal shares. The National Tribal Budget Formulation Workgroup requests $8.2 million in new Direct Operations funding as a placeholder for the establishment of the Nevada Area Office, if approved. This figure includes $2.3 million in one-time start-up funding and $5.9 million for the first year of operation. These funds are in addition to tribal shares to be taken and residual office reductions to the Phoenix Area Office.

Contract Support Costs – New & Expanded - +$12 million – Contract Support Costs (CSC) are defined as reasonable costs for activities that Tribes and tribal organizations must carry out, but that the HHS Secretary either did not carry out in her direct operation of the program or provided from resources other than those under contract. All federally-recognized Tribes and tribal organizations are eligible to contract or compact health programs through Title I and Title V of the Indian Self-Determination and Education Assistance Act, and to receive CSC funding in addition to the amount of program funding that the Secretary would have otherwise provided for the direct operation of the program. This line item request is to cover CSC requirements related to new and expanded P.L. 93-638 contracts.

FACILITIES - +$66.8 million

Maintenance & Improvement - +$11.5 million – Maintenance and Improvement (M&I) funds are the primary source of funding to maintain, repair, and improve existing IHS facilities and tribal health care facilities which are used to deliver and support healthcare services. M&I 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 (energy conservation, handicapped accessibility, security, etc.). The Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) is a measure of the condition of facilities and establishes priorities for larger M&I projects. As of October 1, 2010, the BEMAR for all IHS and reporting tribal facilities was $472.9 million. The $11.5 million increase requested will help to further reduce the BEMAR.

Sanitation Facilities Construction - +$10.7 million – The Sanitation Facilities Construction (SFC) program provides potable water and waste disposal facilities, and has been successful in reducing the rates of infant mortality, gastroenteritis and other environmentally-related diseases by about 80% since 1973. While IHS currently has a balance of $16 million in SFC funding, the National Tribal Budget Formulation Workgroup requests an additional $10.7 million for FY 2013 to increase the current level of activity.

HCFC Authorities - +$10.4 million – The Health Care Facilities Construction (HCFC) program constructs health care facilities and staff quarters, renovates and constructs Youth Regional Treatment Centers, supports tribal construction of facilities under the Joint Venture Construction Program, provides construction funding for tribal small ambulatory care facilities projects, and provides funding for new or replacement dental units. The $10.4 million requested in this line item is in additional to the amounts requested below for the Small Ambulatory Program and Youth Regional Treatment Centers, and is intended to support additional HCFC projects related to new and expanded authorities granted to IHS under the Indian Health Care Improvement Act.

Small Ambulatory Program - +$4.5 million - The Small Ambulatory Program (SAP) provides Tribes and tribal organizations who are operating Indian health care programs under Public Law 93-638 contracts or compacts with the opportunity to obtain funding for the construction, expansion, or modernization of small ambulatory health care facilities. Funding for this program has been limited in recent years, limiting the number of projects that could be awarded. The National Tribal Budget Workgroup requests $4.5 million to support at least two (2) SAP projects in FY 2013.

Youth Regional Treatment Centers - +$3.3 million – The National Tribal Budget Formulation Workgroup is committed to increasing the availability of outpatient and residential substance abuse services for AI/AN youth and requests $3.3 million for construction of one (1) additional Youth Regional Treatment Center.

Facilities & Environmental Health Support - +$20 million - Facilities and Environmental Support programs provide real property, health care facilities and staff quarters construction, maintenance and operation services, community and institutional environmental health, injury prevention, and sanitation

facilities construction services. Facilities Support provides funding for related Area and Service Unit operating costs, such as utilities, building operation supplies, facilities-related personal property, and biomedical equipment repair and maintenance. IHS reduced the energy related utility consumption for IHS managed facilities from 2,190,000 British Thermal Units per Square Meter (BTU/SM) in 2003 to 1,929,000 BTU/SM in 2010 which is a 10.2 percent reduction. These efforts help stem the growth in utility costs. During the period FY 2003 through FY 2010, total utility costs have increased 37 percent from $15.5 million to $21.1 million and total utility costs per Gross Square Meters (GSM) increased 49 percent from $25/GSM to $38/GSM. The IHS continues to aggressively investigate options to reduce energy costs. The Sanitation Facilities Construction (SFC) program provides management and professional engineering services to construct over 400 sanitation projects annually. Program resources also provide technical assistance, training and guidance to AI/AN families and communities regarding the operation and maintenance of essential water supply and sewage disposal facilities. The Environmental Health Services (EHS) program specializes in injury prevention and institutional environmental health, identifying hazards and risk factors in tribal communities and proposing control measures to prevent adverse health effects. Area, district and service unit personnel train tribal environmental health employees to provide higher levels of services to their communities and to support the provision of patient care services. The Injury Prevention Program works with Tribes to collect and analyze injury surveillance data, develop community coalitions, and build local capacity to implement proven and promising community-based strategies to prevent elder falls, motor vehicle accidents and other causes of injury.

Injury Prevention - +$2.6 million – Injury prevention is a top tribal health priority. The IHS Injury Prevention Program has been instrumental in reducing the injury mortality rate of AI/ANs by 58% since it moved from an "education only" focus to a public health approach in the 1970's. Treatment of injuries cost an estimated $350 million per year in direct health care costs to IHS, Tribes and contract facilities. In 2010, the Injury Prevention Program awarded $2.4 million in cooperative agreements to 33 tribal programs to create or continue Tribal Injury Prevention Programs. Seven tribal programs were awarded $70,000 to implement proven or promising motor vehicle or elder fall injury interventions. Given the tremendous cost of treating injuries, the National Tribal Budget Formulation Workgroup recommends an increase of $2.6 million to expand the Tribal Injury Prevention grant program.

Equipment - +$1.8 million – Equipment funds are used for maintenance, replacement, and the purchase of new medical equipment at IHS and tribal health care facilities. Equipment funds are allocated in 3 categories - tribally-constructed health care facilities, TRANSAM and ambulance programs, and replacement equipment. The National Tribal Budget Formulation Workgroup requests an additional $1.8 million for routine replacement of medical equipment for IHS and tribal health care facilities to purchase new medical equipment.

Ambulance - +$2.0 million – AI/AN trauma death rates are 3 times higher than U.S. all races rates, and trauma remains the largest cause of death and disability in Indian country for those under age 45. IHS and tribal trauma care is dependent on distant regional hospitals with advanced critical care capabilities and the safe and efficient transfer of patients from the local IHS facility to the regional trauma center.

The National Tribal Budget Formulation Workgroup requests an additional $2 million for the purchase of ambulances as one component of a comprehensive trauma care program and to provide local emergency medical response.

IHCIA Priorities

Since the 2010 reauthorization of the Indian Health Care Improvement Act (IHCIA), this is the Tribes' first opportunity to include the revised IHCIA authorities in the IHS budget formulation process or as part of the National Tribal Budget Recommendation. Many of the over 80 amended or new IHCIA authorities are seen as potential opportunities for Indian health programs to expand the range of health care services. In addition, some authorities grant long overdue parity between tribal and federal health programs.

Four of the twelve IHS Area Budget Formulation Teams (Alaska, Navajo, Nashville, and Phoenix) submitted recommendations regarding which IHCIA provisions should receive priority in implementation. While the National Tribal Budget Formulation Workgroup did not have a chance to develop a national consensus list at its meeting in Tempe, Arizona, the Area lists submitted provide a snapshot of tribal IHCIA priorities. More importantly, this snapshot aligns with the other recommendations made by Tribes and the National Tribal Budget Workgroup as presented in this document.

Three of four Area Teams identified the following sections as IHCIA priorities:

- **Section 204 – Diabetes Prevention, Treatment and Control**
  This amended provision expands program authority around diabetes care such as providing IHS with the authority to offer dialysis programs. Tribal leaders identified diabetes as their second health priority.

- **Section 205 – Other Authority for Provision of Services & Section 822 – Shared Services for Long Term Care**
  These provisions provide the IHS with the authority 1) to develop long-term care programs such as hospice care, assisted living, long-term care and home and community-based care for the first time, and 2) to directly enter into a contract or compact for the delivery of long-term care. Tribal leaders identified elder health as their ninth health priority and long-term care as the tenth health priority.

Additionally, two of four Area Teams identified the following sections as IHCIA priorities:

- Section 201 – Indian Health Care Improvement Fund
- Section 202 – Catastrophic Health Emergency Act

- Section 212 – Cancer Screenings
- Section 213 – Patient Travel Costs
- Section 218 – Prevention, Control and Elimination of Communicable and Infectious Diseases
- Section 312 – Indian Country Modular Component Facilities Demonstration Program
- Section 509 – Facilities Renovation
- Section 705 – Mental Health Technician Program
- Section 707 – Indian Women Treatment Programs
- Section 711 – Behavioral Health Program
- Section 714 – Domestic and Sexual Violence Prevention and Treatment
- Section 808 – Arizona as Contract Health Service Delivery Area

Both HHS and IHS should be commended for consulting with Tribes regarding the implementation of the IHCIA and Affordable Care Act. It is critical to continue to consult with Tribes and to engage in meaningful discussion on IHCIA provisions and the Affordable Care Act provisions that affect American Indians and Alaska Natives.

Summary Recommendations

U.S. treaties and laws that require the federal government to provide health services to Indian people find support in the U.S. Constitution. Indeed, the federal government has a constitutional obligation to fulfill this trust responsibility. Accordingly, federal spending for Indian Health Service is mandatory, not discretionary. Although IHS has made significant improvements to the health status of Indian people, serious health disparities persist between AI/ANs and the general U.S. population, and in many areas of health that gap is growing alarmingly wider. In addition to health disparities, the Indian health system also faces significant funding disparities, both in per capita spending between IHS and other federal health care programs and within IHS, as reflected by differences in the Level of Need Funded (LNF) across IHS sites. An urgent need exists to invest in infrastructure necessary to modernize neglected health care facilities and third-world sanitation conditions, and to rebuild tribal capacity through fully funding contract support costs.

We must protect recent increases in IHS funding by exempting IHS from budget roll-backs, freezes and rescissions. We must make a commitment to fully fund the IHS Total Need of $22.1 billion over the next 10 years. We must increase the IHS budget for FY 2013 by $1.431 billion over the FY 2012 President's Budget Request to a total of $6.054 billion. We must fully fund Current Services to stay ahead of inflationary erosion of existing services and other binding obligations. Finally, we must provide significant increases for Hospitals & Clinics, Contract Health Services and community-based programs to improve the quality of and access to care for all American Indian and Alaska Natives in FY 2013.

Our political leaders say "Times are tough." To which tribal leaders respond, "When haven't times been tough in Indian country?" We ask "If not now, when?" Failure to make needed investments now to close the health disparity gap between America Indian and Alaska Native people and other Americans and to restrain the increasing human and financial burden of chronic disease threatens the future of both our national economy and our tribal communities. This kind of neglect also harms other communities. As Martin Luther King, Jr. once said "Injustice anywhere is a threat to justice everywhere." Dr. King also said "Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

We are committed to exercising tribal inherent rights of self-governance and self-determination and to work in true partnership with the President, his administration, and the Congress, exercising their trust responsibilities to confront the serious health problems faced by our tribal communities. By working collaboratively with the Secretary to find innovative solutions, we will fulfill the promises of justice, health and prosperity grounded in U.S. treaties and the Constitution for the benefit of future generations of American Indian and Alaska Native people.

Acknowledgements

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Appendix

- AI/AN Needs Based Funding Aggregate Cost Estimate
- Percent of Increase Required to Achieve Full Funding in 10 Years - $22.1 Billion
- Diminished Purchasing Power
- 2010 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita
- Average LNF Score for IHS Area – FY 2010
- National and Area GPRA Targets and Results
- Health Data References

AI/AN Needs Based Funding
Aggregate Cost Estimate

GROSS COST ESTIMATES

Source of Funding is not estimated

Need for Existing Users at I/T Sites	Need Expanded for Eligible AIAN at I/T/U Sites*
1,500,044	2,000,000

SERVICES	$ Per Capita	Billions	Billions
Medical Services	$4,988	$7.48	$9.98
Medical services and supplies provided by health care professionals; Surgical and anesthesia services provided by health care professionals; Services provided by a hospital or other facility, and ambulance services; Emergency services/accidents; Mental health and substance abuse benefits; Prescription drug benefits.	Based on 2008 FDI benchmark ($4,100) inflated to 2013 @4% per year	$ Per Capita * Users	$ Per Capita* Eligible AIAN
Dental & Vision Services	$522	$0.78	$1.04
Dental and Vision services and supplies as covered in the Federal Employees Dental and Vision Insurance Program	2008 BC/BS FPO Vision ($87) and Dental benchmarks ($342) inflated to 2012 @4% per year		
Community & Public Health	$1,170	$1.76	$2.34
Public health nursing, community health representatives, environmental health services, sanitation facilities, and supplemental services such as exercise hearing, infant car seats, and traditional healing.	19% of IHS $ is spent on Public Health. Applying this ratio, $1,082 per capita = (.19/.81*$4612).		
Total Annualized Services	$6,680	$10.02	$13.36

FACILITIES	$ Per Capita	Billions	Billions
Facility Upgrades Upfront Costs		$6.51	$8.77
Annualized for 30 year useful Life		$0.38	$0.51

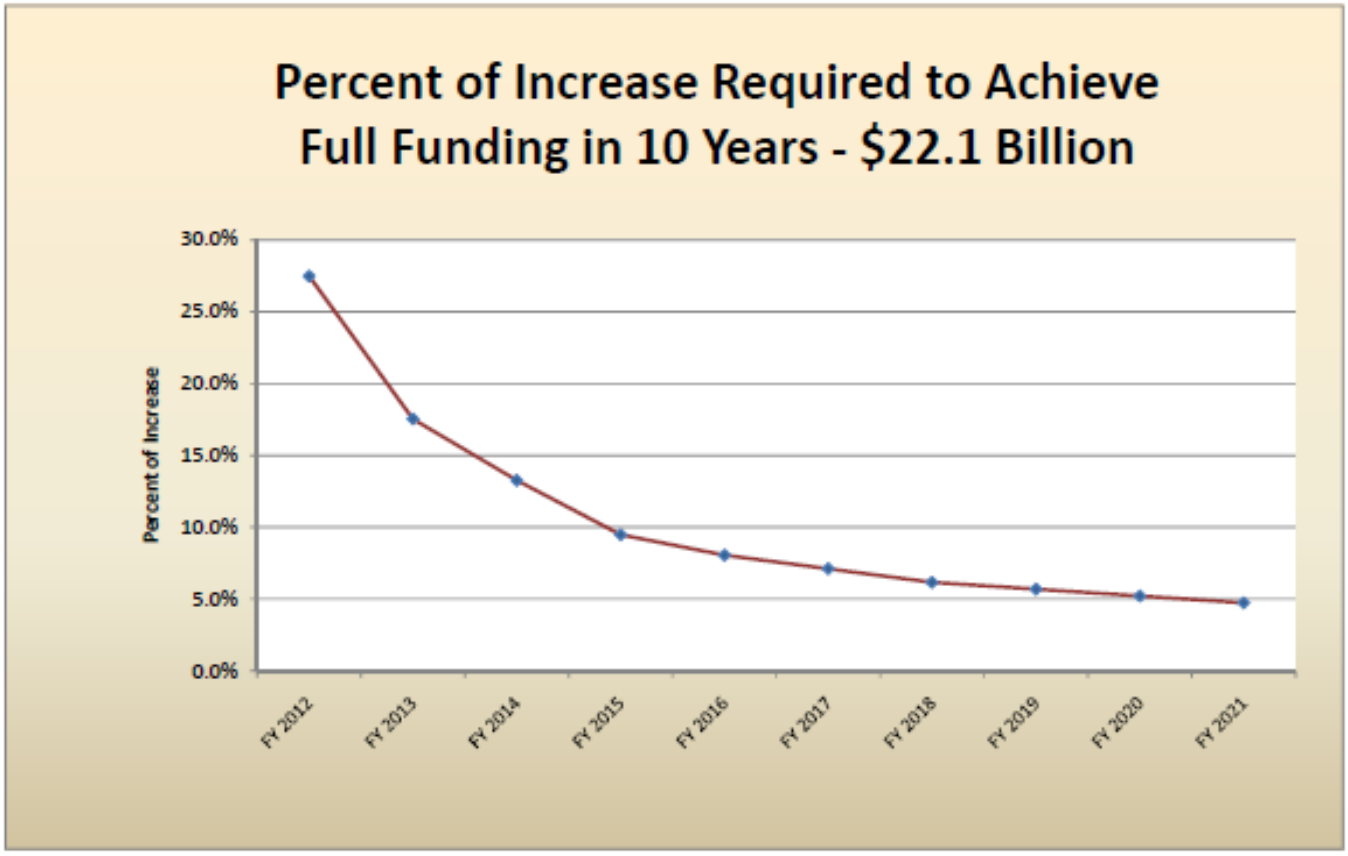
IHS assessed facilities condition (old, outdated, inadequate) and has estimated a one-time cost of $6.5b to upgrade and modernize. A 30 year useful life assumption is used to estimate the annualized cost (assuming 4% interest) of the upgrades.

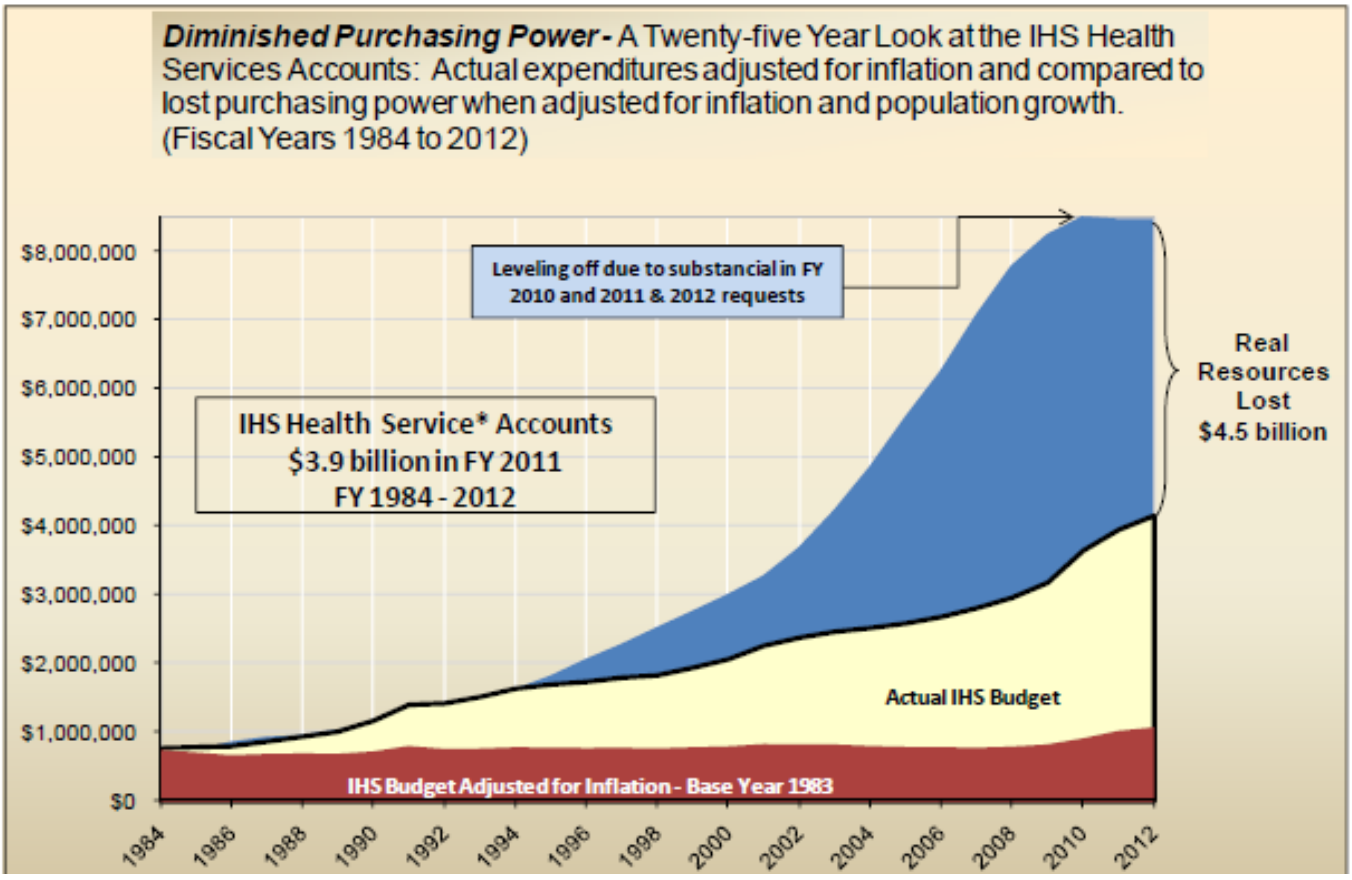
TOTAL

Total Annualized Services + One-time Upfront Facilities Upgrades	$16.53	$22.13

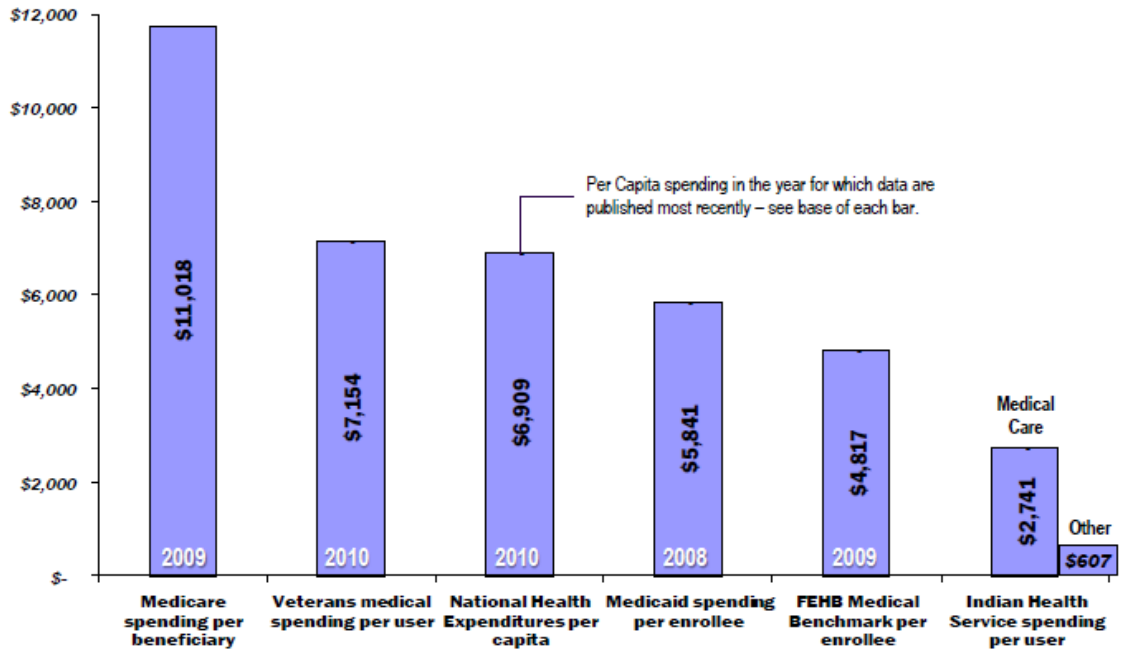
Gross costs for mainstream health care to AIAN and facilities upgrades are based on typical cost factors. The actual costs that would be experienced among I/T/U sites would vary. Gross costs are estimated expenses without specifying sources of payment. Under current law, a portion of gross costs would be paid by Medicare, Medicaid, and private insurance depending on the number of AIAN eligible—which varies place-to-place and time-to-to-time. The extent that gross costs would be offset is not precisely known. For certain planning assumptions, IHS assumes a crude 25% nation-wide.

*Crudely—AIANs residing in service areas, including urban areas, discounted for AIAN already partially served by I/T sites.


Percent of Increase Required to Achieve Full Funding in 10 Years - $22.1 Billion
Percent of Increase
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
FY 2012
FY 2013
FY 2014
FY 2015
FY 2016
FY 2017
FY 2018
FY 2019
FY 2020
FY 2021


Diminished Purchasing Power - A Twenty-five Year Look at the IHS Health Services Accounts: Actual expenditures adjusted for inflation and compared to lost purchasing power when adjusted for inflation and population growth. (Fiscal Years 1984 to 2012)
$8,000,000
$7,000,000
$6,000,000
$5,000,000
$4,000,000
$3,000,000
$2,000,000
$1,000,000
$0
Leveling off due to substancial in FY 2010 and 2011 & 2012 requests
IHS Health Service* Accounts
$3.9 billion in FY 2011
FY 1984 - 2012
Real Resources Lost $4.5 billion
Actual IHS Budget
IHS Budget Adjusted for Inflation - Base Year 1983
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004
2006
2008
2010
2012

2010 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



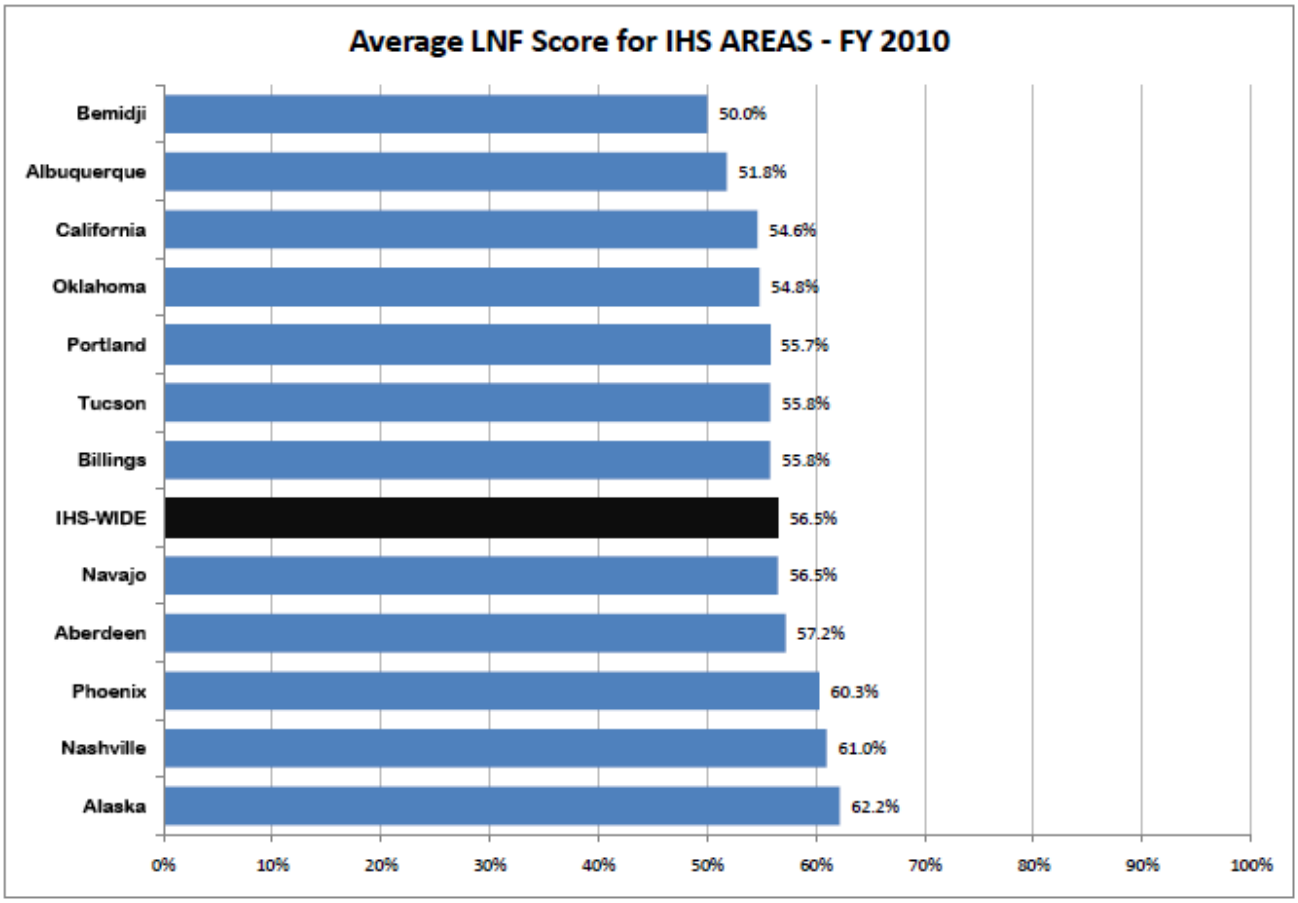
See page 2 notes on reverse for data sources and extrapolation assumptions.

12/20/2010

Data Sources and Assumptions -- Health Care Expenditures Per Capita

1. **2009 MEDICARE EXPENDITURES PER ENROLLEE**: Source – 2010 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS ; available at http://www.cms.gov/ReportsTrustFunds/downloads/tr2010.pdf in Table II.B1 Medicare Data for 2009, page 10
2. **PROJECTED 2010 NATIONAL HEALTH CARE EXPENDITURES PER CAPITA**: Source -- Table 5 Personal Health Care Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2004-2019; available at http://www.cms.gov/NationalHealthExpendData/downloads/proj2009.pdf
3. **2010 MEDICAL CARE PER VETERANS ADMINISTRATION USER**: Source – Volume II – Medical Programs and Information Technology Programs – Congressional Submission, available at http://www.va.gov/budget/docs/summary/Fy2011_Volume_2-Medical_Programs_and_Information_Technology.pdf Per capita spending estimate is calculated by dividing 5,926,302 unique VA patients (page 1A-5 "Unique Patients") into $42,423,000,000 medical care obligations (page 1A-6 "VA Medical Care Obligations by Program)
4. **2008 MEDICAID PAYMENTS PER BENEFICIARY**: The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2009. Available at http://www.statehealthfacts.org/comparemaptable.jsp?ind=177&cat=4 Per capita spending is calculated by dividing 58 million enrollees into $338,791,000,000 total FY2008 Medicaid Spending.
5. **1999 MEDICAL CARE FOR FEDERAL PRISON INMATES**: *No longer included because data have not been updated since 1999.*
6. **2009 FEHB MEDICAL CARE BENCHMARK PER IHS USER**: Source -- Indian Health Service, Level of Need Funded Report (later renamed the Federal Disparity Index Report) by the LNF Workgroup. The LNF study used insurance premiums for the Federal Employee Health Benefits program as a benchmark for actuarial projections for costs of equivalent benefits to IHS users. The estimates for 2009 are calculated using the methods available at http://www.ihs.gov/NonMedicalPrograms/Lnf/index.cfm (see Assumptions, Data, Calculations for FY 2007 Cost Benchmark)
7. **2010 IHS EXPENDITURES PER USER**: Source -- The Indian Health Service budget and appropriations tables for 2010. IHS spending from appropriations plus spending of other collections are totaled and divided by estimated 2010 user counts (FY 2009 counts plus 1% increase). The chart does not display medical care spending for IHS users by other sources because amounts are unknown. The breakout for "medical care" and "non-medical" IHS programs is based on a detailed line-item analysis.

12/20/2010


Average LNF Score for IHS AREAS - FY 2010
Bemidji
Albuquerque
California
Oklahoma
Portland
Tucson
Billings
IHS-WIDE
Navajo
Aberdeen
Phoenix
Nashville
Alaska
50.0%
51.8%
54.6%
54.8%
55.7%
55.8%
55.8%
56.5%
56.5%
57.2%
60.3%
61.0%
62.2%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

GPRA 2010 & 2011 National Targets and National & Area Results for 2010

GPRA Clinical Measures	National 2011 IHS-ALL Target	National 2010 IHS-ALL Target	National 2010 IHS-ALL results	Aberdeen Area	Alaska Area	Albuquerque Area	Bemidji Area	Billings Area	California Area	Nashville Area	Navajo Area	Oklahoma Area	Phoenix Area	Portland Area	Tucson Area
Poor Glycemic Control *	18.0%	16%	18%	20%	9%	17%	15%	19%	15%	21%	23%	12%	22%	15%	25%
Ideal Glycemic Control	32.8%	33%	32%	29%	43%	33%	31%	30%	37%	27%	26%	42%	26%	35%	27%
Controlled Blood Pressure	39.0%	40%	38%	35%	39%	44%	37%	38%	35%	35%	42%	35%	41%	36%	38%
LDL Assessed	68.7%	69%	67%	61%	77%	71%	65%	64%	67%	65%	57%	77%	65%	70%	72%
Nephropathy Assessed	56.4%	54%	55%	69%	32%	71%	54%	54%	48%	59%	53%	55%	48%	53%	63%
Retinopathy Assessed	54.4%	55%	53%	44%	51%	63%	46%	59%	47%	43%	59%	55%	57%	43%	53%
Influenza 65+	63.5%	60%	62%	53%	48%	70%	67%	64%	54%	66%	68%	65%	59%	59%	61%
Pneumovax 65+	86.1%	83%	84%	84%	93%	92%	81%	87%	80%	83%	90%	77%	83%	79%	96%
Childhood Immunizations	81.0%	80%	79%	79%	81%	70%	77%	84%	72%	84%	85%	74%	82%	66%	92%
Pap Screening	60.5%	60%	59%	54%	73%	71%	54%	55%	51%	61%	57%	59%	54%	56%	52%
Mammography Screening	50.9%	47%	48%	44%	55%	45%	46%	46%	45%	51%	45%	55%	40%	38%	60%
Colorectal Cancer Screening	39.8%	36%	37%	25%	55%	29%	38%	36%	32%	38%	34%	47%	24%	38%	35%
Tobacco Cessation	25.7%	27%	25%	27%	15%	25%	29%	36%	25%	26%	8%	37%	10%	27%	14%
Alcohol Screening (FAS)	56.1%	55%	55%	63%	38%	66%	51%	56%	43%	72%	59%	61%	50%	46%	69%
Domestic (IP) Violence	57.3%	53%	53%	57%	34%	63%	54%	50%	48%	64%	56%	59%	48%	42%	68%

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