§ 1621*l*. Patient travel costs

(a) Definition of qualified escort

In this section, the term ''qualified escort'' means—

(1) an adult escort (including a parent, guardian, or other family member) who is required because of the physical or mental condition, or age, of the applicable patient;

(2) a health professional for the purpose of providing necessary medical care during travel by the applicable patient; or

(3) other escorts, as the Secretary or applicable Indian Health Program determines to be appropriate.

(b) Provision of funds

The Secretary, acting through the Service and Tribal Health Programs, is authorized to provide funds for the following patient travel costs, including qualified escorts, associated with receiving health care services provided (either through direct or contract care or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.))[1] under this chapter—

(1) emergency air transportation and nonemergency air transportation where ground transportation is infeasible;

(2) transportation by private vehicle (where no other means of transportation is available), specially equipped vehicle, and ambulance; and

(3) transportation by such other means as may be available and required when air or motor vehicle transportation is not available.

(Pub. L. 94–437, title II, § 213, as added Pub. L. 102–573, title II, § 208, Oct. 29, 1992, 106 Stat. 4551; amended Pub. L. 111–148, title X, § 10221(a), Mar. 23, 2010, 124 Stat. 935.)

REFERENCES IN TEXT

The Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), referred to in subsec. (b), is Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2203, which was classified principally to subchapter II (§ 450 et seq.) of chapter 14 of this title prior to editorial reclassification as chapter 46 (§ 5301 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 5301 of this title and Tables.

This chapter, referred to in subsec. (b), was in the original ''this Act'', meaning Pub. L. 94–437, Sept. 30, 1976, 90 Stat. 1400, known as the Indian Health Care Improvement Act, which is classified principally to this chapter. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of this title and Tables.

CODIFICATION

Amendment by Pub. L. 111–148 is based on sections 101(c)(2) and 129 of title I of S. 1790, One Hundred Eleventh Congress, as reported by the Committee on Indian Affairs of the Senate in Dec. 2009, which were enacted into law by section 10221(a) of Pub. L. 111–148.

AMENDMENTS

2010—Pub. L. 111–148 amended section generally. Prior to amendment, section directed Secretary to provide funds for patient travel costs for emergency air transportation and nonemergency air transportation where ground transportation was infeasible and authorized appropriations for fiscal years 1993 to 2000.

[1] See References in Text note below.

Pub. L. 111–148 substituted ''The Secretary'' for ''(a) The Secretary'' prior to general amendment of section. See above.

§ 1621m. Epidemiology centers

(a) Establishment of centers

(1) In general

The Secretary shall establish an epidemiology center in each Service area to carry out the functions described in subsection (b).

(2) New centers

(A) In general

Subject to subparagraph (B), any new center established after March 23, 2010, may be operated under a grant authorized by subsection (d).

(B) Requirement

Funding provided in a grant described in subparagraph (A) shall not be divisible.

(3) Funds not divisible

An epidemiology center established under this subsection shall be subject to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.),[1] but the funds for the center shall not be divisible.

(b) Functions of centers

In consultation with and on the request of Indian tribes, tribal organizations, and urban Indian organizations, each Service area epidemiology center established under this section shall, with respect to the applicable Service area—

(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian tribes, tribal organizations, and urban Indian organizations in the Service area;

(2) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

(3) assist Indian tribes, tribal organizations, and urban Indian organizations in identifying highest-priority health status objectives and the services needed to achieve those objectives, based on epidemiological data;

(4) make recommendations for the targeting of services needed by the populations served;

(5) make recommendations to improve health care delivery systems for Indians and urban Indians;

(6) provide requested technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

(7) provide disease surveillance and assist Indian tribes, tribal organizations, and urban Indian communities to promote public health.

(c) Technical assistance

The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out this section.

(d) Grants for studies

(1) In general

The Secretary may make grants to Indian tribes, tribal organizations, Indian organiza-

[1] See References in Text note below.

tions, and eligible intertribal consortia to conduct epidemiological studies of Indian communities.

(2) Eligible intertribal consortia

An intertribal consortium or Indian organization shall be eligible to receive a grant under this subsection if the intertribal consortium is—

(A) incorporated for the primary purpose of improving Indian health; and

(B) representative of the Indian tribes or urban Indian communities residing in the area in which the intertribal consortium is located.

(3) Applications

An application for a grant under this subsection shall be submitted in such manner and at such time as the Secretary shall prescribe.

(4) Requirements

An applicant for a grant under this subsection shall—

(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);

(B) consult and cooperate with providers of related health and social services in order to avoid duplication of existing services; and

(C) demonstrate cooperation from Indian tribes or urban Indian organizations in the area to be served.

(5) Use of funds

A grant provided under paragraph (1) may be used—

(A) to carry out the functions described in subsection (b);

(B) to provide information to, and consult with, tribal leaders, urban Indian community leaders, and related health staff regarding health care and health service management issues; and

(C) in collaboration with Indian tribes, tribal organizations, and urban Indian organizations, to provide to the Service information regarding ways to improve the health status of Indians.

(e) Access to information

(1) In general

An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority (as defined in section 164.501 of title 45, Code of Federal Regulations (or a successor regulation)) for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1936).

(2) Access to information

The Secretary shall grant to each epidemiology center described in paragraph (1) access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.

(3) Requirement

The activities of an epidemiology center described in paragraph (1) shall be for the purposes of research and for preventing and controlling disease, injury, or disability (as those activities are described in section 164.512 of title 45, Code of Federal Regulations (or a successor regulation)), for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1936).

(Pub. L. 94–437, title II, § 214, as added Pub. L. 102–573, title II, § 210, Oct. 29, 1992, 106 Stat. 4551; amended Pub. L. 111–148, title X, § 10221(a), Mar. 23, 2010, 124 Stat. 935.)

REFERENCES IN TEXT

The Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), referred to in subsec. (a)(3), is Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2203, which was classified principally to subchapter II (§ 450 et seq.) of chapter 14 of this title prior to editorial reclassification as chapter 46 (§ 5301 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 5301 of this title and Tables.

The Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (e)(1), (3), is Pub. L. 104–191, Aug. 21, 1996, 110 Stat. 1936. For complete classification of this Act to the Code, see Short Title of 1996 Amendments note set out under section 201 of Title 42, The Public Health and Welfare, and Tables.

CODIFICATION

Amendment by Pub. L. 111–148 is based on section 130 of title I of S. 1790, One Hundred Eleventh Congress, as reported by the Committee on Indian Affairs of the Senate in Dec. 2009, which was enacted into law by section 10221(a) of Pub. L. 111–148.

AMENDMENTS

2010—Pub. L. 111–148 amended section generally. Prior to amendment, section related to establishment and functions of epidemiology centers.

§ 1621n. Comprehensive school health education programs

(a) Award of grants

The Secretary, acting through the Service and in consultation with the Secretary of the Interior, may award grants to Indian tribes to develop comprehensive school health education programs for children from preschool through grade 12 in schools located on Indian reservations.

(b) Use of grants

Grants awarded under this section may be used to—

(1) develop health education curricula;

(2) train teachers in comprehensive school health education curricula;

(3) integrate school-based, community-based, and other public and private health promotion efforts;

(4) encourage healthy, tobacco-free school environments;

(5) coordinate school-based health programs with existing services and programs available in the community;

(6) develop school programs on nutrition education, personal health, and fitness;

(7) develop mental health wellness programs;

(8) develop chronic disease prevention programs;

(9) develop substance abuse prevention programs;