

### Detail of Performance Analysis Table

Performance Measures	FY Targets	Actual Performance	Reference
<b>Diabetes Group</b>			
<u>Indicator 1:</u> Assure that the proportion of patients with diagnosed diabetes that have poor glycemic control does not increase [outcome]	FY06: maintain 05 level FY 05: maintain 04 level FY 04: establish the baseline of patients with diagnosed diabetes that have poor glycemic control.  Prevalence of Diabetes FY 04: maintain database FY 03: maintain database FY 02: maintain database FY 01: maintain database FY 00: maintain database FY 99: establish baseline	FY06: FY 05: FY 04: 16/17%***  FY 03: database maintained FY 02: database maintained FY 01: database maintained FY 00: database maintained FY 99: baseline established	3 HP 2010  ***GPRA+ data
<u>Indicator 2:</u> Address the proportion of patients with diagnosed diabetes that have demonstrated glycemic control at the ideal level. [outcome]	<u>Ideal Glycemic Control</u> FY 06: maintain FY 05 level FY 05: maintain at FY 04 level* FY 04: +1% over FY 03 level FY 03: maintain at FY 02 level FY 02: improve from FY 01 FY 01: improved from FY 00 FY 00: improved from FY 99 FY 99: 25%  <u>Good Glycemic Control</u> FY 99: 38%	FY 06: FY 05: FY 04: 34/27%*** FY 03: 31*/28*** FY 02: 30%/25%*** FY 01: 29% ** FY 00: 26% FY 99: 24% FY 98: 22% FY 97: 25%  FY 99: 35% FY 98: 35% FY 97: 25%	3, 5 HP 2010 * indicates revised FY 2005 measure. See Summary of Changes Table.  * revised 1/05 ** revised 8/03 *** GPRA+ data

Performance Measures	FY Targets	Actual Performance	Reference
<p><u>Indicator 3:</u> Address the proportion of patients with diagnosed diabetes that have achieved blood pressure control. [outcome]</p>	<p><u>Ideal Hypertension Control</u> FY 06: maintain FY 05 level FY 05: maintain at FY 04 level FY 04: +1% over FY 03 level FY 03: maintain at FY 02 level FY 02: maintain at FY 01 level FY 01: improve from FY 00 FY 00: improve from FY 99 FY 99: 41%</p>	<p>FY 06: FY 05: FY 04: 34/35% *** FY 03: 33/37% *** FY 02: 32% ** /36% *** FY 01: 36% ** FY 00: 35% FY 99: 36% FY 98: 38% FY 97: 27%</p>	<p>3, 5 HP 2010  *** GPRA+ data **revised 1/04  **revised 01/04</p>
<p><u>Indicator 4:</u> Address the proportion of patients with diagnosed diabetes assessed for dyslipidemia. [outcome]</p>	<p><u>LDL Cholesterol</u> FY 06: maintain FY 05 level FY 05: maintain at FY 04 level FY 04: +1% over FY 03 level FY 03: maintain at FY 02 level FY 02: improve from FY 01 FY 01: improve from FY 00 FY 00: improve from FY 99 FY 99: 32%</p> <p><u>Total Cholesterol</u> FY 99: 82%</p>	<p>FY 06: FY 05:  FY 04: 69%/53% *** FY 03: 65/48% *** FY 02: 64%/44% *** FY 01: 60% FY 00: 54% FY 99: 46% FY 98: 29%</p> <p>FY 99: 72% FY 98: 79% FY 97: 83%</p>	<p>3, 5 HP 2010  *** GPRA+ data</p>

Performance Measures	FY Targets	Actual Performance	Reference
<p><u>Indicator 5:</u> Address the proportion of patients with diagnosed diabetes assessed for nephropathy. [outcome]</p>	<p>FY 06: maintain FY 05 level FY 05: maintain at FY 04 level FY 04: +1% over FY 03 level FY 03: maintain at FY 02 level FY 02: improve from FY 01 FY 01: improve from FY 00 FY 00: improve from FY 99 FY 99: 36%</p>	<p>FY 06: FY 05: FY 04: 63%/42%*** FY 03: 62/38%*** FY 02: 56%/35%*** FY 01: 54% FY 00: 41% FY 99: 36% FY 98: 33% FY 97: 36%</p>	<p>3, 5 HP 2010 ***GPRA+ data</p>
<p><u>Indicator 6:</u> Address the proportion of patients with diagnosed diabetes who receive an annual diabetic retinal examination at designated sites. [outcome]</p>	<p>FY 06: maintain at 05 level FY 05: maintain at 04 level FY 04: +3% over FY 03 level FY 03: +3% over FY 02 level FY 02: no indicator</p>	<p>FY 06: FY 05: FY 04: 55%*** FY 03: 58%*** FY 02: 55%***</p>	<p>3, 5 HP2010 ***GPRA+ data</p>

Performance Measures	FY Targets	Actual Performance	Reference
<b>Cancer Screening Group</b>			
<p><u>Indicator 7:</u> Address the proportion of eligible women patients who have had a Pap screen within the previous three years. [outcome]</p>	<p><u>Pap Screening</u> FY 06: maintain FY 05 levels FY 05: maintain FY 04 level FY 04: maintain FY 03 level FY 03: maintain FY 02 level FY 02: +2% over FY 01 level FY 01: +3% over FY 00 level FY 00: +3% over FY 99 level FY 99: no indicator</p> <p><u>Cervical Cancer</u> FY 99: determine incidence of cervical cancer</p>	<p>FY 06: FY 05: FY 04: 58%*** FY 03: 61%*** FY 02: 43.2% w/in 3 years (+1.3% over FY 2001)/62%*** FY 01: 21% w/in 1 year, 42% w/in 3 years FY 00: 12% w/in 1 year, 18% w/in 3 years FY 99: baseline not adequate</p> <p>FY 99: 8-10 per 100,000 based on 40% of AI/AN</p>	<p>3, 5 HP 2010 ***GPRA+ data</p>
<p><u>Indicator 8:</u> Address the proportion of eligible women who have had mammography screening within the last 2 years. [outcome]</p>	<p>FY 06: maintain FY 05 level FY 05: maintain FY 04 level FY 04: maintain FY 03 level FY 03: maintain FY 02 level FY 02: +2% over FY 01 level FY 01: +2% over FY 00 level FY 00: +3% over FY 99 baseline FY 99: establish baseline</p>	<p>FY 06: FY 05:  FY 04: 40%*** FY 03: 40%*** FY 02: 24.7% w/in 2 years (+3.7% over FY 2001)/42%***  FY 01: 21% w/in 2 years FY 00: 15% w/in 2 years  FY 99: baseline not adequate</p>	<p>3, 5 HP 2010 ***GPRA+ data</p>

Exhibit U

Performance Measures	FY Targets	Actual Performance	Reference
<p><u>Indicator 9:</u> Address the proportion of eligible patients who have had appropriate colorectal cancer screening. [outcome]</p>	<p>FY 06: Establish baseline rate of appropriate colorectal cancer screening</p>	<p>FY 06:</p>	<p>3, 5 HP 2010</p>

Performance Measures	FY Targets	Actual Performance	Reference
<b>Alcohol and Substance Abuse Group</b>			
<p><u>Indicator 10:</u> Assure quality and effectiveness of Youth Regional Treatment Centers. [outcome] [output 05/06]</p>	<p><u>RTC Accreditation:</u> FY 06: achieve 100% accreditation FY 05: ensure 100% accreditation</p> <p><u>RTC Assessment Criteria</u> FY 04: +2% over FY 03 for 4 criterion FY 03: +5% over FY 02 for 4 criterion FY 02: establish RTC baseline for 4 criterion</p> <p><u>Follow-up Rates</u> FY 04: no indicator FY 03: no indicator FY 02: no indicator FY 01: FY 00 level or higher FY 00: 45% (+10% over FY 99 for 3 follow-ups by 12 months post discharge) FY 99: establish baseline</p> <p><u>Abstinence</u> FY 04: no indicator FY 03: no indicator FY 02: no indicator FY 01: +5% over FY 00 FY 00: no indicator</p>	<p>FY 06:</p> <p>FY 05:</p> <p>FY 04: +2% over FY 03 FY 03: +4% over FY 02 for modifiable criteria FY 02: baseline established</p> <p>FY 03: no indicator FY 02: no indicator FY 01: 60% FY 00: 48% % -12 mos (+17%) FY 99: 40.9%</p> <p>FY 03: no indicator FY 02: no indicator FY 01: no reliable data source FY 00: no reliable data source</p>	<p>1, 3, 5</p>

Performance Measures	FY Targets	Actual Performance	Reference
<p><u>Indicator 11:</u> Address screening for alcohol use in appropriate female patients. [outcome]</p>	<p><u>Provide Alcohol Screening</u> FY 06: increase screening over FY 05 FY 05: increase screening over FY 04: During FY 2004, establish the screening rate for alcohol use in women of childbearing age.</p> <p><u>Implement Screening Protocol</u> FY 04: No indicator FY 03: Maintain FY 02 level FY 02: + 2% over FY 01  FY 01: + 10% over FY 00  FY 00: +5% over FY 99  FY 99: establish baseline</p>	<p>FY 06:  FY 05:  FY 04: baseline established</p> <p>FY 03: 95% FY 02: 90.5% (increase of 5.5% over FY 01) FY 01: 85% (decrease of 2.6%) FY 00: 87.6% (+9.2% over FY 99) FY 99: 78.4%</p>	<p>1, 3, 5 HP 2010</p>

Performance Measures	FY Targets	Actual Performance	Reference
<b>Oral Health Group</b>			
<u>Indicator 12:</u> Address access to optimally fluoridated water for the AI/AN population. [outcome]	FY 06: increase by 1% FY 05: measure number of topical fluoride applications and number of patients receiving them* FY 04: 1% over FY 03 for pop. receiving fluor. water FY 03: 1% over FY 02 for pop. receiving fluor. water FY 02: 5% over FY 01 for AI/AN pop. receiving fluor. water FY 01: 10% over FY 00 for demo Areas 5% over FY 00 for other Areas FY 00: 15% over FY 99 for demo Areas FY 99: no indicator	FY 06: FY 05: FY 04: +0.1% FY 03: +0.37% FY 02: +1% for pop FY 01: 28% over FY 00 for demo Areas Same % FY 00 for other Areas FY 00: 18 systems in compliance (38% increase) FY 99: 13 systems in compliance for demo Areas or 2%	3 HP 2010  * indicates revised FY 2005 measure. See Summary of Changes Table.
<u>Indicator 13:</u> Address the proportion patients who obtain access to dental services. [efficiency]	FY 06: maintain at FY 05 level FY 05: maintain at FY 04 level FY 04: maintain at FY 03 level FY 03: maintain at FY 02 level  FY 02: 1% over FY 01  FY 01: 27% FY 00: 23% FY 99: 21%	FY 06: FY 05: FY 04: 24%*** FY 03: 28.1/25%*** FY 02: 27.35% (+1% over FY 01) FY 01: 26.3% FY 00: 25.1% FY 99: 25.1% FY 98: 24.5% FY 97: 22%	3, 5 HP 2010  ***GPRA+ data

Performance Measures	FY Targets	Actual Performance	Reference
<u>Indicator 14:</u> Address the number of sealants placed per year in AI/AN patients. [outcome]	<u>Total Sealants Placed</u> FY 06: maintain at FY 05 level FY 05: at FY 04 levels FY 04: at FY 03 level FY 03: at FY 02 level FY 02: +2.5% over FY 01 total sealants placed	FY06: FY 05: FY 04: 287,158 FY 03: 243,499 FY 02: 227,945 (+7.2% over FY 01)  FY 01: 212,617	3, 5 HP 2010
<u>Indicator 15:</u> Address the proportion of patients diagnosed with diabetes who obtain access to dental services. [outcome]	FY 06: maintain at FY 05 level FY 05: maintain at FY 04 level FY 04: 1% increase over FY 03 FY 03: 2% increase over FY 02 FY 02: 2% increase over FY 01 FY 01: no indicator FY 00: no indicator FY 99: no indicator	FY 06: FY 05: FY 04: 37%*** FY 03: 36%*** FY 02: 36%*** FY 01: 32% FY 00: no indicator FY 99: no indicator	3, 5 HP 2010  ***GPRA+ data

Performance Measures	FY Targets	Actual Performance	Reference
<b>Family Abuse, Violence, and Neglect Indicator</b>			
<p><u>Indicator 16:</u> Address the proportion of women who are screened for domestic violence at health care facilities. [outcome]</p>	<p><u>Screening</u> FY 06: increase over FY 05 level FY 05: maintain FY 04 level* FY 04: at least 15% screened FY 03: no indicator FY 02: no indicator FY 01: no indicator FY 00: no indicator FY 99: no indicator</p> <p><u>Staff Training</u> FY 04: no indicator FY 03: 60% FY 02: 56% FY 01: no indicator FY 00: no indicator FY 99: no indicator</p> <p><u>Policies and Procedures</u> FY 04: no indicator FY 03: 85% FY 02: 82% FY 01: 80% FY 00: 70% FY 99: 60%</p> <p><u>Data Code</u> FY 04: no indicator FY 03: develop standard data code FY 02: no indicator FY 01: no indicator FY 00: no indicator FY 99: no indicator</p>	<p>FY 06: FY 05: FY 04: 4% screened FY 03: no indicator FY 02: no indicator</p> <p>FY 03: 60% FY 02: 70% FY 01: no indicator FY 00: 54% (baseline)</p> <p>FY 04: no indicator FY 03: 84% FY 02: 85% FY 01: 82% FY 00: 72% FY 99: 64%</p> <p>FY 04: no indicator FY 03: standard data code established FY 02: no indicator</p>	<p>1, 3</p> <p>HP 2010</p> <p>* indicates revised FY 2005 measure. See Summary of Changes Table</p>

Performance Indicator	FY Targets	Actual Performance	Reference
<b>Information Technology Development Group</b>			
<p><u>Indicator 17:</u> Expand the automated extraction of GPRA clinical performance measures and improve data quality.  [efficiency05/06]</p>	<p>FY 06: continue the ongoing development and deployment of CIRS software application  FY 05: add 2 new measures of automated data quality assessment  FY 04: a. Implement quality training in all Areas b. +2 new measures to automated data quality assessment “package”  FY 03: a. complete baseline of initial measures b. automate new measures c. distribute automated mapping tools to all I/T/Us  FY 02: assess 5 sites for 5 performance measures  FY 01: setup 5 sites for testing 5 performance measures FY 00: no indicator FY 99: no indicator</p>	<p>FY 06:  FY 05:  FY 04: implemented quality training in all Areas; added 2 new measures to automated quality assessment package FY 03: complete baseline of initial measures; new measures automated; automated mapping tools distributed to all I/T/U sites  FY 02: 5 sites assessed for performance measures FY 01: 5 sites for testing 5 performance measures established</p>	<p>3, 5 </p>

<p><u>Indicator 18:</u> Expand the Behavioral Health Data System by increasing use of appropriate software applications</p>	<p><u>Expand MH/SS Use</u> FY 06: increase the number of sites using new integrated BH software application over the FY 05 level. FY 05: increase over FY 04* FY 04: +5% of programs report minimum data set use over FY 03 FY 03: +3% use over FY 02 FY 02: +5% use over FY 01 FY 01: +10% use over FY 00 FY 00: +10% use over FY 99 FY 99: 50% reported</p> <p><u>Submit Minimum Data Set</u> FY 04: combined into above FY 03: 50% submit minimum data FY 02: no indicator</p>	<p>FY 06:  FY 05: FY 04: 2.3% increase FY 03: 3% increase FY 02: 5% increase FY 01: +12.1% increase FY 00: +24.7% increase FY 99: 51% reported FY 98: 40-45% baseline est.</p> <p>FY 03: 50%  FY 02: no accepted data set</p>	<p>3, 5   * indicates revised FY 2005 measure. See Summary of Changes Table</p>
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<p><u>Indicator 19:</u> Expand Urban Indian Health Program capacity for securing mutually compatible automated information system that captures health status, and patient care data for the Indian health system.</p>	<p><u>I/T/U IT Enhancement</u> FY 04: no indicator FY 03: no indicator</p> <p><u>Urban IT Enhancement</u> FY 06: establish baseline FY 05: implement C&amp;G language FY 04: develop language FY 03: +2 sites over FY 02 level FY 02: +2 sites over FY 01 level FY 01: implemented in 30% of urban programs FY 00: test in at least one site FY 99: develop specs and plan</p>	<p>FY 04: no indicator</p> <p>FY 06: FY 05:</p> <p>FY 04: minimum data set/language developed FY 03: 5 sites added FY 02: 2 sites added FY 01: 32% (11 of 34) urban programs</p> <p>FY 00: tested in several sites FY 99: accomplished 8/99</p>	<p>3, 5</p> 
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Quality of Care Group			
<p><u>Indicator 20:</u> Maintain 100% accreditation of all IHS hospitals and outpatient clinics.</p>	<p>FY 06: 100% FY 05: 100% FY 04: 100% FY 03: 100% FY 02: 100% FY 01: 100% FY 00: 100% FY 99: 100%</p>	<p>FY 06: FY 05: FY 04: 100% FY 03: 100% FY 02: 100% FY 01: 100% FY 00: 100% FY 99: 100% FY 98: 100% (baseline)</p>	<p>3, 5</p>

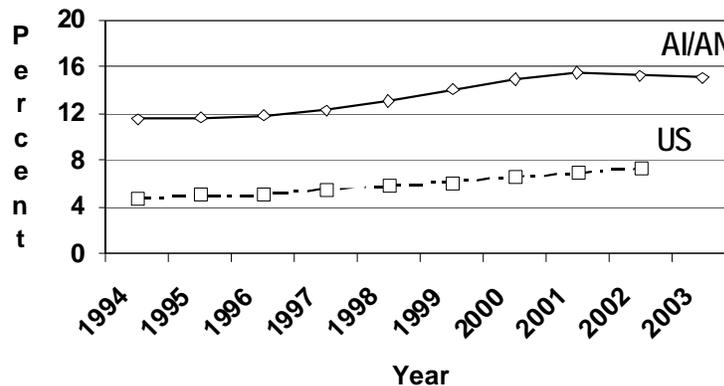
<p><u>Indicator 21:</u> Address medication errors by developing a reporting system to reduce medication error. [outcome]</p>	<p>FY 06: establish and evaluate medical error reporting in 3 areas</p> <p>FY 05: all direct care facilities shall be using the NCCMERP nationally recognized medication error definition, and shall have a non-punitive multi-disciplinary medication error reporting system in place.</p> <p>FY 04: establish baseline data for medication error reporting for all IHS Areas b. pilot test standardized medication error reporting system in two additional areas</p> <p>FY 03: assess baseline and establish pilot sites</p> <p>FY 02: assess current systems for 3 elements</p>	<p>FY 06:</p> <p>FY 05:</p> <p>FY 04: baseline established and expanded Medmarx medication error reporting system into sites in 6 areas</p> <p>FY 03: baseline assessed and pilot sites established</p> <p>FY 02: 3 elements assessed</p>	
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<p><u>Indicator 22:</u> Assess consumer satisfaction with the acceptability and accessibility of health care</p>	<p>FY 06: eliminated in FY 05 FY 05: eliminate FY 04: improve 3% over FY 03 FY 03: establish baseline  FY 02: secure OMB clearance FY 01: secure OMB clearance FY 00: Federal clearance and establish baseline  FY 99: develop instrument and protocol</p>	<p>FY 04: survey not implemented FY 03: baseline established FY 02: OMB clearance secured FY 01: waiting final OMB approval FY 00: submitted but clearance not completed FY 99: instrument and protocol complete</p>	<p>3 5  * indicates revised FY 2005 measure. See Summary of Changes Table</p>
<p>Total Treatment Funding:</p>	<p>FY 06: \$3,309,071,000 * FY 05: \$3,112,367,000* FY 04: \$3,046,729,000* *includes 85% of M/M and PI collections and Diabetes</p>	<p>HP: Chapter #: #: HHS Strategic Goal PMA #</p>	

**Diabetes Group:**

**Indicator 1:** During FY 2006, assure that the proportion of patients with diagnosed diabetes that have poor glycemic control does not increase over FY 2005 level.

### Prevalence\* of diagnosed diabetes among adults, American Indians/Alaska Natives and U.S. general population, 1994–2003



\*Age-adjusted based on the 2000 US standard population  
Source: 1994–2003 IHS outpatient data and 1994–2002 BRFSS



Area age-specific diabetes prevalence rates have been prepared for the American Indian and Alaska Native population based on patients diagnosed with and treated for diabetes, and having at least one outpatient visit during FY 2004. This information is the contextual basis for our series of diabetic indicators.

**Rationale:** This indicator is directed at decreasing the percentage of patients with poor and very poor glycemic control.

**Why is this Important?** Reducing the number of patients with poor control will reduce the prevalence of diabetes complications. Some clinical studies have shown that a 1% decrease in the absolute A1C level translates into a:

- 14% decrease in total mortality,
- 21% decrease in diabetes-related deaths,
- 14% decrease in myocardial infarction,
- 40% decrease in eye disease,
- 43% decrease in amputations,
- and a 24% decrease in kidney failure.

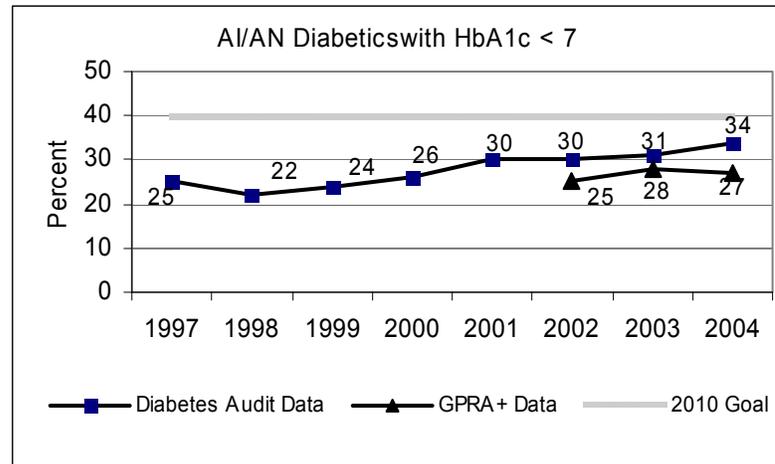
Reducing A1C levels can also save \$800 in annual health care costs.

**Approach:** Glycemic control is measured with a test called the Hemoglobin A1C (HgbA1c) that measures the average blood sugar over the last 1-2 months. The IHS Diabetes Care and Outcomes Audit divides these control levels and identifies “Ideal” as a HgbA1c <7, based on national diabetes care standards.

**Data Source:** RPMS data from local RPMS databases, diabetes registries, yearly IHS Diabetes Care and Outcomes Audit.

**Program Performance: IHS met this indicator in 2004.** In 2004, the indicator was to establish the baseline of those in poor diabetic blood sugar control. In 2004, 17% of diabetic patients had poor glycemic control, according to GPRA+ data. The baseline GPRA+ numbers established for this indicator show that this percentage is unchanged from 2000. Maintaining this rate is a significant accomplishment, considering that between 2000 and 2004 the number of patients with diagnosed diabetes increased from 8% to 10% at the I/T/Us participating in the 2004 GPRA review.

**Indicator 2: During FY 2006, maintain the proportion of patients with diagnosed diabetes that have demonstrated ideal glycemic control at the FY 2005 level.**



**Rationale:** This indicator is directed at maintaining the percentage of diabetic patients with ideal blood sugar control.

**Why is this important?** Keeping blood sugar levels below 7 can slow or prevent the onset and progression of eye, kidney, and nerve disease caused by diabetes. Good blood sugar control also lowers the risk of heart attack and stroke.

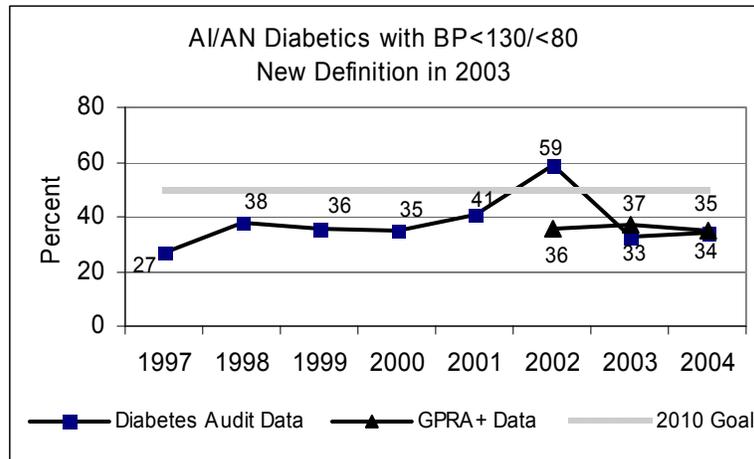
**Approach:** Glycemic control is measured with a test called the Hemoglobin A1C (HgbA1c) that measures the average blood sugar over the last 1-2 months. As stated earlier, “ideal” control is (<7%). The current guidelines recommend the use of HgbA1c cutoffs that determine control at the "Ideal" level.

**Data Source:** GPRA+ data from local RPMS databases, diabetes registries, yearly IHS Diabetes Care and Outcomes Audit.

**Program Performance:** IHS met this indicator in 2004 based on diabetic audit data. The FY 2004 Indicator was to increase the proportion of I/T/U clients with diagnosed diabetes who have achieved ideal glycemic control by 1% over the FY 2003 level. These results reflect meaningful agency accomplishment considering that:

- The prevalence of diabetics in the communities represented by this report has increased from 8% in 2000 to 10% in 2004.
- The number of patients being treated for diabetes in these same communities is 7% higher than the number treated in 2003 and 34% higher than in 2000.
- The number of patients in good control increased from 18,998 in 2003 to 19,743 in 2004.

**Indicator 3:** During FY 2006, maintain the proportion of patients with diagnosed diabetes who have achieved blood pressure control at the FY 2005 level.



**Rationale:** This indicator is directed at reducing complications of diabetes.

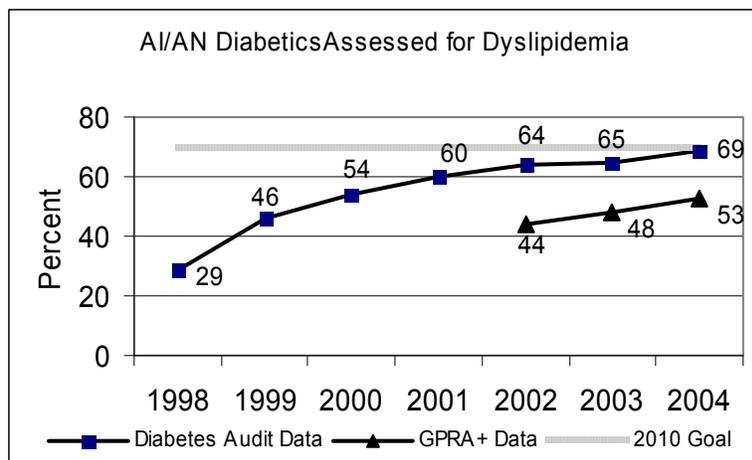
**Why is this Important?** A National Heart, Lung, and Blood Institute report indicates that the risk of heart disease and stroke doubles for every increase of 20 mm in systolic or 10 mm in diastolic pressure. Lower blood pressure levels in people with diabetes reduce the risk of heart disease and stroke by 33-50%. Blood pressure control also reduces the risk of eye, kidney, and nerve disease by one third.

**Approach:** National standards recommend that the ideal goal of diabetic blood pressure control should be 130/80. For the GPRA process, the “ideal” control is defined as <130/80, though this will change as clinical care guidelines are modified.

**Data Source:** GPRA+ data from local RPMS databases, diabetes registries and yearly IHS Diabetes Care and Outcome Audits.

**Program Performance:** IHS met this indicator in FY 2004 based on diabetic audit data. The FY 2004 indicator was to increase the proportion of I/T/U patients with diagnosed diabetes that have achieved blood pressure control by 1% over the FY 2003 level. The FY 2004 diabetic audit data showed that the proportion of patients in good control increased from 33% to 34%. GPRA+ data showed a drop in the percentage of patients who achieved good control from 37% in 2003 to 35% this year, which may be attributable to a change in the definition of good blood pressure control in GPRA+ software.

**Indicator 4:** During FY 2006, maintain the proportion of patients with diagnosed diabetes assessed for dyslipidemia (LDL cholesterol) at the FY 2005 level.



**Rationale:** This indicator is directed at lowering serum LDL cholesterol.

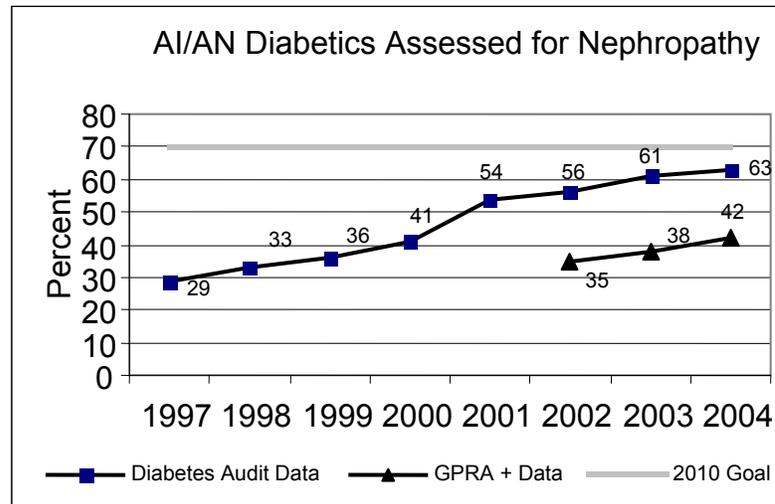
**Why is this important?** Low cholesterol levels help to protect diabetic patients from developing heart disease. Improved control of cholesterol levels reduces the risk of cardiovascular complications by 20-50%. National standards recommend that people with diabetes keep their cholesterol levels below 200 mg/dl, and their LDL cholesterol levels below 130 mg/dl and ideally below 100 mg/dl. Diabetic patients are especially prone to develop heart disease and therefore identification and treatment of elevated lipids in diabetic patients is extremely important. In addition, because persons with diabetes who experience a heart attack have an unusually high death rate either immediately or in the long term, a more intensive prevention strategy is warranted.

**Approach:** This indicator measures screening of LDL in diabetic patients. Trends over time for I/T/U facilities, service units, Areas and IHS-wide are constructed for selected indicators.

**Data Source:** GPRA+ data from local RPMS databases, diabetes registries, yearly IHS Diabetes Care and Outcomes Audit

**Program Performance:** IHS met this indicator in FY 2004. The FY2004 indicator was to increase the proportion of patients with diagnosed diabetes assessed for dyslipidemia by 1% over the FY 2003 level. The target of increasing the number of patients assessed for dyslipidemia was met and substantially exceeded according to both the diabetic audit and GPRA+ data.

**Indicator 5:** During FY 2006, maintain the proportion of patients with diagnosed diabetes assessed for nephropathy at the FY 2005 level.



**Rationale:** This indicator is directed at the assessment of microalbuminuria or proteinuria, measured in the urine with a urinalysis test.

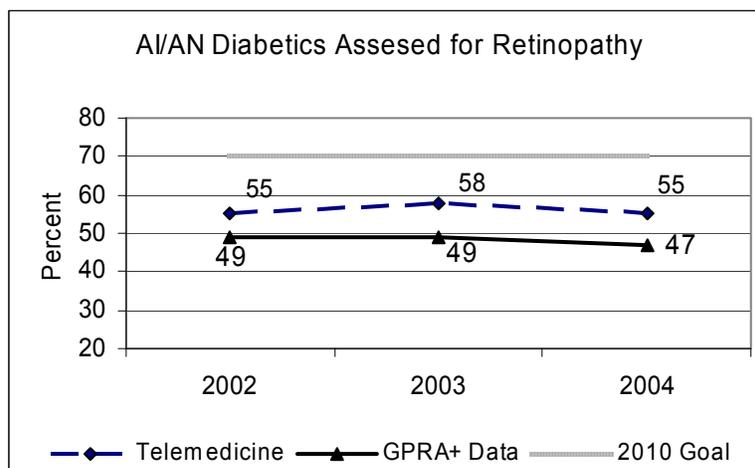
**Why is this important?** Diabetes can cause kidney disease by damaging the parts of the kidneys that filter out wastes. Diabetes is the leading cause of end stage renal disease (ESRD) of kidney failure, a growing problem in Indian communities. Early identification of at risk patients may help prevent or delay the need for dialysis or renal transplant. Microalbumin in the urine is an early sign of diabetic kidney disease. Proteinuria is also an independent predictor of cardiovascular disease, which is the number one killer of American Indian and Alaska Native adults.

**Approach:** The benefits of aggressive interventions to lower blood pressure in diabetics relative to kidney health have been well described in the literature and numerous practice guidelines and standards exist. A special sub-report of the IHS Diabetes Care and Outcomes Audit, called the Kidney Health Profile, generated annually, assesses screening and treatment for kidney health in a community. Each year's reported rate will be used to provide trend analysis.

**Data Source:** GPRA+ data from local RPMS systems, diabetes registries, yearly IHS Diabetes Care and Outcomes Audit.

**Program Performance:** IHS met this indicator in FY 2004. The FY 2004 indicator was to increase the proportion of patients with diagnosed diabetes assessed for nephropathy by 1% over the FY 2003 level. This goal was met and exceeded, with a 4% increase in the number of patients assessed based on GPRA+ data and a 2% increase according to the diabetic audit data.

**Indicator 6: During FY 2006, maintain the proportion of patients with diagnosed diabetes who receive an annual retinal exam.**



**Rationale:** The purpose of this indicator is to reduce the level of vision loss from diabetic retinopathy in the American Indian and Alaska Native population.

**Why is this Important?** Diabetes can affect sight by damaging the blood vessels inside the eye, a condition known as “diabetic retinopathy.” Diabetic eye disease is a leading cause of blindness in the United States. Early detection of diabetic retinopathy (DR) is a fundamental part of the effort to reduce visual disability in diabetic patients. Clinical trials demonstrated that effective laser photocoagulation treatment of early DR could reduce vision loss by 90%.

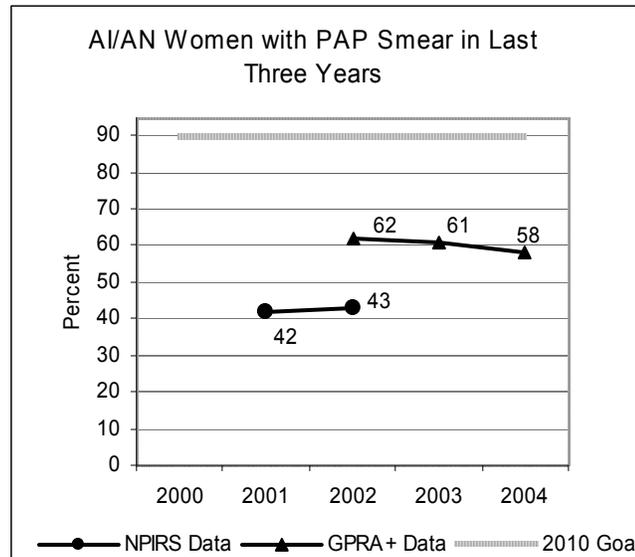
**Approach:** The IHS retinopathy screening rate has remained relatively unchanged since rates have been tracked. Some facilities have telemedicine projects in place designed to screen diabetics for diabetic retinopathy (pilot sites), and performance at these sites is being evaluated to determine the impact of this approach on screening rates. Pilot sites designated for FY 2004 are Phoenix Indian Medical Center, Tuba City Medical Center, Fairbanks Health Center, San Carlos Indian Hospital, Benewah Health Center, Hopi Health Care Center, Parker Indian Hospital, and Carl Albert Indian Health Facility.

**Data Source:** GPRA+ data from RPMS databases at selected pilot sites as well as all other facilities.

**Program Performance:** IHS did not meet this indicator in FY 2004. The FY 2004 indicator was to increase the proportion of patients with diagnosed diabetes who receive an annual diabetic retinal examination at designated sites by 3%. In FY 2003, the examination rate for pilot sites was 58%; in FY 2004, the rate dropped to 55%. Reasons for this drop include an increase in the size of the diabetic population as well as eye department staff decreases, or lack of staff increases. Adjusting for these variables, increases can be shown at all pilot sites except Parker, where the Tmed-DR program was minimally operational in 2004 due to staffing issues. Compared with the results of all sites participating in GPRA in FY 2004, the results at pilot sites are impressive. The rates for all sites dropped from 49% in FY 2003 to 47% in FY 2004.

**Cancer Screening Group:**

**Indicator 7:** During FY 2006, maintain the proportion of female patients ages 21 through 64 without a documented history of hysterectomy who have had a Pap screen within the previous three years at FY 2005 level.



**Rationale:** The purpose of this indicator is to reduce the mortality and morbidity of cervical cancer, which occurs at higher rates among American Indian and Alaska Native women than in the general U.S. population.

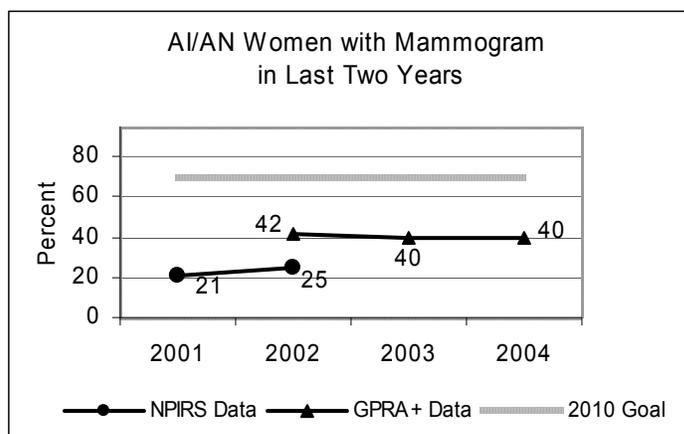
**Why is this Important?** American Indian women have a cervical cancer mortality rate of 4.4 (1999-2001) that exceeds the 2000 rate of 2.8 for U.S. all races. More than any other racial or ethnic group, American Indian women report having never had a Pap screen. Regular screening with a pap smear lowers the risk of developing invasive cervical cancer by detecting pre-cancerous cervical lesions that can be treated. If cervical cancer is detected early, the survival rate is almost 100 percent with appropriate treatment and follow-up.

**Approach:** The IHS Office of Public Health Support is responsible for overall coordination of efforts to achieve these indicators.

**Data Source:** GPRA+ data from RPMS.

**Program Performance:** IHS did not meet this indicator in FY 2004. The FY 2004 indicator was to maintain the proportion of eligible women patients who have had a Pap screen within the previous three years at the FY 2003 levels. In 2004 the Pap smear rate was 58%, a drop of 3% from the 61% rate reported in 2003. Some of this drop can be attributed to a change in the measure for a Pap test. Previously, all reported pelvic exams counted toward the Pap smear rate, but in 2004 only Pap smears were counted. Therefore, the 2004 rate is more accurate.

**Indicator 8:** During FY 2006, maintain the proportion of female patients ages 50-64 who have had mammography screening within the last 2 years at the FY 2005 level.



**Rationale:** The purpose of this indicator is to reduce the mortality and morbidity of breast cancer among American Indian and Alaska Native women.

**Why is this Important?** Biennial screening of women between the ages of 50 and 69 has been shown to be a cost effective way to decrease the breast cancer mortality rate. Breast cancer is the second leading cause of cancer death among U.S. women (lung cancer is first). Regular mammography screening can reduce breast cancer mortality by 20-30%. AI/AN women diagnosed with breast cancer have lower 5-year survival rates in comparison to whites, mainly because their cancers are less likely to be found in earlier stages.

**Approach:** Mammography screening is provided to American Indian and Alaska Native women directly by IHS facilities, by mobile mammography units supported either by CDC funds or through contract health arrangements with private radiology groups. The IHS Office of Public Health Support performs the overall coordination of this effort. Linkages with CDC and State screening programs are critical to success. CDC has funded the National Indian Women's Health Support Center to provide technical assistance to Tribal mammography programs.

**Data Source:** GPRA+ data from local RPMS database.

**Program Performance:** IHS met this indicator in FY 2004. This indicator called for maintaining the proportion of eligible women patients who have had mammography screening within the last 2 years at the FY 2003 rate. The 2004 mammogram rate remained unchanged from the 2003 rate of 40%. Because many tribal and urban facilities lack the equipment to perform mammograms on site, this rate is a difficult one to increase.

**Indicator 9: During FY 2006, establish baseline rate of colorectal cancer screening for clinically appropriate patients aged 50 and over.**

**Rationale:** The purpose of this indicator is to reduce the mortality and morbidity of colorectal cancer among American Indians and Alaska Natives.

**Why is this Important?** Colorectal cancers are the fourth most commonly diagnosed cancers in the United States, and are the second leading cause of cancer deaths, after lung cancer. Colorectal cancer rates among the Alaska Native population are well above the national average. Although colorectal cancer rates among American Indians are low compared to the overall US average, there is strong evidence that the number of colorectal cancer cases has been rising in recent years. Screening and preventative measures such as removal of polyps have been well proven to reduce the rates and lethality of colorectal cancer. Colorectal cancers have long asymptomatic periods during which they can be diagnosed and treated. Yearly screening has been shown to result in a 33.4 percent reduction in colorectal cancer mortality

**Approach:** Colorectal screening is provided to American Indian and Alaska Native patients directly by IHS facilities or through contract health arrangements with private radiology groups. IHS recognizes that 90% of colorectal cancer is preventable with appropriate screening interventions. Appropriate screening interventions will be based upon current colorectal cancer screening guidelines. IHS recognizes that the majority of sites will not be able to offer screening colonoscopy; however, current guidelines include stool guaiacs as an appropriate screening mechanism. Local sites will have the option of establishing appropriate screening guidelines based upon nationally endorsed guidelines.

**Data Source:** GPRA+ reports from local RPMS database

**Program Performance:** No report for FY 04. New indicator for FY 06

**Substance Abuse Treatment Group:**

**Indicator 10: During FY 2006, the Youth Regional Treatment Centers that have been in operation for 18 months or more will achieve 100% accreditation either through CARF, or a comparable accreditation process.**

**Rationale:** This indicator is intended to evaluate Youth Regional Treatment Centers and ensure that these programs are appropriately managed.

**Why is this Important?** Successful completion of residential treatment can help reduce drug and alcohol use relapse in youths.

**Approach:** Accreditation by JCAHO, CARF, or comparable state accrediting bodies ensures that the Youth Regional Treatment Centers met acceptable standards of treatment care. This indicator has changed to focus on accreditation, as the components of the previous indicator are met and surpassed with accredited facilities.

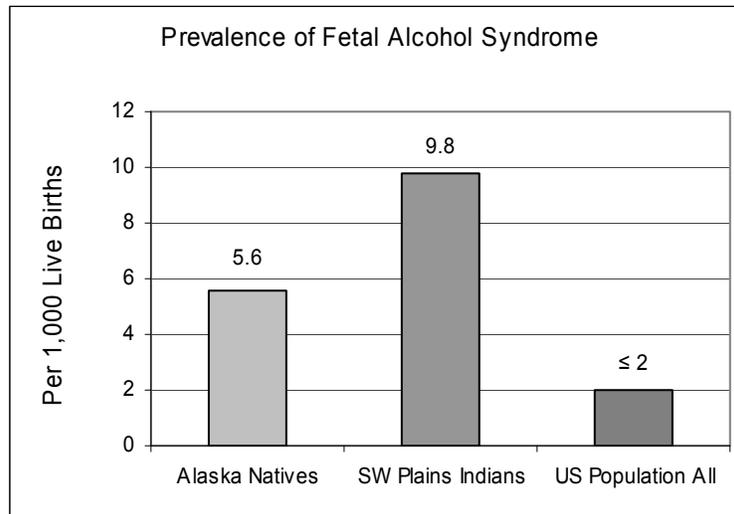
**Data Source:** Data for this indicator are collected from the YRTCs. The Division of Behavioral Health, Office of Public Health will be responsible for coordinating data collection from the Regional Treatment Centers.

**Program Performance: IHS met this indicator in 2004.** The FY 2004 performance measure was to show a 2% improvement over FY 2003 YRTC data for the following measures:

- Percent of youths who successfully completed alcohol/substance abuse treatment at IHS funded YRTCs. (70% in FY 2004 compared to 63% in FY 2003)
- Percent of youth (that completed treatment) who developed an aftercare plan with their appropriate aftercare agency (100% in FY 2004 compared to 99.6% in FY 2003)
- Percent of youth who have this after care plan communicated to the responsible follow-up agency; documentation of this communication must be in the youth YRTC record (100% in FY 2004 compared to 99.5% in FY 2003)
- Percent of YRTC programs that have a family week opportunity for youth that participate in the YRTCs (stable at 100% in FY 2003 and FY 2004)

These results are based on the eight YRTCs reporting data in both FY2004 and FY 2003. Completion of treatment, improvement in aftercare communication, established aftercare, and family week participation are known factors contributing to improved outcomes.

**Indicator 11:** During FY 2006, increase the screening rate for alcohol use in females ages 15-44 over the FY 05 rate.



**Rationale:** The purpose of this indicator is a reduction in the incidence of Fetal Alcohol Syndrome (FAS).

**Why is this Important?** Heavy drinking during pregnancy can cause significant birth defects, including Fetal Alcohol Syndrome (FAS). FAS is the leading known, and preventable, cause of mental retardation. Rates of FAS are higher among American Indians and Alaska Natives than the general population. Studies have found alcohol consumption rates among AI/AN women of childbearing age to be higher than average. The US Preventative Services Task Force recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings. Screening with intervention has been shown to be effective in reducing alcohol misuse in pregnancy and to reduce the incidence of FAS.

**Approach:** The Division of Behavioral Health works with facilities to educate, establish and increase the rates of screening for alcohol use in this age cohort. In addition, RPMS Health Summary ensures that there is an automatic health care reminder for alcohol screening. This reminder is visible to the end health care provider at the time of the provider visit.

**Data Source:** RPMS data extraction

**Program Performance:** IHS met this indicator in FY2004. The FY 2004 indicator called for establishing a baseline screening rate for alcohol use in women of childbearing age.

*Oral Health Group:*

**Indicator 12:** During FY 2006, increase by 1% (1) the number of topical fluoride applications provided to American Indian and Alaska Native patients, with a maximum number of four applications per patient per year and (2) the number of American Indian and Alaska Native patients receiving at least one topical fluoride application above the FY 2005 levels.

**Rationale:** Prevention of tooth decay improves nutritional health.

**Why is this Important?** Fluoride application is an effective measure for reducing the prevalence of dental decay in all age groups.

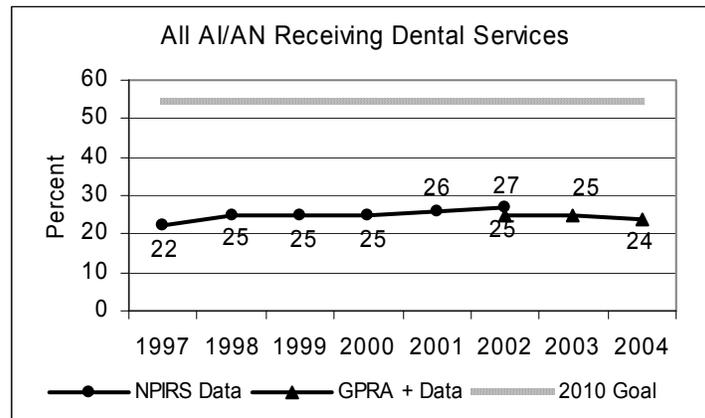
**Approach:** The effect on the tooth surface is essentially the same, regardless of whether the source is in the water or in topical applications. Area dental officers as a group have determined that tracking topical fluoride applications and the number of patients receiving these applications is a good alternative to measuring water fluoridation.

**Date Sources:** CRS data from local RPMS database

**Program Performance:** IHS did not meet this indicator in FY 2004. The FY 2004 indicator committed to a .5% increase in the number of American Indian and Alaska Native people benefiting from fluoridated drinking water. In FY 2004 an additional 1,713 individuals gained access to fluoridated water, an increase of 0.1%.

Significant progress has been made in most Areas with respect to water fluoridation, but the final objective of all the efforts, successful, consistent, monitored fluoridation on a widespread basis, has not yet occurred.

**Indicator 13: During FY 2006, maintain the proportion of patients who obtain access to dental services at the FY 2005 level.**



**Rationale:** This indicator is directed at improving the oral health status of the American Indian and Alaska Native population.

**Why is this Important?** This indicator is directed at improving the oral health status of the American Indian and Alaska Native population. Untreated tooth decay can cause abscesses and infections, pain, dysfunction and weight loss. Dental problems result in the loss of almost 2.5 million workdays each year. Access to dental care improves oral health as well as the overall health of AI/AN people.

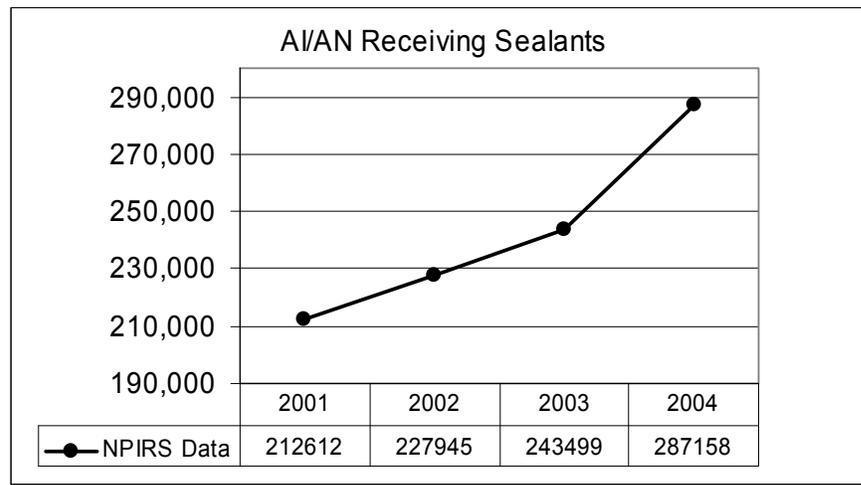
**Approach:** Access to dental services in FY 2006 will be maintained at 100% of the FY 2005 level through a combination of strategies that include:

- Increasing the I/T/U dental workforce.
- Increasing retention and productivity of dental providers.
- Updating and simplify the automated dental record keeping system.
- Expanding essential dental specialty services through contracts with the private sector.
- Targeting specific populations.

**Data Source:** IHS Dental Data System component of the RPMS; GPRA+ data from local RPMS.

**Program Performance:** **IHS did not meet this indicator in FY 2004.** The FY 2004 indicator called for maintaining the percent of patients who accessed dental services in 2004. In FY 2004 the percentage of patients obtaining access dropped by 1% to 24%. The key national factor contributing to this drop is the continued high vacancy rate in the dental program, which remains around 23%. Access to care, over recent years, seems closely tied to vacancy rates. A second factor is a substantial drop (9%) in the percentage of patients reported as accessing dental service in one Area. An investigation into this anomaly showed that that two reporting facilities had substantial data entry problems. These two facilities did have manual tallies available. If we take these into account, the indicator is met.

**Indicator 14: During FY 2006, maintain the number of dental sealants placed per year in American Indian and Alaska Native patients at the FY 2005 level.**



**Rationale:** The intent of this indicator is to reduce dental decay by increasing both the number of patients with dental sealants (the prevalence of sealants in the population) and the number of sealants per patient (the intensity of coverage per individual).

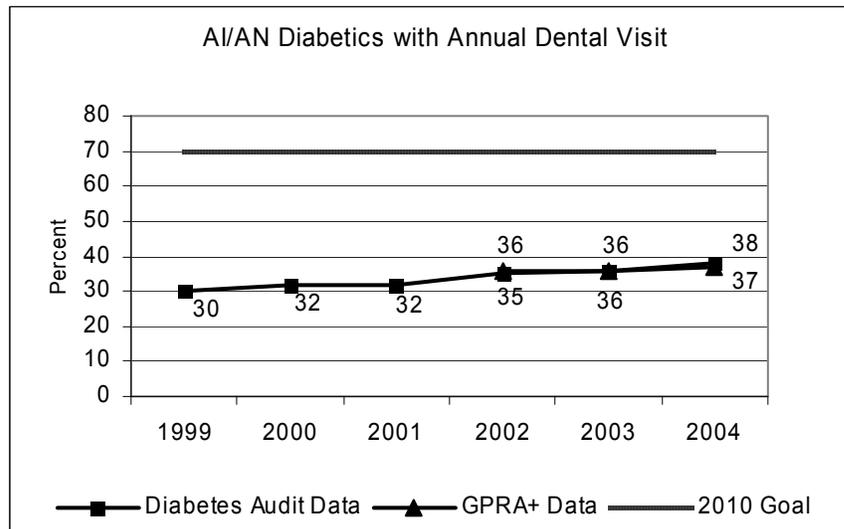
**Why is this Important?** Surveys of American Indian and Alaska Native children have consistently identified them as having significantly higher dental decay rates than the general U.S. population. Dental sealants, a recognized standard in preventive dental care, are an effective measure for reducing dental decay rates and can be effectively applied by dental auxiliaries at relatively low cost. Sealants reduce both the ravages and costs of treating dental decay.

**Approach:** Local dental clinics are responsible for implementing/maintaining effective and efficient sealant programs that are either school-based or school-linked and targeted for children ages 6-14 years (to coincide with the eruption of first and second permanent molar teeth). In order to maintain the number of sealants placed on the posterior teeth of Indian patients in FY 2006, an innovative approach will be required. One option involves the use of contract 4-handed dental sealant teams hired from the private sector. Dental Community Health Aides may be trained to assist dental hygienists and dental assistants in placing sealants. Additional portable equipment to be used in the schools is an efficient way to make use of lack of clinic space.

**Data Source:** NPIRS. In 2005, sealant data will be reported based on data collected at local facilities using CRS software.

**Program Performance:** **IHS met this indicator in FY 2004.** The FY 2004 indicator called for maintaining the number of dental sealants placed per year in American Indian and Alaska Native patients at the FY 2003 level. As measured by NPIRS, the total number of sealants increased from 243,499 in 2003 to 287,158 in 2004.

**Indicator 15: During FY 2006, maintain the proportion of patients diagnosed with diabetes who obtain access to dental services at the FY 2005 level.**



**Rationale:** The purpose of this indicator is to improve both oral health status and diabetic control for American Indian and Alaska Native diabetics.

**Why is this Important?** Diabetics are at increased risk for destructive periodontal disease and subsequent tooth loss. All diabetic patients should receive a complete dental exam on an annual basis. In addition, untreated periodontitis in diabetics may complicate glycemic control. Access to both primary and secondary treatment and preventive services for diabetics can lessen periodontal disease progression and the subsequent effects on diabetes and overall health. Regular visits provide opportunities for prevention, early detection, and treatment.

**Approach:** Individual I/T/U hospitals and clinics provide access to care for diabetic patients in a wide variety of ways. At a minimum, a yearly examination provides an educational opportunity to enlighten the diabetic patient on their oral health status and proper home care to reduce periodontal disease and its effect on diabetic control. Those programs with additional time and resources can provide anything from extraction of teeth that are severely involved with periodontal disease to comprehensive periodontal therapy and dentures. The proposed FY 2006 IHS budget will support the capacity to maintain access at the FY 2005 level in the face of population growth and rising costs of treatment.

**Data Source:** GPRA+ from local RPMS databases; diabetes registries, yearly IHS Diabetes Care and Outcomes Audit.

**Program Performance:** IHS met this indicator in FY 2004. This indicator was to increase access to dental services at 1% over FY 2003 level. The diabetic audit data showed a 2% increase, and the GPRA+ data showed a 1% increase.

**Family Violence, Abuse, or Neglect Indicator:**

**Indicator 16: During FY 2006, increase the screening rate of domestic violence in females ages 15 through 40 over the FY 2005 rate.**

**Rationale:** This indicator is designed to help ascertain, evaluate and reduce the prevalence of family violence, abuse and neglect in American Indian and Alaska Native communities.

**Why is this important?** Rates of intimate partner violence are double for American Indian and Alaska Native people compared to whites, and 1½ times greater than U.S. all races. The health consequences of intimate partner violence are numerous. Women who experience domestic violence are more often victims of nonconsensual sex, have higher levels of smoking, chronic pain syndromes, depression, generalized anxiety, substance abuse, and Post-Traumatic Stress Disorder. Screening and appropriate referrals should help decrease the morbidity and mortality associated with intimate partner violence.

**Approach:** IHS has developed training materials that are specific for American Indian and Alaska Native communities. IHS has entered into a collaborative agreement with the Family Violence Prevention Fund as well as ACF, DHHS. This agreement facilitated the development of our teaching materials as well as the implementation and evaluation of a multifaceted systems approach to screening at clinical facilities throughout American Indian and Alaska Native communities.

**Data Source:** GPRA+ from local RPMS databases.

**Program Performance:** **IHS did not meet this indicator in FY 2004.** The FY 2004 indicator was to screen at least 15% of female patients ages 16-24 for domestic violence at health care facilities. Only 4% of eligible patients were screened in FY2004. The IHS will focus on additional training and screening tools during FY 2005.

**Information Technology Development Group:**

**Indicator 17: During FY 2006, continue the automated extraction of GPRA clinical performance measures through ongoing development and deployment of CRS (clinical reporting system) software.**

**Rationale:** This indicator is designed to continue to improve passive extraction of GPRA clinical data from RPMS- IHS health information system.

**Why is this Important?** Increased local clinical data information results in improved quality of care.

**Approach:** IHS continues to develop GPRA+ software; this software will be renamed CRS (clinical information reporting system) in FY 05. Ongoing requirements development, as well as increased emphasis on clinical quality data improvement, will remain in place.

**Data Source:** CRS software application

**Program Performance:** **IHS met this indicator in FY 2004.** The FY 2004 indicator was to expand the automated extraction of GPRA clinical performance measures and improve data quality by adding 2 new measures of automated data quality assessment to the GPRA software. The GPRA+ software included an additional 4 automated data quality indicators in FY 04; this software was successfully distributed to all 12 IHS areas.

**Indicator 18:** A new behavioral health clinical performance indicator will be developed for FY 2006 that utilizes the enhanced functionality in the IHS Integrated Behavioral Health (IBH) application and reflects patient outcomes. The IBH application will be deployed within the IHS Electronic Health Record by the end of FY 2005.

**Rationale:** The purpose of this indicator is to collect data in order to track and evaluate improvements in the behavioral health status of American Indian and Alaska Native people.

**Why is this Important?** Better BH data collection and analysis will improve planning, implementation and evaluation of mental health, alcohol and substance abuse, and social services efforts across I/T/U programs.

**Approach:** Improving behavioral health outcomes relies on two important activities: data collection as close to point of care as possible, and data reporting in a standardized way that can be understood across the Indian health system. Standardized data reporting can be achieved by providing a usable, provider-driven and provider friendly computerized application to I/T/U sites.

A key activity that began in FY 2002 was the design and implementation of an integrated Behavioral Health system. The behavioral health Interim Solution, deployed during FY 2003, helped address the need for incremental improvements in existing RPMS systems, as well as facilitated a standardized suicide data collection system within the RPMS package. By 2005, a new integrated behavioral health application will be developed and deployed to interested sites. Increased use of this application should result in increased quality of BH care to AI/AN communities using this system.

The IHS Indian Health Performance Evaluation System (IHPES) has also developed a national Mental Health SAS database.

**Data Source:** RPMS, the Mental Health Database, and appropriate surveys.

**Program Performance:** IHS did not meet this indicator in FY 2004. The FY 2004 performance measure was to improve the Behavioral Health (BH) Data System through a 5% increase in the number of the programs reporting minimum agreed-to behavioral health-related data to the national data warehouse. The actual number for FY 2004 represents a 2.3% increase. One reason for missing this target is that resources were devoted to implementing the new GUI interface at sites that were already submitting data to the national data warehouse. Nevertheless, the increase in sites using and exporting from 2002 to 2004 continues to be quite significant (33%).

**Indicator 19: During FY 2006, IHS will establish baseline participation in urban data sharing.**

**Rationale:** The urban health programs are currently capturing data for the Urban Indian Health Program Common Reporting Requirement (UCRR).

**Why is this Important?** A minimum data set and a baseline measure of participation in urban data sharing will help address additional urban data needs, including GPRA reporting.

**Approach:** The urban program will facilitate a data workgroup to develop this minimum data set. This group will develop this minimum data set by during FY 04. Mandatory reporting on this data set will be included as part of the C&G language starting in FY 05.

**Data Source:** Review of Urban Program Contracts and Grants language

**Program Performance:** IHS met this indicator in FY 2004. The 2004 target was to develop a specific minimum data set as well as appropriate language for the urban C&G. The data elements sub workgroup developed data elements that constitute a minimum data set. In addition, draft language for inclusion in the Contracts and Grants has been completed.

Adequate health status and health services data are essential for the effective planning and management of any health care delivery system. Urban data must eventually reach parity with that collected by tribal and IHS facilities to allow for a more accurate portrayal of the needs and services available to American Indians and Alaska Natives (AI/AN) residing in urban areas, the existing disparities in health status that afflict them, and supporting local health program needs as well as provide data for the larger IHS requirements, including GPRA. The Urban Indian Health Programs support the considerable health care need of the AI/AN people residing in urban areas and to meet the Healthy People 2010 goal of achieving equivalent and improved health status for all Americans.

**Quality of Care Indicator Group:**

The following indicators address the quality of health care provided in IHS settings from the perspectives of accreditation, medication errors, and consumer satisfaction.

**Indicator 20: During FY 2006, maintain 100% accreditation of all IHS-operated hospitals and outpatient clinics.**

**Rationale:** The accreditation of IHS hospitals and clinics represents the most objective and respected measure of health care quality.

**Why is this Important?** Accreditation is essential for maximizing third-party collections, and contributes both directly and indirectly to improved clinical quality.

**Approach:** The local I/T/U multidisciplinary team approach to accreditation and ongoing quality management has been the mainstay of success in this important activity. Additional support and guidance from Areas and Headquarters staff will continue to support this indicator. This is one of the most demanding indicators to meet, given the growing clinical quality of care assessments that are required as well as issues related to health facilities maintenance, improvement, and renovation that are critical to accreditation. The accrediting body used for hospitals and some ambulatory health centers is the Joint Commission on the Accreditation of Health Care Organizations (JCAHO). However, there was an increase in the ambulatory health centers that obtained accreditation from the American Association of Ambulatory Health Centers (AAAHC).

**Data Source:** IHS compiled a database generated from accreditation reports submitted by IHS Area Quality Assurance coordinators.

**Program Performance:** **IHS met this indicator in FY 2004.** The FY 2004 indicator committed to maintaining 100% accreditation of all IHS hospitals and outpatient clinics and was achieved. During FY 2004, twenty-one IHS hospitals were evaluated by either JCAHO, CMS, or AAAHC. All twenty-one maintained full accreditation. In addition, sixteen ambulatory health centers participated in accreditation visits from JCAHO and AAAHC and all were accredited.

**Indicator 21: During FY 2006, IHS will establish and evaluate a medical error reporting system at 3 areas.**

**Rationale:** The intent of this indicator is to improve patient safety by establishing and evaluating a medical error reporting system within 3 areas.

**Why is this Important?** It is estimated that medical errors kill 48,000-98,000 Americans each year, and injure an additional one million. It is estimated that adverse drug reactions are between the fourth and sixth leading causes of death in the U.S. By developing a national medical error reporting system, which includes adverse reaction monitoring, IHS will be able to evaluate medical errors and develop appropriate interventions.

**Approach:** Initially, the IHS will rely on medication error reporting systems. It will then draw on national federal expertise to establish and evaluate all types of medical errors and reporting systems, including the VHA, DOD and AHRQ.

**Data Source:** In FY 2006, IHS will establish a national mechanism for medical error reporting, and evaluate its performance within 3 areas. Data will be obtained via direct contact with these 3 areas.

**Program Performance:** **IHS met this indicator in FY 2004.** The FY 2004 performance indicator was that the IHS would establish baseline data for medication error reporting for all IHS Areas and Pilot test standardized medication error reporting system in two additional Areas. Med Marx, the web based medication error reporting system, was pilot tested for one year at all of IHS and most tribal sites in the Phoenix and Albuquerque areas. Results of the pilot test were favorable and other areas were encouraged to adopt Med Marx or another standardized medication error reporting system. To date, 55 facilities in the Alaska, Aberdeen, Bemidji, Oklahoma, and Phoenix areas are using Med Marx.

The second part of the Medication Error Reporting indicator is related to assessing baseline data for reported errors. The Phoenix area was the pilot and established an area-wide baseline both prior to and after implementation of the Med Marx reporting system.

**Indicator 22: Eliminated in FY 2005**

**Rationale:** The intent of this indicator is to maintain consumer satisfaction.

**Why is this Important?** Assessing consumer satisfaction is fundamental to health care quality, and is one of the Institute of Medicines cornerstones of health care quality. Improved consumer satisfaction is also associated with higher consumer compliance levels with provider health recommendations, which can result in improved health outcomes.

**Approach:** In FY 1999, the IHS developed a comprehensive culturally sensitive consumer satisfaction survey instrument that was based on a tested and validated instrument from the private sector. Clearance was obtained in late FY 2002, and baseline data was obtained during FY 02. Additional assessments have been undertaken in FY 2003, with a follow-up survey to determine improvement scheduled to be completed in FY 2004.

The responsible parties for implementation are the local service sites with assistance from the IHS Area office staff. The local staff is part of the local quality assurance program and the aggregate staff will be part of the IHS epidemiology centers/program.

**Data Source:** IHS Consumer Satisfaction Survey

**Program Performance:** **IHS did not meet this indicator in FY 2004.** The FY 2004 indicator committed to improving customer satisfaction rates by 3% over the FY 2003 baseline. However, a follow-up survey was not conducted. Because Indicator 20 requires all IHS facilities to maintain accreditation, which includes a customer satisfaction component, Indicator 22 will be eliminated in FY 2005.

**Prevention Indicators**

**Detail of Performance Analysis Table**

Performance Measures	Targets	Actual Performance	Reference
<b>Public Health Nursing Indicator</b>			
<p><u>Indicator 23:</u> Address the number of public health nursing services (primary and secondary treatment and preventive services) provided by public health nursing. [efficiency]</p>	<p><u>Total Visits</u>            FY 06: Pending new indicator            FY 05: maintain FY 04 levels            FY 04: maintain FY 03 level            FY 03: maintain FY 02 level            FY 02: +2% over FY 01            FY 01: +3% over FY 00            FY 00: 7% over 97 or 363,033            FY 99: no indicator</p> <p><u>Home Visits</u>            FY 05: no indicator            FY 04: maintain FY 03 level            FY 03: +2% over FY 02            FY 02: +2% over FY 01            FY 01: +3% over FY 00            FY 00: 7% over 97 or 127,846            FY 99: no indicator</p>	<p>FY 06:            FY 05:            FY 04: 423,379***            FY 03: 359,089 ***            FY 02:            400,347/343,844***            FY 01: 383,436            (+3.1%)            FY 00: 371,548 (9.5% over FY97)            FY 99: 336,134            FY 97: 339,283            baseline</p> <p>FY 05: no indicator            FY 04: 192,121***            FY 03: 160,650***            FY 02:            151,370/156,263***            FY 01: 153,852            (+20%)            FY 00: 127,873 (7% over 97)            FY 99: 111,836            FY 97: 119,482            baseline</p>	<p>1, 3, 5            ***GPRA+            data</p>
<b>Immunization Group</b>			

Performance Measures	Targets	Actual Performance	Reference
<u>Indicator 24:</u> Address rates for recommended immunizations for AI/AN children patients 19-35 months. [outcome]	FY 06: maintain baseline rates compared to FY 05 FY 05: maintain FY 04 level for children 19-35 months FY 04: +2% over FY 03 for children 3-27 months and establish baseline rates for 19-35 month old children FY 03: at FY 02 level FY 02: +1% over FY 01 level FY 01: +1% over FY 00 level FY 00: +2% over FY 99 level FY 99: 91%	FY 06: FY 05: FY 04: 81%; baseline established FY 03: 80% FY 02: 80% FY 01: 83% 12 of 12 Areas (-3%) FY 00: 86% 12 of 12 Areas (-3%) FY 99: 89% 12 of 12 Areas 87% 11 of 12 Areas FY 98: 88% (baseline 11 of 12 Areas)	7 1, 3 HP 2010
<u>Indicator 25:</u> Address influenza vaccination rates among non-institutionalized adult patients aged 65 years and older. [outcome]	<u>Influenza</u> FY 06: at FY 05 levels FY 05: at FY 04 levels FY 04: at FY 03 level FY 03: at FY 02 level FY 02: +1% over FY 01 level FY 01: +1% over FY 00 level FY 00: 65% FY 99: no indicator  <u>Pneumococcal</u> FY 03: moved to # 25 below FY 02: no indicator FY 01: secure electronic baseline FY 00: 65% FY 99: no indicator	FY 06: FY 05: FY 04: 54%*** FY 03: 51% *** FY 02: 31%/51%*** FY 01: 34.8% FY 00: 30.7%  FY 03: moved to # 25 below FY 02: no indicator FY 01: data not available FY 00: data source inadequate	1, 3, 5 HP 2010 ***GPRA+

Performance Measures	Targets	Actual Performance	Reference
<u>Indicator 26:</u> Address pneumococcal vaccination rates among non-institutionalized adult patients age 65 years and older. [outcome]	FY 06: maintain at FY 05 levels FY 05: maintain at FY 04 levels FY 04: maintain at FY 03 levels FY 03: maintain at FY 02 levels FY 02: no indicator FY 01: secure electronic baseline FY 00: 65% FY 99: no indicator	FY 06: FY 05: FY 04: 69%*** FY 03: 65%*** FY 02: 17%/ 64%*** FY 01: 11.2% FY 00: data source inadequate	1, 3, 5 HP 2010 ***GPRA+
<b>Injury Prevention Group</b>			
<u>Indicator 27:</u> Support community-based injury prevention programs.	<u>Web Based Reporting:</u> FY 06: implement web-based data collection system FY 05: maintain at FY04 level  <u>IP Intervention Projects</u> FY 04: maintain at least 36 injury prevention projects. FY 03: implement at least 36 injury prevention projects.  <u># of Comprehensive IP Programs</u> FY 03: no indicator FY 02: maintain at least 25 sites* FY 01: no indicator FY 00: no indicator	FY 06: FY 05:  FY 04: 37 injury prevention projects maintained FY 03: 36 injury prevention projects implemented  FY 03: no indicator FY 02: 25 sites FY 01: 25 sites FY 00: baseline 25 sites	1, 3 .

Performance Measures	Targets	Actual Performance	Reference
<p><u>Indicator 28</u>: Address the number of unintentional injuries for AI/AN people. [outcome]</p>	<p><u>Deaths</u>  FY 06: maintain or reduce FY 2005  FY 05: maintain or reduce FY 04    FY 04: maintain or reduce FY 03  FY 03: maintain or reduce FY 02 rate  FY 02: at FY 01 rate, or less    FY 01: no indicator    FY 00: no indicator    FY 99: 93/100,000 (ICD-9)  95.84/100,000 (ICD-10)    <u>Hospitalizations</u>  FY 01: 70 per 10,000  FY 00: 71.5 per 10,000</p>	<p>FY 2006    FY 05:    FY 04: Available December 2008  FY 03: Available December 2006  FY 02: 51.4/100,000  FY 01: 51.4/100,000  FY 00: 51.5/100,000  FY 99: 95.5/100,000    FY 96-98:  94.7/100,000 deaths  FY 94-96:  92.6/100,000 deaths  FY 92-94:  95.0/100,000 deaths    FY 01: data not available  FY 00: data not available  FY 98: 72.5 /10,000 hosp.  FY 96: 74.7/10,000 hosp.</p>	<p>1, 5  HP 2010</p>

Performance Measures	Targets	Actual Performance	Reference
<b>Suicide Prevention Indicator</b>			
<u>Indicator 29</u> Support suicide prevention by collecting comprehensive data on the incidence of suicidal behavior.	FY 06: establish baseline data FY 05: integrate the Behavioral Health suicide reporting tool into RPMS * FY 04: implement national reporting plan FY 03: + 5% over FY 02 level FY 02: + 10% over FY 01 level  FY 01: 50% of I/T/Us implemented.  FY 00: no indicator FY 99: no indicator	FY 06: FY 05:  FY 04: national reporting plan implemented FY 03: increased by 30% FY 02: 22% of I/T/Us implemented (+10% over FY 01) FY 01: 12% of I/T/Us implemented FY 00: FY 99: FY 98: estimated 25%	3, 5 HP 2010  * indicates revised FY 2005 measure. See Summary of Changes Table
<b>Developmental Prevention and Treatment</b>			
<u>Indicator 30:</u> Support clinical and community-based cardiovascular disease prevention initiatives. [outcome in 05/06]	FY 06: Increase # adult patients with lipid screening FY 05: baseline number of eligible patients screened for lipids FY 04: Evaluation implemented and 1 site added FY 03: Evaluation implemented and 1 site added FY 02: 3 sites implementing interventions FY 01: 3 sites with intervention plans FY 00: no indicator FY 99: no indicator	FY 06: FY 05:  FY 04: evaluation implemented and two additional sites added FY 03: 4 sites implemented intervention plans  FY 02: 3 sites implemented intervention plans  FY 01: 3 sites with intervention plans	1, 3 HP 2010

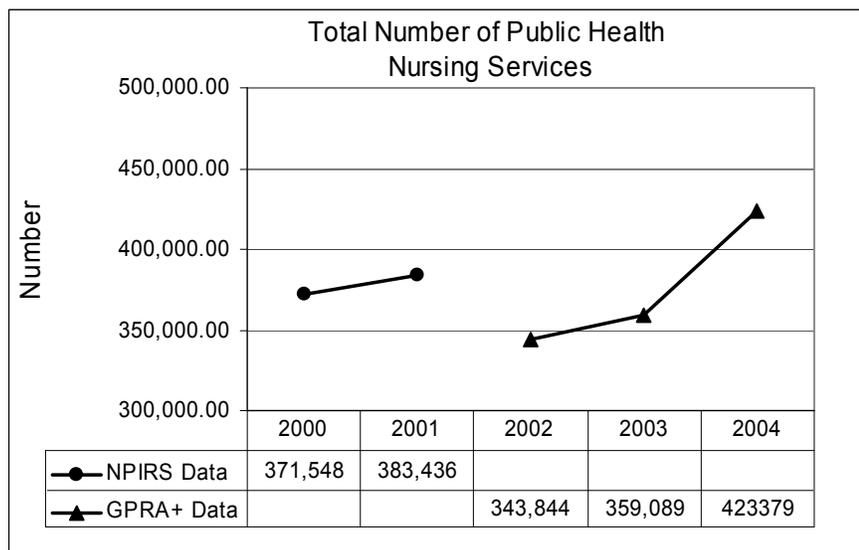
Performance Measures	Targets	Actual Performance	Reference
<p><u>Indicator 31: Support clinical and community-based obesity prevention initiatives. [outcome]</u></p>	<p><u>BMI measured</u>  FY 06: decrease obesity rates in children, 2-5 years  FY 05: increase % of patients with BMI measured  FY 04: establish baseline BMI measures</p> <p><u>Develop Model Pilot Sites</u>  FY 03: implement a 3-element obesity prevent. /treat. plan  FY 02: develop a 3-element obesity prevent treat. plan  FY 01: implement obesity prevention program and monitor pilots and comparisons sites  FY 00: establish five pilot sites  FY 99: develop approach and baselines</p>	<p>FY 06:  FY 05:  FY 04: baseline BMI measures established  FY 03: 3 element obesity prevention /treatment plan implemented  FY 02: 3 element obesity prevent/treatment plan developed  FY 01: implementation and monitoring commenced at sites  FY 00: pilot sites established  FY 99: approach and baseline accomplished</p>	<p>1, 3  HP 2010</p>

Performance Measures	Targets	Actual Performance	Reference
<p><u>Indicator 32</u>: Support local level initiatives directed at reducing tobacco usage. [outcome]</p>	<p>FY 06: Establish rates of tobacco using patients receiving tobacco cessation intervention</p> <p><u>Determine Screening Rates</u></p> <p>FY 05: maintain screening at FY 04 levels</p> <p>FY 04: establish baseline screening rates</p> <p><u>Pilot Test Strategies</u></p> <p>FY 03: develop 5-year tobacco control plan for IHS</p> <p>FY 02: commence all prescribed control activities in 5 sites</p> <p>FY 01: establish 5 tobacco control centers</p> <p>FY 00: establish baseline rates for tobacco usage</p> <p>FY 99: no indicator</p>	<p>FY 06:</p> <p>FY 05:</p> <p>FY 04: baseline tobacco screening rates established</p> <p>FY 03: 5 year tobacco control plan for IHS developed</p> <p>FY 02: commence all prescribed control activities in 5 sites</p> <p>FY 01: 7 tobacco control centers established</p> <p>FY 00: baseline rates established</p>	<p>1, 3</p> <p>HP 2010</p>
<b>HIV/AIDS Group</b>			
<p><u>Indicator 33</u>: Support screening for HIV infections in appropriate population groups. [outcome]</p>	<p>FY 06: increase screening rates for HIV in pregnancy</p> <p>FY 05: establish baseline rates for screening of HIV infection in pregnant women</p> <p>FY 04: +10 Sites</p> <p>FY 03: +5% over FY 02</p> <p>FY 02: secure baseline in 3 new Areas</p> <p>FY 01: Establish baseline</p> <p>FY 00: no indicator</p> <p>FY 99: no indicator</p>	<p>FY 06:</p> <p>FY 05:</p> <p>FY 04: not met</p> <p>FY 03: .1 % over baseline</p> <p>FY 02: baseline in 3 areas</p> <p>FY 01: baseline for limited sites</p> <p>FY 00: no baseline</p>	<p>HP 2010</p>

Performance Measures	Targets	Actual Performance	Reference
<b>Environmental Surveillance Indicator</b>			
<p>Indicator 34: Implement automated web-based environmental health surveillance data collection system in tribal systems.</p>	<p>FY 06: 50% more environmental health programs above FY 2005 level will have reported the regionally appropriate environmental health priorities based on current community data</p> <p>FY 05: 12 environmental health programs will have reported the regionally appropriate environmental health priorities based on current community data into WebEHRs.</p> <p>FY 04: +15% over FY 03 level</p> <p>FY 03: +15% over FY 02 level</p> <p>FY 02: implement in at least 10 sites</p> <p>FY 01: 15% of communities assessed</p> <p>FY 00: develop surveillance protocol and plan</p> <p>FY 99: no indicator</p>	<p>FY 06:</p> <p>FY 05:</p> <p>FY 04: +15% over FY 03 level ( 26 sites added)</p> <p>FY 03: +116% over FY 02 level (implemented in 22 more sites)</p> <p>FY 02: implemented in 19 more sites</p> <p>FY 01: automated system distributed to all IHS field sites</p> <p>FY 00: protocol and plan partially completed</p> <p>FY 99: no surveillance systems in place</p>	<p>3, 4</p> <p></p> <p>* corrected 1/05 from 16% (+3 sites)</p>
<p>Total Prevention Funding :</p>	<p>FY 06: \$140,871,000</p> <p>FY 05: \$130,096,000</p> <p>FY 04: \$126,492,000</p>	<p>HP: Chapter #</p> <p>#: HHS Strategic Goal</p> <p>: PMA#</p>	

**Public Health Nursing Indicator:**

**Indicator 23:** During FY 2006, a new interim outcome indicator will be developed.



**Rationale:** The purpose of this current indicator is to improve the health status of American Indian and Alaska Native people through maintaining access to services associated with improved health outcomes.

**Why is this Important?** Public health nursing is a method of delivering services to outside of the I/T/U setting. Public health nurses provide health assessment, health promotion, disease prevention, and infectious disease management.

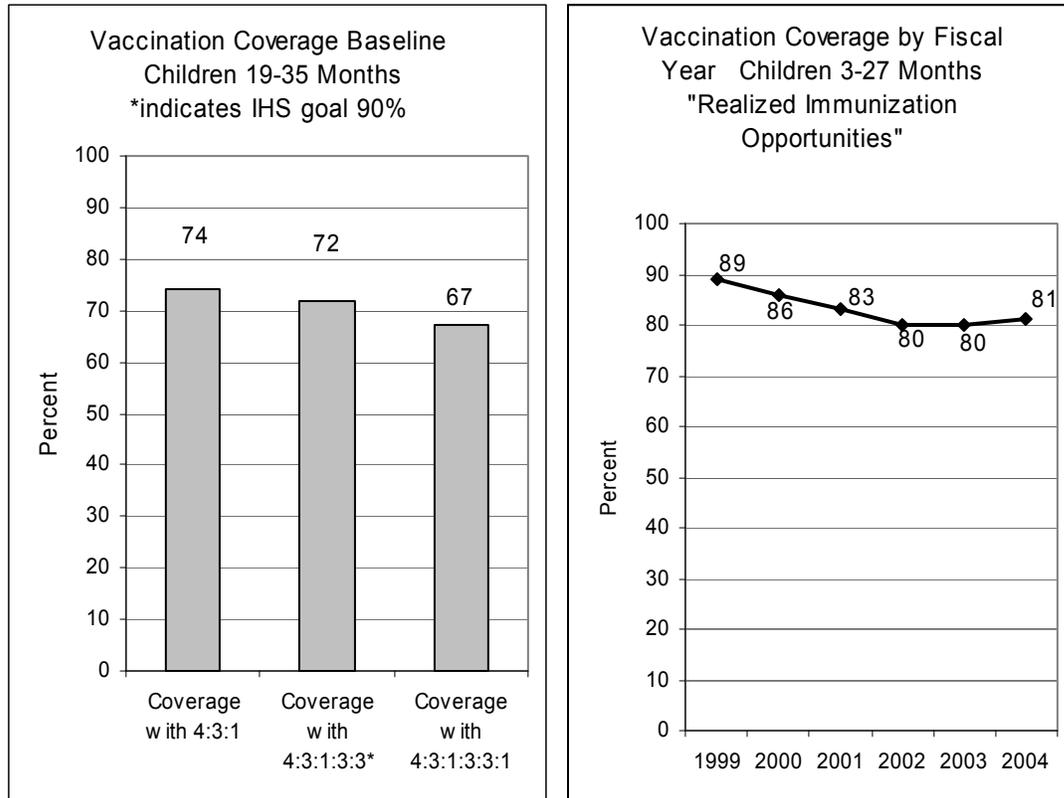
**Approach:** The population base for public health nursing services is the IHS user population residing within the official boundaries of the Area. However, in some service units, the user population is greater than the reported census population. In these cases, the Indian user population is used as an estimate of the service population to reflect PHN service to both stable communities and transient populations.

**Data Sources:** IHS PCC, GPRA+, and written reports submitted by Tribes using non-RPMS systems.

**Program Performance:** **The IHS met this indicator in FY 2004.** The FY 2004 indicator was to maintain the total number of public health nursing services provided to individuals in all settings and the total number of home visits at the 2003 workload levels. The total number of home visits reported in 2004 was 192,121 compared to 160,650 visits reported in 2003. The total number of visits in all settings was 423,379 in 2004, compared to 359,089 visits reported in 2003. It is important to note, though, that the number of facilities reporting in 2004 increased significantly.

**Immunization Group:**

**Indicator 24: During FY 2006, maintain baseline rates for recommended immunizations for American Indian and Alaska Native children 19-35 months compared to FY 05.**



**Rationale:** The National Immunization Survey, which is used to estimate immunization coverage for each state and for the U.S., collects information on children 19-35 months. The Healthy People 2010 goal is 90% coverage with routine immunizations for children 19-35 months. We will continue to assess our performance using the 19-35 month cohort.

**Why is this Important?** Routine immunizations represent a cost-effective public health measure that significantly improves the health of children. Among all US children aged 19-35 months, vaccine coverage in 2003 reached an all-time high. National coverage levels are now over 90 percent for each vaccine recommended through age 35 months. National Immunization Survey statistics show that AI/AN children have vaccination rates that are below the national averages.

**Approach:** Through FY 2004, the IHS collected data on immunizations for children aged 3-27 months on a quarterly basis. The totals for the year do not represent individual children. The IHS determines the number of vaccination opportunities in FY 2004, and the number of vaccination opportunities that were realized. "Immunization opportunities" are the number of times that children were eligible to receive a vaccine. "Realized immunization opportunities" means the child received the required vaccination.

**Data Source:** Quarterly immunization reports on children 3-27 months old and an annual 2 year old immunization report based on IHS patient care records and public health nursing records of children who receive immunizations at an IHS facility. GPRA+ data will be used in future years.

**Program Performance: IHS did not meet this indicator in FY 2004.** The indicator called for 1) increasing coverage for children 3-27 months by 2% over 2003 and 2) establishing baseline rates for recommended immunizations for American Indian and Alaska Native children 19-35 months. Although a baseline rate was established for children 19-35 months, the coverage rate for 3-27 month old children was raised only by 1%, from 80% to 81%.

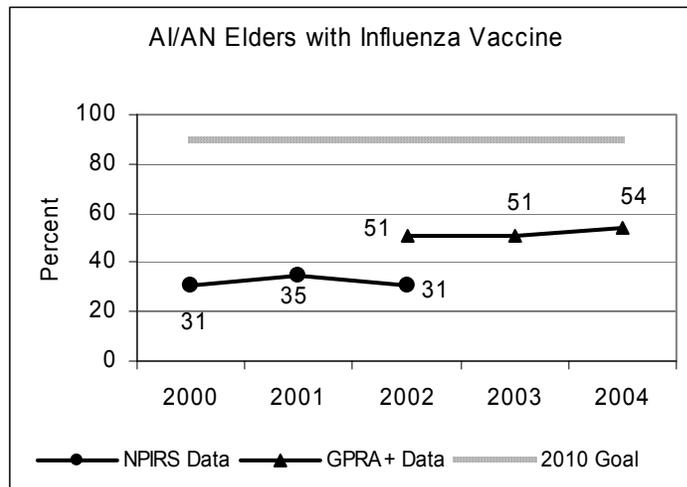
Challenges in meeting the FY 2004 indicator for children ages 3-27 months included:

- Vaccine shortages. There were extensive shortages for 6 of the routinely recommended childhood vaccinations in FY 2001 and FY 2002, including DTaP, some hepatitis B/Hib combination vaccines, and MMR. Shortages led to the suspension of routinely recommended doses in some states (such as the 4<sup>th</sup> DTaP), so that many children were not up-to-date with their vaccines. While the shortages were resolved in FY 2003, there may have been delays in catching children up that likely affected vaccine coverage levels for FY 2004.
- Vacancies in positions essential for the delivery, tracking, and reporting of immunizations (e.g. public health nurses, and medical records staff).
- The IHS immunization software package. This package is not fully utilized at many local facilities.
- An increasingly complex immunization schedule.
- Incomplete tracking due to multiple sources of health care, including non-IHS.

The IHS is working to address these challenges.

- The IHS is working with CDC and state immunization programs to prioritize limited vaccine supply to ensure the highest risk and most vulnerable children receive priority.
- Data-quality initiatives are ongoing and will likely result in lower immunization coverage levels initially. Improved data, however, will also allow IHS to identify low-performing areas to target for intervention.
- The IHS is addressing agency-wide recruitment and retention problems.
- A contract is in place to update the RPMS Immunization software package and to provide training in its use in all clinics.

**Indicator 25: In FY 2006, maintain the FY 2005 rate for influenza vaccination levels among non-institutionalized adult patients age 65 years and older.**



**Rationale:** The purpose of this indicator is to reduce morbidity and mortality due to influenza among adults.

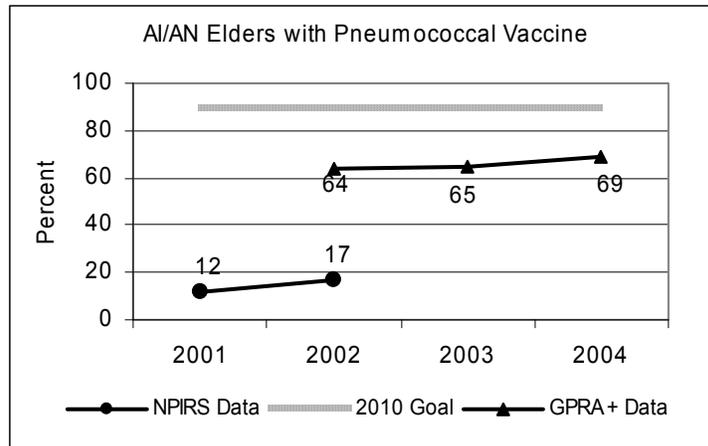
**Why is this Important?** Influenza is a highly contagious respiratory disease that can cause potentially life-threatening secondary infections. Elders who get influenza are also at increased risk of hospitalization and death from heart disease and stroke, and vaccination reduces that risk. In one study comparing vaccinated to non-vaccinated persons aged 65 and older over two influenza seasons, researchers found a 20% reduction in hospitalization for cardiovascular and cerebrovascular events in addition to a 30% reduced hospitalization for influenza and a 50% reduction in death from all causes.

**Approach:** IHS clinics are encouraged to provide influenza vaccine to adults 65 years of age during clinic visits and during mass immunization clinics. Educating patients is a part of the strategy to ensure influenza vaccine is provided. The proposed FY 2006 IHS budget will support the capacity for sites to continue existing strategies and maintain current immunization coverage levels in the face of population growth.

**Data Source:** GPRA+ from the RPMS database.

**Program Performance: IHS met this indicator.** This indicator was to maintain the percentage of adults 65 years old and older that receive influenza vaccine at the FY 2003 level. The target of maintaining the influenza vaccination rate was met and exceeded, with the percentage of eligible patients receiving influenza vaccine at 54%. This rate is 3% higher than the percentage reported last year and more than 20% higher than the percentage reported in 2000. Continued efforts must be made in order to reach the HP 2010 goal of a 90% immunization rate. Studies show that system interventions such as standing orders to administer vaccine increased rates by 39%, more than any other type of intervention.

**Indicator 26:** In FY 2006, maintain the FY 2005 rate for pneumococcal vaccination levels among non-institutionalized adult patients age 65 years and older.



**Rationale:** The purpose of this indicator is to reduce morbidity and mortality due to pneumococcal disease among adults.

**Why is this Important?** Elder health is an increasingly important issue as more and more of the population survives beyond the age of 65. Pneumococcal disease includes pneumonia, bacteremia, and meningitis. Pneumococcal disease has the highest death toll from a vaccine-preventable bacterial disease and patients over the age of 65 account for more than 51% of the deaths. Vaccination of the elderly against pneumococcal disease is one of the few medical interventions that has been found to improve health and save on medical costs.

**Approach:** IHS clinics are encouraged to provide pneumococcal vaccine to adults 65 years of age during clinic visits. The proposed FY 2006 IHS budget will support the capacity for sites to continue existing strategies and maintain current immunization coverage levels in the face of population growth.

**Data Source:** GPRA+ from the RPMS database.

**Program Performance:** IHS met this indicator in FY 2004. The indicator was to maintain the FY 2003 rate for pneumococcal vaccination levels among non-institutionalized adult patients age 65 years and older. In 2004 the percentage of patients receiving pneumococcal vaccinations rose 4% compared to the percentage reported in 2003.

**Injury Prevention Group:**

The following two indicators address the process and outcome of comprehensive community-based injury prevention efforts across I/T/U settings.

**Indicator 27: During FY 2006, implement web-based data collection system to report injury prevention projects.**

**Rationale:** The purpose of this indicator is to reduce injury rates in the American Indian and Alaska Native communities through the implementation of proven injury intervention strategies across I/T/U settings.

**Why is this Important?** Proven injury prevention interventions are projects that address a specific identified injury problem; employ a multiple-strategy approach; are based on a proven effective, evaluated injury prevention strategy; or are epidemiologically identified from local data and designed on a proven prevention approach. Examples of projects include Sleep Safe Project sites, national IHS Part II Injury Infrastructure Grants, and Injury Prevention Specialist Fellowship.

**Approach:** Since the mid-1980's IHS has developed the capacity of IHS staff and tribes to epidemiologically assess the injury hazards and risk factors in communities and develop intervention strategies. Injury intervention projects are underway through I/T/U settings to reduce the burden of injury experienced. This measure will report on the community specific initiatives underway throughout IHS.

**Data Sources:** Data to report on this indicator is compiled and reported by Area Injury Prevention Specialists.

**Program Performance:** **IHS met this indicator in FY 2004.** The FY 04 indicator committed to maintain at least 36 community-based, proven injury prevention intervention projects across I/T/U settings. IHS funded 37 Injury prevention cooperative agreement grantee projects in FY 04. In addition to these, each IHS Area has at least 1 to 5 injury prevention projects addressing a specific identified injury problem. At least thirteen Sleep Safe and Ride Safe projects were implemented as several I/T/U locations. The 2003-2004 Injury Prevention Specialist Fellowship program development projects implemented in FY 2004 involved community-based IP projects that addressed a specific identified injury project and designed on a proven prevention approach.

**Indicator 28: During FY 2006, reduce deaths caused by unintentional injuries to no higher than the FY 2005 level.**

**Rationale:** Injuries are a leading cause of hospitalization for American Indian and Alaska Native people. Annually, forty six percent (46%) of the Years of Potential Life Lost (YPLL) for American Indian and Alaska Native people are the result of injuries.

**Why is this Important?** Injuries are the number one cause of mortality for American Indian and Alaska Native people for ages 1-44 years and third for overall death rates. The single largest expenditure of contract medical care funds is for the treatment of injuries. The systematic implementation of prevention strategies through partnerships with tribes and outside agencies has demonstrated significant improvements in injury rates of American Indian and Alaska Native people.

**Approach:** The IHS has assigned an Injury Prevention Program Manager, who coordinates activities and resources with specially trained Injury Prevention Specialists at the Area, District, Service Unit and tribal levels. IHS maintains a broad base Injury Prevention program that includes a \$1.475 million Infrastructure Grant Program, an internationally recognized training program, community-based epidemiologic assessment, and partnerships with other agencies to fund and implement proven intervention projects in communities.

**Data Source:** In its original form in the FY 1999 performance plan, this indicator targeted injury mortality as the performance measure. However, efforts to apply this approach in FY 2000 and FY 2001 revealed that the hospitalization data do not accurately reflect the number of unintentional injury cases that are hospitalized in IHS or tribal hospitals. Coding omissions have resulted in injury codes frequently not being noted.

**Program Performance:** No data is currently available to report on the 2004 indicator. IHS expects that we will be able to report on this indicator by 2008..

**The FY 2002 indicator was met.** The FY 2002 indicator committed to maintaining the rate of deaths due to unintentional injuries for American Indian and Alaska Natives at the FY 2001 level or less. In CY 2001, the age-adjusted mortality rate was 51.43 per 100,000. This is below the CY 2000 rate of 51.49 per 100,000.

**Suicide Prevention Indicator:**

**Indicator 29: During FY 2006, establish baseline data on suicide using the RPMS suicide reporting tool.**

**Rationale:** This indicator is part of an expanding systematic effort at reducing the prevalence of suicide in the American Indian and Alaska Native population. The suicide death rate for the American Indian and Alaska Native population has actually increased in the 1990s and is currently 72% greater than the national average.

**Why is this Important?** IHS has known that our data is incomplete, as many attempted suicides and completed suicides are not currently recorded in our data system. The Division of Behavioral Health, along with the Information Technology Support Center, has developed a comprehensive suicide data reporting system. A systematic assessment will be conducted to evaluate the impact of the deployed suicide surveillance plan.

**Approach:** Programs are responsible for implementing a national suicide reporting system. A suicide surveillance system is being encouraged for use at clinical facilities to assure that routine suicide screenings and case management are nationally consistent, but also tailored to the needs and resources of each site. This suicide surveillance instrument is integrated into the interim behavioral health software application, but will also be deployed into the general RPMS application. This will ensure that primary and emergency medicine providers can also enter data into this system.

**Data Source:** Local programs send reports to the national ITSC with identified data sources linked with RPMS as appropriate. Aggregated data is used to assess current rates. Effective deployment of the new interim behavioral health application ensures that the national suicide reporting system is being utilized appropriately.

**Program Performance: IHS met this indicator in 2004.** In 2004 this indicator committed to implementing the national reporting plan to support national performance management of AI/AN suicide. The Suicide reporting form was deployed in the BH RPMS package in FY 2004, and Behavioral Health staffs with this package in all IHS Areas are now reporting this data. However, primary care physicians are not able to access this package. As a result IHS has changed the 05 Indicator to address this issue and deploy this form into the PCC and EHR to allow for comprehensive reporting.

**Developmental Prevention and Treatment Group:**

**Indicator 30: During FY 2006, increase the number of patients ages 23 and older that receive blood cholesterol screening.**

**Rationale:** Cardiovascular disease represents the single largest cause of death for American Indian and Alaska Native people above the age of 45.

**Why is this Important?** Screening for blood lipid levels can identify patients that are at high risk for cardiovascular disease. Appropriate screening and identification can help prevent cardiovascular disease development and complications.

**Approach:** This indicator focuses on evaluating screening and prevention for CV disease in adult patients.

**Data Source:** GPRA+ from local RPMS database

**Program Performance:** **IHS met this indicator in 2004.** During FY 2004, the four Tribal programs:

- continued to implement their Community Action Plan;
- did actual tracking of the Cardiovascular Disease Clinical Indicators selected by the three Tribes (lipids, cholesterol, body mass index, tobacco cessation rates, and exercise education) through GPRA+ software designed especially to track CVD; and
- assessed their communities through evaluating community knowledge, behaviors, and risks of CVD.

In addition, two more sites initiated culturally sensitive community-directed pilot cardiovascular disease prevention programs.

Activities for FY 2005 include the establishment of a baseline of the number of adult patients that received appropriate screening for blood lipids (which is also a HP 2010 goal.) This data will be evaluated by using the RPMS GPRA+ software application.

**Indicator 31: During FY 2006, decrease the obesity rates in children, ages 2-5 years.**

**Rationale:** This indicator is part of a comprehensive long-term effort to identify effective interventions to prevent and reduce obesity in American Indian and Alaska Native people.

**Why is this Important?** Obesity is a risk factor for high blood pressure, asthma, arthritis, coronary heart disease, stroke, colon cancer, post-menopausal breast cancer, endometrial cancer, gall bladder disease, and sleep apnea. Obesity is also a major risk factor for type 2 diabetes particularly among American Indians. Body Mass Index (BMI) is a simple measure of weight in relation to height. An estimated 65% of U.S adults aged 20 years and older are either overweight or obese, defined as having a body mass index (BMI) of 25 or more. Rates among American Indian and Alaska Native populations exceed the national averages.

**Approach:** The approach to this indicator includes an emphasis on decreasing childhood obesity through integrated community efforts, including involvement of WIC, Head Start, and local faith based initiatives.

**Data Source:** GPRA+ data from local RPMS databases

**Program Performance:** IHS met this indicator in FY 2004. This FY 2004 indicator was to establish baseline BMI measures.

**Indicator 32: During 2006, establish the rates of tobacco-using patients that receive tobacco cessation intervention.**

**Rationale:** Tobacco users who quit enjoy longer and healthier lives, on average, than those who do not. Even a long-time smoker can significantly reduce their risk of heart disease and other complications by quitting. Advice from a health care provider and group and individual cessation counseling can help smokers quit. Smoking cessation treatments, including nicotine replacement therapy and bupropion SR (e.g. Wellbutrin) have been found to be safe and effective.

**Why is this Important?** The use of tobacco represents the second largest cause of preventable deaths for American Indian and Alaska Native people. Smoking rates in many communities are almost twice the national average. Tobacco use contributes to the leading causes of mortality among American Indians and Alaska Natives. Lung cancer is the leading cause of cancer death among AI/ANs. Cardiovascular disease is the leading cause of death among AI/ANs, and tobacco use is an important risk factor for this disease.

**Approach:** In FY 2005, IHS will maintain these screening rates. In FY 2006, the rates of tobacco using patients that receive tobacco cessation intervention will be assessed.

**Data Source:** GPRA+ from local RPMS databases

**Program Performance:** **IHS met this indicator in FY 2004.** The 2004 indicator called for the IHS to establish rates of screening for tobacco use. Screening for tobacco use is essential to identifying patients at risk for complications of tobacco abuse. This indicator will eventually support tobacco cessation initiatives aimed at reducing tobacco usage in the AI/AN community. Because tobacco has a unique status among many American Indian and Alaska Native tribes as a sacred plant, any plan for control activities must have significant input from American Indian and Alaska Native community leaders.

**HIV/AIDS Indicator:**

**Indicator 33: In FY 06, increase the screening rates for HIV in pregnancy.**

**Rationale:** The purpose of this indicator is to reduce the spread of HIV infection in American Indian and Alaska Native communities. In 2005, this indicator will begin to track screening rates for HIV in pregnant women with the goal of eliminating HIV infections in children.

**Why is this Important?** Identification of HIV in pregnancy can result in decreased transmission of HIV. Universal screening for HIV in pregnancy is recommended by the CDC as the most effective way to stop vertical transmission of HIV infections.. In 1995, the CDC reported that almost 90% of AIDS cases among children and virtually all new HIV infections among children in the United States were the result of perinatal transmission of HIV.

**Approach:** A baseline of HIV screening in pregnancy will be established in FY 05. RPMS will be used for documentation of screening and/ or patient education

**Data Source:** GPRA+ data from RPMS database

**Program Performance:** **The IHS did not meet this indicator in FY 2004.** The FY 2004 indicator called for determining the percentage of high-risk sexually active persons who have been tested for HIV at an additional 10 sites. IHS was not able to meet this target because of difficulty in expanding the IDWeb project in FY 2004. In FY 2005 this indicator will change to tracking HIV rates in pregnant women. This measure reflects the current CDC recommendations for screening pregnant women.

**Environmental Surveillance Indicator:**

**Indicator 34: By the end of FY 2006, 50% more environmental health programs above FY 2005 level will have reported the regionally appropriate environmental health priorities based on current community data (a total of 18 programs in FY 2006) into WebEHRS.**

**Rationale:** This indicator is directed at reducing environmental threats to health by collecting community information for decision-making. Community environmental health status has traditionally been determined by completing environmental health surveys of individual facilities listed on the Facility Data System (FDS) inventory. Current changes in data collection methodology and technological advances will support more consistent assessment of community environmental health services by building a more comprehensive dataset to analyze and use to determine direction.

**Why is this Important?** Environmental health programs (federal and tribal) will begin using WebEHRS to track environmental health priorities identified through whatever means possible, e.g., community environmental health assessments, focus groups, environmental health advisory groups, etc. and will be able to determine whether the current activities are the appropriate best practices.

**Approach:** The Environmental Health Services program utilizes the Web-based Environmental Health Reporting System (WebEHRS) in conjunction with Tribal partners to collect community and facility information to be used for ongoing surveillance. At the regional level, this project is coordinated with the IHS Area Environmental Health Officers in partnership with the tribes and local IHS Environmental Health Services programs.

**Data Source:** Data is gathered using the current Web-based Environmental Health Reporting System (WebEHRS) developed in FY 2000 and implemented in IHS in FY 2001.

**Program Performance: IHS met this indicator in FY 2004.** The FY 2004 indicator committed to increasing the number of active tribal user accounts for the automated Web-based environmental surveillance system by 15% over the FY 2003 level for AI/AN tribes not currently receiving direct environmental health services. In FY 2004, 26 additional accounts, representing a 15 percent increase above the FY 2003 level, were added. There are approximately 70 tribal environmental health programs eligible to begin using the reporting system. Of those 70 tribal environmental health programs, 67 have begun using WebEHRS by the end of the reporting period.

The Division of Environmental Health developed and implemented WebEHRS, [webehrs.hqe.ihs.gov](http://webehrs.hqe.ihs.gov), a web-based bottom up driven environmental health data and field support system. The data fields consist of environmental health related facilities and services found in American Indian and Alaskan Native communities. WebEHRS database is maintained on an IHS HQ-based server.

## Capital Programming/Infrastructure Category

### Performance Budget Integration

#### Detail of Performance Analysis Table

Performance Measures	Targets	Actual Performance	Reference
<b>Capital Programming/Infrastructure Group</b>			
<u>Indicator 35:</u> Provide sanitation facilities to new or like-new homes and existing Indian homes. [efficiency]	FY 06: 20,000 homes FY 05: 20,000 homes FY 04: 20,000 homes FY 03: 15,255 homes  FY 02: 2,528 New/L. New <u>12,727</u> Existing Total 15,255  FY 01: 3,800 New/L. New <u>10,930</u> Existing Total 14,730  FY 00: 3,740 New/L. New <u>11,035</u> Existing Total 14,775  FY 99: 5,900 New/L. New <u>9,330</u> Existing Total 15,230	FY 06: FY 05: FY 04: 24,928 homes FY 03: 22,750 homes  FY 02: 3,342 New/L. <u>17,883</u> Existing Total: 21,225  FY 01: 3,551 New/L. New <u>14,451</u> Existing Total 18,002  FY 00: 3,886 New/L. New <u>14,490</u> Existing Total 18,376  FY 99: 3,557 New/L. New <u>13,014</u> Existing Total 16,571	3  HP 2010
<u>Indicator 35A:</u> During FY 2006 20% of the homes served will be at Deficiency Level 4 or above as defined by 25 USC 1632	FY 06: 20% of homes at Deficiency Level 4 or above FY 05: no indicator	FY 06:  FY 05: no indicator	

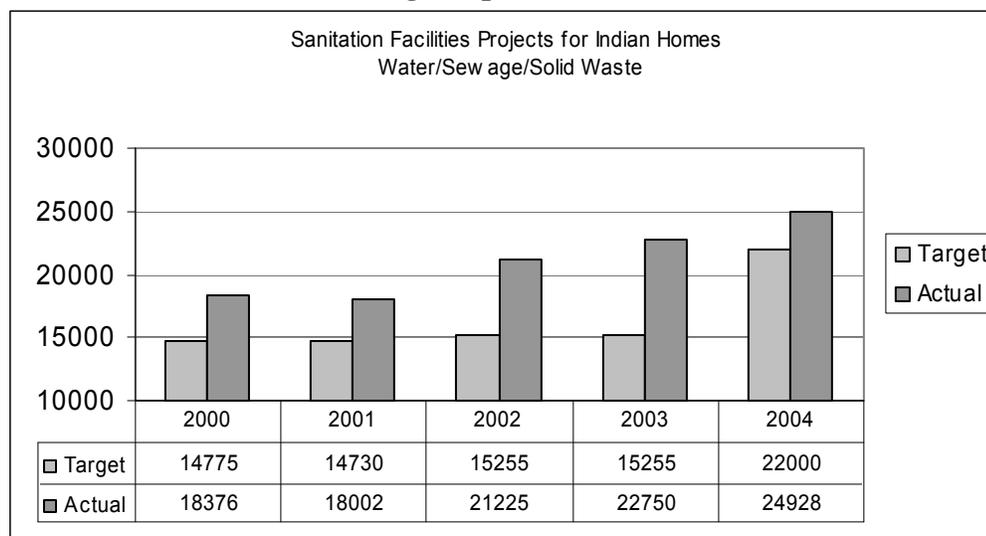
Performance Measures	Targets	Actual Performance	Reference
<p><u>Indicator 36:</u> Improve access to health care by construction of the approved new health care facilities. [efficiency]</p>	<p>FY 06: complete scheduled phase of construction of appropriated facilities  FY 05: complete scheduled phase of construction of appropriated facilities*  FY 04: complete scheduled phase of construction of appropriated facilities  FY 03: complete scheduled phase of construction of appropriated facilities  FY 02: complete scheduled phase of construction of appropriated facilities  FY 01: complete scheduled phase of construction of appropriated facilities  FY 00: complete scheduled phase of construction of appropriated facilities  FY 99: complete scheduled phase of construction of appropriated facilities</p>	<p>FY 06:  FY 05:  FY 04: all scheduled phase of construction of appropriated facilities completed  FY 03: phases for 12 of 12 projects completed on schedule  FY 02: phases for 10 of 10 projects completed on schedule, plus phases for 2 projects not completed the previous year were completed  FY 01: Phases for 5 of 7 projects completed on schedule, plus phase for one project not completed the previous year was completed.  FY 00: phases for 5 of 6 projects completed on schedule  FY 99: phases for ad projects completed on schedule</p>	<p>3  * indicates revised FY 2005 measure. See Summary of Changes Table.</p>

Exhibit U

Performance Measures	Targets	Actual Performance	Reference
Total Capital Programming/ Infrastructure Funding:	FY 06: 396,232,000 ** FY 05: \$443,200,000** FY 04: \$446,156,000** ** includes 15% of M/M and PI Collections and Quarters Collections	HP: Chapter # #: HHS Strategic Goal PMA#	

**Capital Programming /Infrastructure Group:**

**Indicator 35: During FY 2006, provide sanitation facilities projects to 20,000 Indian homes with water, sewage disposal, and/or solid waste facilities.**



**Rationale:** This indicator directly supports improved environmental health for American Indian and Alaska Native people. The IHS Sanitation Facilities Construction Program has carried out those authorities since 1960 using funds appropriated for Sanitation Facilities Construction and contributed funds from Tribes and other Federal agencies to provide potable water and waste disposal facilities for AI/AN communities.

**Why is this Important?** This work is recognized as a significant factor in the rate reduction of infant mortality, gastroenteritis morbidity, and other environmentally related diseases by as much as 80 percent since 1973. American Indian and Alaska Native homes are twelve times more likely to be without clean water than homes in the broader U.S.

**Approach:** This program regularly updates the needs for sanitation facilities based on the Indian Health Care Improvement Amendments. End-of-year FY 2004 estimates reflect a cost of technically and economically feasible projects to correct the needs for existing homes at \$915 million out of a total need of \$1.861 billion. It is considered feasible to provide sanitation facilities for between 95 and 98 percent of all existing Indian homes.

**Data Source:** The SFC Sanitation Deficiency System (SDS), and Project Data System

**Program Performance:** **IHS met this indicator in FY 2004.** The FY 2004 performance measure to provide sanitation facilities to 22,000 homes was exceeded by service to 24,928 homes. These homes are served with water, sewer and solid waste facilities. This significant increase in existing homes was the result of funding more projects to upgrade existing community sanitation facilities infrastructure. IHS has received between \$30 million to \$100 million annually from outside contributors since 1996.

**Indicator 35A: During FY 2006, 20% of the homes served by the Sanitation Facilities Construction Program funding, for the backlog of needs for existing homes will be at Deficiency Level 4 or above as defined by 25 USC 1632.**

**Rationale:** This indicator directly supports improved environmental health for American Indian and Alaska Native people. The IHS Sanitation Facilities Construction Program has carried out those authorities since 1960 using funds appropriated for Sanitation Facilities Construction and contributed funds from Tribes and other Federal agencies to provide potable water and waste disposal facilities for American Indian and Alaska Native people.

**Why is this Important?** This work is recognized as a significant factor contributing to a reduction in the rates for infant mortality, gastroenteritis morbidity, and other environmentally related diseases by as much as 80 percent since 1973. American Indian and Alaska Native homes are still seven times more likely to be without clean water than homes in the broader U.S. with most of these homes located in geographically isolated areas.

**Approach:** This program regularly updates the needs for sanitation facilities based on the Indian Health Care Improvement Amendments (Title II, Section 302(g) 1 and 2 of P.L. 100-713).

**Data Source:** The SFC Sanitation Deficiency System (SDS), and Project Data System

**Program Performance:** New indicator in FY 06

**Indicator 36: During FY 2006, increase the modern health care delivery system to improve access and efficiency of health care by assuring the timely phasing of construction of the following health care facilities:**

- a. Winnebago, NE – continue providing Drug Dependency Unit portion of project.
- b. Phoenix Indian Medical Center (PIMC) System, SE Ambulatory Care Center (ACC), Upper Santan, AZ – complete planning and commence design of new satellite health center.
- c. PIMC System, SW ACC, Komatke, AZ – complete planning and commence design of new satellite health center.
- d. Barrow, AK – complete site acquisition and continue design of replacement hospital.
- e. Red Mesa, AZ – complete construction of a new health center and supporting staff quarters.
- f. St. Paul, AK – complete construction of replacement health center and supporting staff quarters.
- g. Metlakatla, AK – complete construction of replacement health center and supporting staff quarters.
- h. Sisseton, SD – continue construction of a replacement health center and supporting staff quarters.
- i. Clinton, OK – continue construction of replacement health center.
- j. Eagle Butte, SD – commence design of replacement health center.
- k. Kayenta, AZ – prepare to commence design of replacement health center.
- l. San Carlos, AZ – prepare to commence design of replacement health center.
- m. Zuni, NM – complete design and construction of staff quarters supporting existing health care facility.
- n. Wagner, SD – continue design and construction of staff quarters supporting existing health care facility.
- o. Fort Belknap, MT – continue design and construction of staff quarters supporting existing health care facility in Harlem, MT, and satellite health care facility in Hays, MT.
- p. Phoenix-Nevada Youth Regional Treatment Center (YRTC) – continue construction of this satellite YRTC.
- q. Central-Southern California YRTC – continue site acquisition.
- r. Northern California YRTC – continue site acquisition.
- s. Small Ambulatory Program (SAP) – until completed, continue to monitor tribal construction projects receiving FY 2001, FY 2002, and FY 2003

awards. Award additional competitively selected tribally owned health center SAP projects using FY 2005 funding.

**Rationale:** This indicator supports the replacement of health care facilities to increase access to medical services supported by the IHS. These medical services are comparable to medical services available to the general population (appointments to see primary care physicians, nurses, dentists, etc.). Efficient space for health care delivery allows for more appointments, and for patients to see more health care providers in one trip. Although accessible is synonymous in this usage with obtainable health care services, the IHS can demonstrate that workloads have increased or services that are more comprehensive are provided in new facilities.

**Why is this Important?** Modern health care facilities help with the recruitment and retention of health care providers, which, in turn, can result in improved access and continuity of health care. Once a replacement facility has been completed and fully staffed, the IHS has experienced an average increase in patient visits of approximately 60% over the old facility. New health care facilities help contribute to improved quality of care.

**Approach:** The IHS uses the congressionally-directed Health Facilities Construction Priority System (HFCPS) methodology to identify inpatient and outpatient facilities project needs for placement on respective priority lists. Responding to Congressional language accompanying the FY 2000 appropriation, the IHS, in consultation with the tribes, is currently reviewing the HFCPS to revise as needed.

Through a two step process, the IHS applies the HFCPS methodology, evaluating the projected workload, existing facility age, isolation and existing space to determine the proposed projects to be considered during Phase III, during which a Program Justification Document (PJD) is prepared to justify the construction project. When the PJD is approved, the project is added to the bottom of the appropriate priority list.

Likewise, the Quarters Construction Priority System (QCPS) identifies staff quarters projects to support existing health care facilities. Staff quarters associated with replacement health care facilities are part of those projects and are not processed under the QCPS.

**Data Source:** Projects remain on the respective priority lists until they have been fully funded. Annually, the IHS updates its five-year planned construction budget for Health Care Facilities Construction, which is the basis for annual funding requests through the President to the Congress. The IHS Inpatient, Outpatient, Quarters and Youth Regional Treatment Centers Priority Lists show the priorities for proposed construction projects.

**Program Performance:** **IHS met this indicator in 2004.** The FY 2004 indicator was accomplished with the timely phased construction of the following health care facilities as outlined below and will lead to enhanced access to care for the American Indian and Alaska Native population:

**Pinon, AZ:** For this fully funded project, construction continued for the new health center and staff quarters project, with a scheduled 4<sup>th</sup> quarter FY 2005 project completion.

Red Mesa, AZ: For this fully funded project, funding is being used for construction. The project is scheduled for 2<sup>nd</sup> quarter FY 2006 completion.

Metlakatla, AK: For this fully funded project, construction is proceeding and is scheduled for 2<sup>nd</sup> quarter FY 2006 completion.

Sisseton, SD: For this fully funded project, the project is proceeding. The Tribe is developing the site for the IHS under a P.L. 93-638 Subpart J construction contract. The project is scheduled for 1<sup>st</sup> quarter FY 2007 completion.

In addition to the preceding four projects targeted for FY 2004, IHS also made progress on the following:

Ft. Defiance, AZ: For this fully funded project, the replacement hospital was completed in June 2002 and opened for service on August 1, 2002. The replacement and additional staff quarters portion of the project was completed ahead of schedule on February 25, 2004. The project was completed in FY 2004.

Winnebago, NE: The replacement hospital portion of the project was completed in FY 2004. Renovation of the old structure continued for the Drug Dependency Unit (DDU) portion of the project until it was determined that the renovation of the old structure was no longer feasible. Method is being revised for providing the DDU.

Pawnee, OK: This fully funded project was completed in the 2<sup>nd</sup> quarter FY 2004.

St. Paul, AK: For this fully funded project, construction is proceeding and is scheduled for 2<sup>nd</sup> quarter FY 2006 completion.

Clinton, OK: For this fully funded project, the project is proceeding by the Tribe performing the design under a P.L. 93-638 Subpart J design contract. The project is scheduled for 1<sup>st</sup> quarter FY 2007 completion.

Eagle Butte, SD: Project planning, in concert with the Tribe, is proceeding.

Bethel, AK: Project is fully funded. Provided funding is being used by the Yukon-Kuskokwim Health Corporation, through a design-build contract under an agreement with the IHS, to design and construct the staff quarters. The project is scheduled for a 2<sup>nd</sup> quarter FY 2005 completion.

Wadsworth, NV: This fully funded Phoenix-Nevada Satellite Youth Regional Treatment Center is proceeding under the design-build method, with a scheduled 2<sup>nd</sup> quarter FY 2007 completion.

Small Ambulatory Program: Twenty-one tribal projects have received awards under the Small Ambulatory Program (SAP) using funding provided in FY 2001, FY 2002, and FY 2003. For the FY 2001 SAP, tribes have received awards for nine projects, and six projects have been completed. For the FY 2002 SAP, tribes have received awards for eight projects, and five projects have been completed. For the FY 2003 SAP, tribes have received awards for four projects. Uncompleted projects are either in design or under construction by the tribes. The FY 2005 funding will allow for the selection and award of additional SAP projects.

Dental Facilities Program: Using FY 2004 funding, two additional projects are being processed for design and construction under this program, which will make a total of 29

projects being provided under this program since 1994. The FY 2005 funding will allow two additional dental units to be provided.

## Partnerships, Consultation, Core Functions, and Advocacy Indicators

## Detail of Performance Analysis Table

Performance Measures	Targets	Actual Performance	Reference
<b>Consultation Improvement Indicator</b>			
<u>Indicator 37</u> : Improve the level of satisfaction with the processes for consultation and participation provided by the IHS, as measured by a survey of I/T/Us.	FY 06: eliminated FY 05: eliminated FY 04: 3% increase over FY 03 FY 03: establish baseline satisfaction rate* FY 02: secure OMB clearance for instrument and baseline FY 01: implement policy and submit instrument FY 00: revise policy and instrument  FY 99: establish policy and collect baseline	FY 05: FY 04: not met FY 03: baseline rate established FY 02: secured clearance; no baseline FY 01: policy implemented and instrument submitted FY 00: revised policy proposed and instrument developed FY 99: policy established but baseline delayed	3 * indicates lack of adjustment in not meeting FY 02 measure. ** indicates revised FY 2005 measure. See Summary of Changes Table.
<b>Administrative Efficiency, Effectiveness, and Accountability Group</b>			
<u>Indicator 38</u> : Improve the level of Contract Health Service (CHS) procurement of inpatient and outpatient hospital services for routinely used providers under contracts or rate quote agreements at the IHS-wide reporting level.	FY 06: new indicator will be developed F.Y 05: no indicator in FY 05* ( changes in CMS law ensure that rate quote agreements must be met) FY 04: +1% over FY 03 FY 03: +1% over FY 02 FY 02: 88% FY 01: 79% FY 00: no indicator FY 99: no indicator	FY 05: FY 04: 90% FY 03: 92% FY 02: 89% FY 01: 80% FY 00: no indicator FY 99: 86% FY 97: 74%	3, 8  * indicates revised FY 2005 measure. See Summary of Changes Table.

Performance Measures	Targets	Actual Performance	Reference
<p><u>Indicator 39:</u> Assure appropriate administrative and public health infrastructure is in place in response to agency reorganization and accountability requirements.</p>	<p>FY 06: completed in FY 05; no indicator in FY 06            FY 05: assess pub health infrastructure in additional 3 area offices            FY 04: assess pub. health infrastructure in one additional Area Offices            FY 03: assess pub. health infrastructure for HQ and 6 Areas            FY 02: no indicator            FY 01: no indicator            FY 00: 1876 FTE or less            FY 99: at least 10% under FY 97 level or 1876 FTE</p>	<p>FY 05:            FY 04: PH infrastructure assessed for one additional Area Office            FY 03: PH infrastructure assessed for HQ and 3 areas ( not 6 areas)            FY 02: no indicator            FY 01: no indicator            FY 00: 1,569 FTE            FY 99: -22% (1,619 FTE)            FY 97: 2085 FTE baseline</p>	<p>2            3  </p>
<p><u>Indicator 40:</u> Increase the proportion of I/T/Us who have implemented Hospital and Clinic Compliance Plans to assure that claims meet the rules, regulations, and medical necessity guidance for Medicare and Medicaid payment.</p>	<p>FY06: no indicator            FY 05: no indicator            FY 04: no indicator            FY 03: improve 10% over FY 02 baseline            FY 02: no indicator            FY 01: no indicator</p>	<p>FY 05: no indicator            FY 04: no indicator            FY 03: 100% compliance            FY 02: no indicator            FY 01: no indicator</p>	<p>3  </p>

Performance Measures	Targets	Actual Performance	Reference
<p><u>Indicator 41: Support Tribal Self-Determination through technical assistance</u></p>	<p>Technical Assistance  FY 06: No indicator  FY 05: No indicator  FY 04: No indicator  FY 03: 100% of new tribes  FY 02: tribal approval of protocol  FY 01: develop protocol</p> <p>Contract Support Cost Review  FY 05: No indicator  FY 04: No indicator  FY 03: 100% use of protocol for new tribes  FY 02: secure tribal acceptance  FY 01: develop protocol  FY 00: no indicator  FY 99: no indicator</p>	<p>FY 04: no indicator  FY 03: 100% of new tribes  FY 02: tribal approval  FY 01: protocol developed</p> <p>FY 04: no indicator  FY 03: 10/03  FY 02: tribal acceptance  FY 01: protocol developed</p>	<p>3  </p>
<p>Quality of Work Life and Staff Retention Group</p>			

Performance Measures	Targets	Actual Performance	Reference
<p><u>Indicator 42:</u> Assess scholarship program for placement and efficiency [efficiency]</p>	<p><u>Placement Scholarship Recipients</u></p> <p>FY 06: Increase efficiency by placing recipients within 90 days of graduation</p> <p>FY 05: improve placement rate by 2%</p> <p>FY 04: Secure baseline rate for placement of scholarship recipients</p> <p><u>Nurse Retention</u></p> <p>FY 03: identify nurse retention problems and develop plan</p> <p>FY 02: no indicator</p> <p>FY 01: no indicator</p>	<p>FY 06:</p> <p>FY 05</p> <p>FY 04: baseline rate established</p> <p>FY 03: nurse retention assessed and plan developed</p> <p>FY 02: no indicator</p> <p>FY 01: no indicator</p>	<p>3 8</p> 
<p>Total Consultation, Partnerships, Core Functions, and Advocacy Funding:</p>	<p>FY 06: \$0</p> <p>FY 05: \$88,432,000</p> <p>FY 04: \$86,756,000</p>		

**Partnerships, Consultation, Core Functions, and Advocacy Indicators**

In an attempt to streamline our GPRA report, and decrease the number of GPRA indicators, this section will be eliminated by FY 2006. The above table illustrates that many of these indicators are completed by FY 2005, or have legal statutes that require compliance and achievement of these indicators.

**Indicator 37: Eliminated in FY 2006**

**Program Performance:** The IHS did not meet this indicator in FY 2004. The FY 2004 indicator was to increase stakeholder satisfaction with the agency's consultation process by 3% over the FY 2003 baseline. However no follow-up survey has been conducted yet. IHS is currently in a joint partnership process with the Office of Intergovernmental Affairs in DHHS to review and revise both the DHHS and IHS tribal consultation policies. One of the items on the agenda for this group is how to evaluate and determine the effectiveness of DHHS and IHS consultation policies.

**Indicator 38: IHS will develop a new indicator for FY 2006 that will move under the TREATMENT category. The Contract Health Service (CHS) procurement improvement indicator has been eliminated in FY 2005.**

**Program Performance:** The IHS did not meet this indicator in FY 2004. The FY 2004 indicator was to improve the level of CHS procurement of inpatient and outpatient hospital services for routinely used providers by at least +1% over the FY 2003 level of the total dollars paid to contract providers or rate quote agreements at the IHS-wide reporting level. In 2004 the level dropped to 90% from 92% in FY 2003.

**Indicator 39: Eliminated in FY 2006**

**Program Performance:** The IHS met this indicator in FY 2004. The FY 2004 indicator committed to complete a systematic assessment of the public health infrastructure for Headquarters and one additional Area Office. Assessments have been completed for Headquarters and the Albuquerque, Tucson, and Navajo Area Offices. An assessment of Aberdeen Area Office is in progress.

**Indicator 40: Eliminated effective FY 2004**

**Indicator 41: Eliminated effective FY 2004**

The following scholarship indicator will move under TREATMENT category:

**Managing Human Capital Indicator:**

**Indicator 42:** During FY 2006, the IHS will increase its efficiency in placing Health Profession Scholarship recipients in Indian health settings within 90 days of graduation over the established FY 2004 baseline.

**Rationale:** The purpose of this indicator is to increase the efficiency in placing Health Profession Scholarship recipients in Indian health settings and increase access to critical health services for AI/AN people. The Indian Health Care Improvement Act (IHCIA), P.L. 94-437, as amended, authorizes IHS to conduct three interrelated scholarship programs to train the health professional personnel necessary to staff IHS, tribal, and urban health programs serving American Indians and Alaska Natives

**Why is this Important?** Increased efficiency in placing health profession scholarships recipients can and will help improve the health care delivery system at I/T/U facilities.

**Approach:** The IHS will utilize Area Office staff, IHS Headquarters health professionals, IHS website, mailings to tribes and urban facilities for announcement of students who will be completing their degree programs. Specific activities will include:

- a. Identify a staff person at each Area Office to assume the responsibility of an IHS Area Scholarship Coordinator.
- b. Provide IHS, Tribal, and urban recruiter's information on students who are graduating from their degree programs for recruitment purposes.
- c. Maintain a comprehensive database to track students during their award year in order to provide information on students by date of graduation and health/allied health professions.

**Data Source:** During FY 2003, the IHS Scholarship program implemented a new data system to monitor the status of scholarship recipients and their placement in I/T/U settings. For FY 2004 a baseline rate for placing these recipients was established and the system will be used to monitor progress in improving the efficiency in placing them in succeeding years.

**Program Performance:** The IHS met this indicator in FY 2004. The FY 2004 indicator was to establish a baseline for the proportion of Health Professional Scholarship recipients that are placed in I/T/U programs within 90 days of graduation from their health/allied health discipline. For FY 2004 the baseline is 20%. In FY 2003-2004 we had 165 students graduate. Twenty-six students have been placed; four students went into deferment; and twenty-nine students graduated December 2004 and have not yet been placed. The reason for the low number of students not being placed within 90 days is licensing. A majority of students in the FY 2003-2004 year graduated in May 2004 and are waiting to take their boards.