PART II - PROGRAM PLANNING AND ASSESMENT

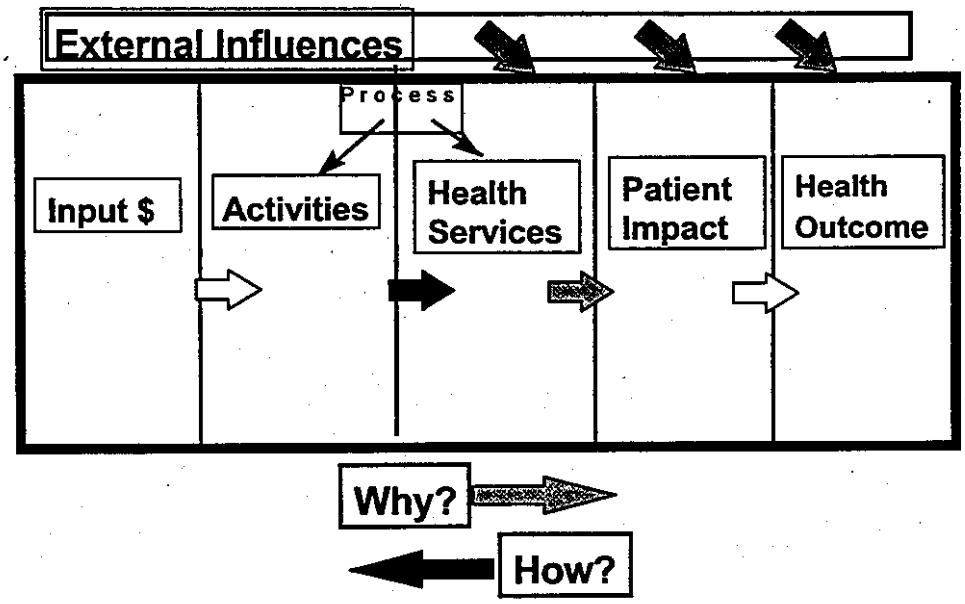
It must be borne in mind that the tragedy of life doesn't lie in not reaching your goal. The tragedy lies in having no goal to reach. It isn't calamity to die with dreams unfulfilled, but it is a calamity not to dream. It is not a disaster to be unable to capture your ideal, but it is a disaster to have no ideal to capture. It is not a disgrace not to reach the stars, but it is a disgrace to have no star to reach for. Not failure, but low aim is sin.

Benjamin Mays

Introduction and Rationale

The diagram that follows has been used the past three years to explain the GPRA process and shows that it is essentially the same as the public health approach the IHS has long followed in health planning and evaluation. The logic of this model links resources to activities or "process" (both support and direct health services) which leads to reductions in risk factors for diseases and conditions (i.e., impact) and over an extended period of time results in improved health outcomes. The model also depicts how external influences such as economic status (see Section 1.4, *The Role of Poverty*) isolation, or social norms can have powerful effects on the success of interventions, particularly in addressing lifestyle related health outcomes.

The Public Health/GPRA Approach



In light of this conceptual model, three broad categories of indicators are of relevance.

Process Indicators:

Indicators that assess the quantity or quality of activities that have the potential to contribute, at least indirectly, to reduced mortality or morbidity in the population over time.

Process indicators include activities such as the construction of clinics, identification of the prevalence of a disease or condition, implementation of consumer satisfaction surveys, and the provision of some health services (i.e., services for which the link to improved health

outcomes has not been consistently demonstrated). These are important activities that may be essential to running an effective health care program, but do not in and of themselves result in improved health outcomes. The GPRA represents a process requirement, and committing to comply with these requirements represents a process indicator. (See Activities and Health Services boxes in diagram)

Impact Indicators:

These are indicators that assess the quantity or quality of activities that have a scientific evidenced-based link to improved health outcomes usually by a demonstrated reduction in a recognized risk factor of mortality or morbidity in a population. These indicators are referred to as "interim outcomes" in much of the GPRA literature. They include activities such as immunizations, dental sealants, assuring safe drinking water, and cancer screenings. Over time these activities result in improved morbidity and/or mortality. Impact indicators are usually the most appropriate type of indicator for annual performance plans because they provide the most measurable link between funding and results. (see Patient Impact box in diagram)

Outcome Indicators:

These are indicators directly relate to reducing mortality or morbidity relative to a disease or condition that program(s) address. While these indicators are the ultimate goal of health care, for many health conditions it is often years before outcome benefits are realized. Furthermore, identifying the cost of an observed outcome is often difficult our impossible in the cases of conditions that multiple providers many be addressing simultaneously while addressing other health conditions. Thus, outcome indicators are usually not the most appropriate choice for annual performance plans, but are essential to identify for long-term goals such as in the GPRA Strategic Plan. Examples include reducing the prevalence of obesity, diabetic complications or reducing the unintentional injury mortality rate (see Health Outcome box in diagram).

It is appropriate to note that general workload types of indicators such as total outpatient visits and inpatient days are not included in this performance plan because any meaningful link to health outcomes is indirect or circuitous, at best. As noted earlier, outpatient visits have grown with population growth rather than varied with level of funding. Inpatient days have been declining across the country as well as in the I/T/U care systems to control costs and neither of these measures have shown an interpretable correlation with improved health status. However, these data will continue to be monitored and presented to the Department as part of the IHS annual accountability report because they are of significance in the context of expenditures and demands on the I/T/U system.

The IHS performance indicators represent sentinel indicators that are specifically focused on the most significant health problems affecting AI/ANs and/or the essential services that address them and identified by local I/T/Us. These problems include: diabetes, alcohol and substance abuse, cancer, dental diseases, mental health, heart disease, family abuse and violence, injuries, poor living environment, mental health, tobacco use, obesity, environmental hazards, and the unique health problems of elders, women and children. They all represent important links in the

GPRA/public health process directed towards outcomes. Some represent primary prevention that attempts to prevent a disease or condition before it occurs (e.g., immunizations or controlling weight to prevent heart disease or diabetes). Others are "secondary preventive" in nature in that

they attempt to reduce the morbidity and mortality associated with a disease or condition after it has occurred (e.g., access to dental care or breast cancer screening). Given that there will always be ten leading causes of death, our focus is to intervene early in the processes that contribute significantly to mortality and morbidity, rather than to target end point problems such as heart attacks and stroke. This is the essence of the cost-effective public health approach that has resulted in the improvements in health status of AI/AN people over the last three decades.

We have also included indicators for improving how our consumers perceive the quality of and access to services, how employees perceive the quality of their work-life, and how our stakeholders perceive our performance in assuring adequate consultation and advocating for their needs. In addition, several indicators address expanding our information technology capacity to improve health care delivery and performance management.

The indicators in this plan do not represent the complete spectrum of activities and challenges the Agency and the I/T/Us address as part of a comprehensive public health organization. To do so would probably require several hundred indicators and require significant increases in resources just to collect the data. Consistent with the proposed GAO guidance, these indicators are limited to a vital few, represent multiple priorities, are linked to the responsible programs, and in many cases are measures we have used for many years for program evaluation. Several are focused primarily on better defining the magnitude of certain problems and improving our evaluation capability.

A major challenge in selecting indicators for a one-year plan is that many of the processes necessary for intervening in complex chronic diseases require years or decades of focused efforts to realize significant progress, even with significant resource enhancements. Therefore, only a few of these indicators directly address health outcomes, while most are incremental activities that will lead to such outcomes over time. Finally, all health-problem related indicators support the HHS HP 2010 goals, and all indicators and the entire plan support the Department's recently revised Strategic Plan.

However, these indicators were developed in partnership with Area and I/T/U staff and AI/AN tribal leaders with the first priority being the need to reflect the problems and strategic activities of the I/T/Us collectively. We believe this approach is essential to secure the high level of collective support we will need with our diverse and decentralized programs. Because of the diversity across I/T/Us and the freedom of tribal programs to participate in GPRA activities at their discretion, not all indicators will be of priority to all I/T/Us. Furthermore, there are activities that are not included in these indicators that will continue to be priorities, particularly health issues unique to local I/T/Us.

Application of the Balanced Scorecard Conceptual Model to Health Performance Measures

The IHS has elected to incorporate a modification of the Balanced Scorecard conceptual model as an additional classification of each indicator under the subheading "Type of Indicator." Based on this model originally proposed by Robert Kaplan and David Norton in their seminal article in the *Harvard Business Review* in 1992, it is essential for each company to address performance measurement by answering four basic questions:

1. How do customers see us (customer perspective)?
2. What must we excel at (internal perspective)?
3. Can we continue to improve and create value (innovation and learning perspective)?

4. How do we look to shareholders (financial perspective)?

While this model was designed to fit the context of profit-oriented companies, we contend that with slight modification it has significant utility in a Federal agency such as the IHS. Clearly the first question has relevance for the IHS as a health care organization. The IHS Goal, presented on page six, addresses the availability and acceptability of culturally acceptable health services. Indicator 21 relates to a consumer satisfaction survey designed to capture the critical elements of health care consumer satisfaction that have been identified in the related literature. Additionally, Indicator 37 assesses I/T/U stakeholders (internal customers) satisfaction with the consultation process relative to budget and policy issues.

The second question targets the critical internal capabilities that are essential to meeting customer demands as well as the long-range mission-critical operations of an organization. For the IHS this clearly relates to our ability to efficiently and effectively provide comprehensive health services that many of our indicators are based on. In addition, it is critical that we also address support functions such as securing health care and health status data, building and maintaining facilities, and developing appropriate management structures. Thus, the majority of indicators in this plan address this question.

The third question addresses our ability to learn and grow as an organization and has tremendous significance for the IHS because some of the health problems we face have yet to be solved anywhere in the world in a public health setting. Thus, indicators that pilot new technologies and approaches to such problems as childhood obesity and diabetes (Indicator 29) represents field research and intervention technology development. Similarly, indicators addressing suicide prevention, personal and organizational fitness, and tobacco control represent learning and applying technologies proven effective from other settings to the unique environments across Indian Country (applications research).

The final question relates to financial success or profitability and in essence is a look back at how the business has worked in the past. On the surface the notion of profitability is perhaps more difficult to apply to a Federal public health agency such as the IHS, since profit is not part of our focus. However, we would contend that the analogous currency of profitability to a public health organization would be improvements in the health status of the served population brought about by the efficient and effective delivery of high quality health care. In this context public health profitability is a look back at what has been accomplished in terms of improving health status and an analysis of the cost and relative productivity in providing services.

It is worth noting that this view of "public health profitability" is virtually the same construct as the Public Health/GPRA Approach outlined earlier in this section, or more globally, the essence of GPRA itself for public health. As will be pointed out several times in this plan, it is often not possible to show "public health profitability" in a one-year period when dealing with chronic diseases. Therefore few indicators in this plan address the outcome issue, but focus on reducing the risk factors as describe earlier in the description of "impact indicators."

The utility of applying the Balanced Scorecard in the context of planning and evaluation in the IHS is similar to the benefits realized in the private sector. It guides our focus to not only look back on what we have accomplished, how our consumers feel about it, and to determine what things to continue, but also where we need to move in the future and what capabilities we must develop or purchase to get there. Perhaps this process of finding the ideal balance in making

future resource decisions is the most challenging part of public health. Investing in "potential" versus the "proven" is usually a risky process but the use of the Balanced Scorecard can assist in making such decisions consciously with the best available information. Over time, we believe the use of Balanced Scorecard can enhance the effectiveness of our GPRA process.

Budget and Program Aggregation

Because of the number and diversity of IHS health programs, these activities can be organized in many different ways. Our goal in presenting our performance measures is to relate to the best of our ability, performance to our budget. This is a serious challenge to the IHS for several reasons we will articulate. We have selected an aggregation approach largely based on the way our programs are managed and have selected four functional areas for the aggregation of the 24 budget categories identified in the IHS "Detail of Change Table": 1.) Treatment, 2.) Prevention, 3.) Capital Programming/Infrastructure, and 4.) Consultation, Partnerships, Core Functions, and Advocacy. While this approach may appear to be an overly simplistic "lumping" of categories, it is important to realize that there is no aggregation or disaggregation that allows mutually exclusive activities linked to mutually exclusive health problems.

This conundrum exists because addressing most chronic diseases and problems such as diabetes, injuries, and family violence requires multidisciplinary interventions to be successful. In such cases, there may be several health programs (and thus funding categories) simultaneously addressing a health problem such as diabetes. Confounding the issue further, these same diverse providers may be addressing other health issues such as tobacco use, blood pressure control, or mental health during the same encounter. Lastly, tribal programs, which now manage over 40% of the total IHS budget, have the legal flexibility to reprogram funding categories to meet their identified health priorities and likewise use an accounting tailored to their needs and preferences. As a result, with the exception of the facilities construction category, tribes tend to use resources based on individual tribal priorities and the link between named categories in the IHS budget and how the funds are actually used in tribal programs may not be highly correlated.

Thus, for tribal programs the aggregation issue is probably moot. For IHS managed programs, aggregation of budget categories that not only splits out activities and funding sources but also allows a valid cost accounting link to health outcomes cannot be provided. In such cases, the accounting link can go no farther than services. A manufacturing type of accounting mindset taken to an extreme simply does not fit well in the context of a comprehensive public health program. Therefore, the aggregation approach we have selected seems reasonable given the limitations of any approach and that we do have the option to disaggregate these inputs if desired for a more narrowly focused look at well circumscribed programs such as dental services or public health nursing.

There is no priority order to these categories and all are important in accomplishing the mission of the IHS. Chart II that follows shows the relationship between the funding categories in IHS Detail of Change Table and the appendix of the "Budget of the United States" and our GPRA aggregation. A brief explanation of the components of each aggregation category precedes each set of performance indicators.

Chart II
Budget Category Aggregation

INDIAN HEALTH SERVICE Detail of Change Table	APPENDIX Budget of the United States items from left column	GPRA AGGREGATION items from left column
SERVICES:	**SERVICES:**	
1 Hospitals & Health Clinics		
2 Dental Services		1. Treatment (1,2,3,4,5,10,11,12,14,15)
3 Mental Health		
4 Alcohol & Substance Abuse		2. Prevention (6,7,8,9,19b)*
5 Contract Health Services		
Total, Clinical Services	1 Clinical Services (1-5)	3. Capital Programming/ Infrastructure (16-20)**
6 Public Health Nursing		
7 Health Education		4. Partnerships, Consultation, Core Functions, and Advocacy (13,19a-c)***
8 Comm. Health Reps		
9 Immunization AK		
Total, Prev Hlth	2 Preventive Health (6-9)	*The Prevention category includes 35% of Environmental Health Support (19b) activities.
10 Urban Health	3 Urban Health (10)	
11 Indian Health Professions	4 Indian Health Professions (11)	**The Capital Programming/Infrastructure category includes 80% of Facilities Support (19a), 60% of Environmental Health Support (19b), and 20% of OEHE Support (19c) activities.
12 Tribal Management	5 Tribal Management (12)	
13 Direct Operations	6 Direct Operations (13)	
14 Self Governance	7 Self Governance (14)	***The Partnerships, Consultation, Core Functions, and Advocacy category includes 20% of Facilities Support (19a), 5% of Environmental Health Support (19b), and 80% of OEHE Support (19c) activities.
15 Contract Support Costs	8 Contract Support Costs (15)	
Total, Services	Total, Services	
FACILITIES:	**FACILITIES:**	
16 Maint. & Improvement	9 Maint. & Improvement (16)	
17 Sanit. Facil. Constr.		
18 Hlth Care Facs. Constr.	10 Hlth Care Facs. Constr. (17-18)	
19 Facil. & Envir. Hlth Sup	11 Facil. & Envir. Hlth Sup (19a-c)	
19a Fac. Support		
19b Env. Health Support		
19c OEHE Support		
20 Equipment	12 Equipment (20)	
Total, Facilities	Total, Facilities	
(20) Total, IHS	(12) Total, IHS	(4) Total, IHS

Budget Category Aggregation
Crosswalk to FY 2002 Budget Request

	Category/Sub-sub activity	FY 2002 Request
	TREATMENT	
1	Hospitals & Health Clinics	1,137,711,000
2	Dental Services	95,305,000
3	Mental Health	47,142,000
4	Alcohol and Subtance Abuse	135,005,000
5	Contract Health Services	445,776,000
10	Urban Health	29,947,000
11	Indian Health Professions	30,565,000
12	Tribal Management	2,406,000
14	Self-Governance	9,876,000
15	Contract Support Costs	288,234,000
	M/M and PI Collections (85%)	424,987,000
	Diabetes	100,000,000
	Total	$2,746,954,000
	PREVENTION	
6	Public Health Nursing	37,781,000
7	Health Education	10,628,000
8	Community Health Representatives	49,789,000
9	Immunization AK	1,526,000
19b	Environmental Health Support (35%)	18,500,000
	Total	$118,224,000
	CAPITAL PROGRAMMING/ INFRASTRUCTURE	
16	Maintenance & Improvement	45,331,000
17	Sanitation Facilities	93,827,000
18	Health Care Facilities Construction	37,568,000
19a	Facilities Support (80%)	50,426,000
19b	Environmental Health Support (60%)	31,713,000
19c	OEHE Support (20%)	2,177,000
20	Equipment	16,294,000
	M/M and PI Collections (15%)	74,998,000
	Quarters	4,700,000
	Total	$357,034,000
	PARTNERSHIPS, CONSULTATION, CORE FUNCTIONS, AND ADVOCACY	
13	Direct Operations	65,323,000
19a	Facilities Support (20%)	12,606,000
19b	Environmental Health Support (5%)	2,643,000
19c	OEHE Support (80%)	8,710,000
	Total	$89,282,000