

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
FY 2007 Performance Budget Submission**

TABLE OF CONTENTS

Performance Detail

	<u>PD</u>
Summary of Measures	1
Detail of Performance Analysis	2
Changes and Improvements over Previous Years.....	38

THIS PAGE LEFT BLANK INTENTIONALLY

Summary of Measures and Results Table

	Measures	Total Reported		Total Met	Total Not Met		
		Results Reported	% Reported		Improved	Total Not Met	
FY	Total in Plan	Results Reported	% Reported	Met	Improved	Total Not Met	% Met
2002	40	38	95%	31		7	78%
2003	41	38	93%	31		7	76%
2004	39	38	97%	28 ¹		10	72%
2005	35 ²	34	97%	29	1	5	83%
2006	35						
2007	35						

¹ Results of one measure revised from Not Met to Met in May 2005 based on provision of additional data.

² 2005 total measures reduced by 2 from 2006 CJ for the following reasons: (a) consumer satisfaction measure, which was reported as discontinued in Exhibit W Changes and Improvements, was not deleted from Exhibit DD Summary of Measures and Results Table in the 2006 CJ; (b) influenza measure was placed on hold for 2005 based on projected national vaccine shortages, reducing total measures to 35.

Detail of Performance Analysis

Treatment Measures: Diabetes Group

Measure	FY	Target	Result
There is no measure or goal for the proportion of patients who have had an A1c test; however, this information is provided for context. IHS is well above the Healthy People 2010 Goal of 50 percent for A1c testing rates.	2007	N/A	Oct/2007
	2006	N/A	Oct/2006
	2005	N/A	78%
	2004	N/A	77%
	2003	N/A	75%
	2002	N/A	73%
Tribally-Operated Health Programs	2007	N/A	Oct/2007
	2006	N/A	Oct/2006
	2005	N/A	76%
	2004	N/A	74%
	2003	N/A	73%
	2000	N/A	63%
(1) Diabetes: Poor Glycemic Control: Proportion of patients with diagnosed diabetes that have poor glycemic control (HbA1c > 9.5). *First figure in results column is Diabetes audit data; second is CRS. [outcome]	2007	/15%	Oct/2007
	2006	/15%	Oct/2006
	2005	16/17%*	/15%*
	2004	Baseline	16/17%*
	2003	N/A	N/A
	2002	N/A	N/A
Tribally-Operated Health Programs NOTE regarding all Tribally-Operated Health Programs (TOHP) performance measures: Tribal targets for 2006 and 2007 were established during the OMB PART evaluation of TOHPs. The targets were based on Tribal FY 2005 GPRA results, which varied from the IHS All results on some measures. Additional modifications of these targets will require consultation with the Tribes.	2007	12%	Oct/2007
	2006	12%	Oct/2006
	2005	17%	12%
	2004	Baseline	15%
	2003	N/A	N/A
	2000	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; diabetic registries; yearly IHS Diabetes Care and Outcome Audit.			
Data Validation: Annual comparison of CRS and Diabetes Audit results			
Cross Reference: Healthy People 2010; HHS Strategic Goal 3			

Reducing the number of patients with poor glycemic control will lower health care costs by reducing the prevalence of diabetes complications. It will also lower the number of diabetes-related deaths. The ultimate goal for this measure is to *lower* the A1c level of patients with diabetes with poor glycemic control. The FY 2005 target was met and exceeded. In FY 2005, 15% of patients diagnosed with diabetes had poor glycemic control, as measured by the Hemoglobin A1c test that measures average blood sugar over the last 1-2 months. The rate was reduced by 2% from FY 2004.

Measure	FY	Target	Result
(2) Diabetes: Ideal Glycemic Control: Proportion of patients with diagnosed diabetes with ideal glycemic control (A1c <7.0). *First figure in results column is Diabetes audit data; second is CRS. [outcome]	2007	36/34%*	Oct/2007
	2006	36/32%*	Oct/2006
	2005	34/27%*	36/30%*
	2004	1%>2003	34/27%*
	2003	Maintain	31/28%*
	2002	>2001	30/25%*
Tribally Operated Health Programs	2007	33%	Oct/2007
	2006	33%	Oct/2006
	2005	27%	33%
	2004	1%>2003	28%
	2003	Maintain	26%
	2000	24%	13%
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; diabetic registries; yearly IHS Diabetes Care and Outcome Audit.			
Data Validation: Annual comparison of CRS and Diabetes Audit results			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

Increasing the number of patients with diabetes with ideal control will lower health care costs and reduce the mortality rate from diabetes. Clinical studies show that lower A1c levels are associated with lower heart-attack rates, lower rates of eye, kidney, and nerve disease, and fewer amputations among diabetics. The target for this measure was met and exceeded. In FY 2005 30% of American Indian and Alaska Native (AI/AN) patients with diabetes had ideal glycemic control, as measured by the Hemoglobin A1c test that measures average blood sugar over the last 1-2 months using CRS data. This rate was 3% higher than the 27% reported in FY 2004, despite a significant increase in the number of patients with diabetes in the same period. The targets for FY 06 and FY 07 include a 2% increase each year in the CRS data set. Achievement of this goal assumes a 1.6% increase in user population as well as comparable increases in patients served who have diabetes.

Measure	FY	Target	Result
(3) Diabetes: Blood Pressure Control: Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<130/80). *First figure in results column is Diabetes audit data; second is CRS. [outcome]	2007	/37%	Oct/2007
	2006	/37%	Oct/2006
	2005	34/35%*	/37%*
	2004	1%>2003	34/35%*
	2003	Maintain	33/37%*
	2002	Maintain	32/36%*
Tribally-Operated Health Programs	2007	36%	Oct/2007
	2006	36%	Oct/2006
	2005	35%	36%
	2004	1%>2003	33%
	2003	Maintain	32%
	2000	>36%	27%
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; diabetic registries; yearly IHS Diabetes Care and Outcome Audit.			
Data Validation: Annual comparison of CRS and Diabetes Audit results			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

This measure is directed at reducing complications of diabetes. Lower blood pressure levels in people with diabetes reduce the risk of heart disease and stroke by 33-50%. The target for this measure was met and exceeded. During FY 2005, the percentage of patients who achieved good control improved by two percent to 37% from 35% in FY 2004.

Measure	FY	Target	Result
(4) Diabetes: Dyslipidemia Assessment: Proportion of patients with diagnosed diabetes assessed for dyslipidemia (LDL cholesterol). *First figure in results column is Diabetes audit data; second is CRS. [outcome]	2007	76/59%	Oct/2007
	2006	72/56%	Oct/2006
	2005	69/53%*	70/53%*
	2004	1%>2003	69/53%*
	2003	Maintain	65/48%*
	2002	Maintain	64/44%*
Tribally-Operated Health Programs	2007	50%	Oct/2007
	2006	49%	Oct/2006
	2005	53%	48%
	2004	1%>2003	52%
	2003	Maintain	47%
	2000	>46%	22%
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; diabetic registries; yearly IHS Diabetes Care and Outcome Audit.			
Data Validation: Annual comparison of CRS and Diabetes Audit results			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

Low cholesterol levels help to protect diabetic patients from developing heart disease. Diabetic patients are especially prone to develop heart disease and therefore identification and treatment of elevated lipids in diabetic patients is extremely important. The FY 2005 target of maintaining the number of patients assessed for dyslipidemia was met, despite a significant increase in the overall population of patients diagnosed with diabetes. In addition, this measure is included in the “One HHS” 10 Department-wide Management Objectives to attain a 10% relative increase by FY 2007.

Measure	FY	Target	Result
(6) Diabetic Retinopathy: Proportion of patients with diagnosed diabetes who receive an annual retinal examination (at pilot sites only until FY 2006). This measure changes in FY 2006: retinal examination rates will be measured at all sites. Target is to maintain at designated pilot sites and establish baseline at all sites. In FY 2007, examination rates at designated pilot sites will not be reported separately. [outcome]	2007	maintain	Oct/2007
	2006	50%/ Baseline	Oct/2006
	2005	55%	50%
	2004	61%	55%
	2003	58%	58%
	2002	N/A	55%
Tribally-Operated Health Programs *This data was collected and reported but the GPRA target for this period related to pilot sites only	2007	Maintain	Oct/2007
	2006	Baseline	Oct/2006
	2005	N/A	50%*
	2004	N/A	45%*
	2003	N/A	47%*
	2000	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; diabetic registries; yearly IHS Diabetes Care and Outcome Audit.			
Data Validation: Annual comparison of CRS and Diabetes Audit results			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

Diabetes can affect vision by damaging the blood vessels inside the eye, a condition known as “diabetic retinopathy.” Early detection of diabetic retinopathy (DR) is a fundamental and critical part of the effort to reduce visual loss among people with diabetes. Clinical trials demonstrate that timely laser photocoagulation treatment of DR reduces vision loss by over 90%. IHS did not meet the target for this measure in FY 2005. The proportion of diabetic patients who received an annual diabetic retinal exam declined from 55% in FY 2004 to 50% in FY 2005 at designated sites. However, at all sites the exam rate was 50%, representing an increase from the FY 2004 rate of 47%.

There are many barriers for significant improvement in the diabetic retinopathy surveillance rate over the past few years. Prominent among them is a substantial and sustained increase in the prevalence of diabetes. Because of this growth in the number of individuals with diabetes, the small observed decreases in the surveillance rate still represents a real increase in the number of retinopathy examinations. Since controlled studies indicate great advantages from the technology used at the demonstration sites, its use will be broadened in FY 2006 in the effort to increase the DR examination rate to meet or exceed target goals. In FY 2006, rates for diabetic retinal exams at all sites will be reported along with rates from designated sites.

Treatment Measures: Cancer Screening Group

Measure	FY	Target	Result
(7) Pap Smear Rates: Proportion of eligible women who have had a Pap screen within the previous three years. [outcome]	2007	60%	Oct/2007
	2006	60%	Oct/2006
	2005	58%	60%
	2004	61%	58%
	2003	62%	61%
	2002	42%	62%
Tribally-Operated Health Programs	2007	61%	Oct/2007
	2006	61%	Oct/2006
	2005	58%	61%
	2004	61%	59%
	2003	62%	60%
	2000	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases.			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

In 2002, American Indian women had a cervical cancer mortality rate that exceeded the rate for US 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. In FY 2005 the Pap smear rate was 60%, an increase of two percent from the 58% rate reported in FY 2004.

Measure	FY	Target	Result
(8) Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. [outcome]	2007	41%	Oct/2007
	2006	41%	Oct/2006
	2005	40%	41%
	2004	40%	40%
	2003	42%	40%
	2002	23%	42%
Tribally-Operated Health Programs	2007	44%	Oct/2007
	2006	44%	Oct/2006
	2005	40%	44%
	2004	40%	43%
	2003	42%	44%
	2000	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases.			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

Breast cancer is the second leading cause of cancer death among U.S. women (lung cancer is first). Between 1992 and 2002, breast cancer mortality rates declined for all racial and ethnic groups except AI/AN women, who experienced no decline. Biennial screening of women between the ages of 50 and 69 has been shown to be a cost effective way to decrease breast cancer mortality. In FY 2005, the mammogram screening rate increased by 1% from the FY 2004 rate of 40%.

Measure	FY	Target	Result
(9) Colorectal Rates: Proportion of eligible patients who have had appropriate colorectal cancer screening.* [outcome]	2007	Maintain	Oct/2007
	2006	Baseline	Oct/2006
	2005	N/A	N/A
	2004	N/A	N/A
	2003	N/A	N/A
	2002	N/A	N/A
Tribally-Operated Health Programs	2007	Maintain	Oct/2007
	2006	Baseline	Oct/2006
	2005	N/A	N/A
	2004	N/A	N/A
	2003	N/A	N/A
	2000	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases.			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

Colorectal cancers are the third most common cancers in the United States, and are the third leading cause of cancer deaths. Colorectal cancer rates among the Alaska Native population are well above the national average and rates among American Indians are rising. Yearly screening has been shown to result in a 33.4 percent reduction in colorectal mortality. *New measure for FY 2006.

Treatment Measures: Alcohol and Substance Abuse Group

Measure	FY	Target	Result
(10) RTC Improvement/Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more). [output]	2007	100%	Oct/2007
	2006	100%	Oct/2006
	2005	100%	100%
	2004	+2%	+2%
	2003	+5%	+4%
	2002	baseline	baseline
Data Source: Reports from Youth Regional Treatment Centers			
Data Validation: Review by Division of Behavioral Health			
Cross Reference: HHS Strategic Goals 1, 3, 5			

This measure evaluates Youth Regional Treatment Centers (YRTC) and ensures that these programs are appropriately accredited. Successful completion of residential treatment can help reduce drug and alcohol use relapse in youths. Accreditation by JCAHO, CARF, or comparable state accrediting bodies ensures that the Youth Regional Treatment Centers meet acceptable standards of treatment care. The FY 2005 target was to assure that 100 percent of YRTC programs had accreditation. IHS met this goal and will continue the 100% accreditation target into FY 2006.

Measure	FY	Target	Result
(11) Alcohol Screening (FAS Prevention): Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients. [outcome]	2007	13%	Oct/2007
	2006	12%	Oct/2006
	2005	8%	11%
	2004	Baseline	7%
	2003	Maintain	95%
	2002	+2%	90.5%
Tribally-Operated Health Programs	2007	13%	Oct/2007
	2006	12%	Oct/2006
	2005	>7%	11%
	2004	Baseline	9%
	2003	N/A	N/A
	2000	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3, 5			

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 AI/ANs than the general population. Screening with intervention has been shown to be effective in reducing alcohol misuse in pregnancy and to reduce the incidence of FAS. This measure is included in the “One HHS” 10 Department-wide Management Objectives to achieve a relative increase 10% increase by FY 2007. The agency has already met and exceeded that targeted increase. Moreover, the number of patients screened for alcohol use increased dramatically. Based on FY 2005 results, this measure’s target has been changed to 12% for FY 2006.

Treatment Measures: Oral Health Group

Measure	FY	Target	Result
(12) Topical Fluorides: Proportion of patients receiving one or more fluoride treatments. (In FY 2006 changes to: number of AI/AN patients receiving at least one topical fluoride application.) FY 2005 measure target included both number of applications and number of patients. Prior to FY 2005 this measure calculated increase in number of individuals with access to fluoridated water [outcome]	2007	85,318	Oct/2007
	2006	85,318 *	Oct/2006
	2005	baseline	113,324applications/ 85,318 patients
	2004	+1%	+0.1%
	2003	+1%	+0.37%
	2002	+5%	+1%
(13) Dental Access: Percent of patients who receive dental services. [outcome]	2007	24%	Oct/2007
	2006	24%	Oct/2006
	2005	24%	24%
	2004	25%	24%
	2003	27.35%	25%
	2002	27.3%	27.35%
(14) Dental Sealants: Number of sealants placed per year in AI/AN patients. *Data source changed from NPIRS to CRS in FY 2005; the FY 2004 CRS sealant result is 230,295 [outcome]	2007	249,882	Oct/2007
	2006	249,882	Oct/2006
	2005	287,158/ 230,295*	249,882
	2004	243,499	287,158
	2003	227,945	243,499
	2002	217,932	227,945
(15) Diabetes: Dental Access: Proportion of patients with diagnosed diabetes who obtain access to dental services. Measure eliminated effective FY 2006. [outcome]	2007	eliminated	N/A
	2006	eliminated	N/A
	2005	37%	39%
	2004	37%	37%
	2003	38%	36%
	2002	34%	36%
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; sealant data from National Patient Information Reporting System (NPIRS) 2002-2004.			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

These measures are directed at improving the oral health status of the AI/AN population. AI/ANs remain among the nation's most dentally underserved people. A recent study showed that AI/ANs have reported larger unmet dental health needs compared to Non-Hispanic Whites. However, according to Trends in Indian Health, the number of direct and contract dental services provided by IHS and Tribal Programs has increased 272 percent since FY 1970 and in FY 2001, over 2.7 million dental services were provided.

Measure 12, which measure topical fluoride treatments, established a baseline of 113,324 fluoride applications to 85,318 patients in FY 2005. The goal was to establish a baseline, and the IHS met the target for this measure. The National Oral Health Council has determined that measuring the number of patients receiving one or more fluoride applications will provide an adequate measure of fluoride program efficacy. The 2006 goal is to maintain the number of fluoride treatments to the same number of patients, an ambitious goal given the continuing shortage of dentists within the I/T/U network.

Measure 13 was established to ensure that the agency maintains adequate access to dental care for all patients. Increasing access to care should result in decreased intensity or severity of disease and, decreased prevalence of disease. In FY 2005, IHS met the target of maintaining the FY 2004 rate of 24%. Prior to 2005, the IHS saw a number of years in which access to oral health care decreased. To “stem the decreased flow” and maintain access at a constant level represents a small but significant victory over previous years.

Measure 14 called for maintaining the number of dental sealants placed per year in AI/AN patients at the FY 2004 level. Dental sealants, a recognized standard in preventive dental care, are an effective measure for reducing dental decay rates and can be applied by dental auxiliaries at a relatively low cost. IHS exceeded this target in FY 2005, increasing the number of dental sealants from 230,295 in FY 2004 to 249,882 in FY 2005.

Measure 15, which assesses diabetic patients with diabetes’ access to dental care, will be eliminated in FY 2006. However, in FY 2005 IHS exceeded the goal of maintaining the FY 2004 level of 37%, with 39% of patients receiving dental care. This is a significant accomplishment due to the increase in incidence of diabetic patients. In FY 2006, this measure will be eliminated. The National Oral Health Council determined that measure 13, Dental Access, which includes diabetic patients, is an adequate measure of access.

Treatment Measures: Family Abuse, Violence, and Neglect Measure

Measure	FY	Target	Result
(16) Domestic (Intimate Partner) Violence Screening: Proportion of women who are screened for domestic violence at health care facilities. [outcome]	2007	15%	Oct/2007
	2006	14%	Oct/2006
	2005	4%	13%
	2004	15%	4%
	2003	60/85%	60/84%
	2002	56/82%	70/85%
Tribally-Operated Health Programs	2007	11%	Oct/2007
	2006	10%	Oct/2006
	2005	4%	9%
	2004	15%	5%
	2003	N/A	N/A
	2000	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3			

This measure is designed to help ascertain, evaluate and reduce the prevalence of family violence, abuse and neglect in AI/AN communities. AI/AN women experience domestic violence at rates similar to or higher than the national average. In addition, this measure is included in the “One HHS” 10 Department-wide Management Objectives to attain a 10% relative increase by FY 2007. The DV/IPV measure has already reached and exceeded that goal. Based on FY 2005 results, this measure’s target has been changed to 14% for FY 2006.

Treatment Measures: Information Technology Development Group

Measure	FY	Target	Result
(17) Data Quality Improvement: Number of GPRA clinical measures that can be reported by CRS software. [Output]	2007	All	Oct/2007
	2006	Increase	Oct/2006
	2005	+2	+4
	2004	+2	+2
	2003	Baseline	baseline
	2002	N/A	N/A
(18) Behavioral Health: Number of programs reporting minimum agreed-to behavioral health-related data to warehouse. In 2006 changes to: “Proportion of adults ages 18 and over who are screened for depression.” * Revised from 2.3 percent, 5/2005; changes FY 2004 performance from Not Met to Met. [outcome]	2007	Maintain	Oct/2007
	2006	Baseline	Oct/2006
	2005	Increase	+4%
	2004	+5%	+7%*
	2003	+3%	+3%
	2002	+5%	+5%
Tribally-Operated Health Programs	2007	Maintain	Oct/2007
	2006	Baseline	Oct/2006
	2005	N/A	N/A
	2004	N/A	N/A
	2003	N/A	N/A
	2000	N/A	N/A
(19) Urban IS Improvement: 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. [output]	2007	N/A	N/A
	2006	N/A	Oct/2006
	2005	Dataset	Not met
	2004	Language	Met
	2003	7 sites	18 sites
	2002	13 sites	13 sites
Data Source: CRS application			
Data Validation: Office of Information Technology			
Cross Reference: HHS Strategic Goals 3, 5			

These measures are designed to improve the quality of care through the use of appropriate technology. Measure 17 is designed to improve passive extraction of GPRA clinical data from RPMS health information system. In FY 2005, IHS met this measure by adding four new measures of automated data quality assessment. In FY 2006, the target is to continue to increase the automated extraction of GPRA clinical performance measures through ongoing development and deployment of clinical reporting (CRS) software. The FY 2007 target is to assure that all GPRA clinical performance measures based on RPMS data can be reported by CRS software

Measure 18 is focused on the collection of data in order to track and evaluate improvements in the behavioral health status of AI/AN people. IHS met this measure. The number of I/T/U sites exporting behavioral data in FY 2005 has increased 4.4% from FY2004. This number is expected to increase even more as final FY 2005 data becomes

available. In FY 2006, this measure will establish a baseline rate of annual screening for depression in adults ages 18 and over collected from the behavioral health and other RPMS software packages.

Measure 19 measures the delivery of care in urban settings. The FY 2005 target was to develop a specific minimum data set as well as appropriate language for the urban contracts and grants. The data elements sub-workgroup drafted data elements that constitute a minimum data set, but did not draft language for contracts and grants. *In FY 2006, the target will be to increase the number of urban sites reporting clinical GPRA performance measures through the national clinical reporting process over FY 2005 levels. IHS analyzed GPRA FY 2004 results and identified urban programs that submitted data, establishing a baseline level from which to track progress.

Treatment Measures: Quality of Care Group

Measure	FY	Target	Result
(20) Accreditation: Percent of hospitals and outpatient clinics accredited (excluding tribal and urban facilities). [output]	2007	100%	Oct/2007
	2006	100%	Oct/2006
	2005	100%	100%
	2004	100%	100%
	2003	100%	100%
	2002	100%	100%
(21) Medication Error Improvement: Number of areas with a medication error reporting system. In 2006, measure changes to Medical Error Improvement: Number of areas with a medical error reporting system. [outcome]	2007	3 Areas	Oct/2007
	2006	3 Areas	Oct/2006
	2005	6 Areas	All Areas
	2004	4 Areas	4 Areas
	2003	Baseline	Pilot Established
	2002	N/A	N/A
Data Source: Reports from hospitals and clinics			
Data Validation: JCAHO and AAAHC web sites			
Cross Reference: HHS Strategic Goals 3, 5			

Accreditation is essential for maximizing third-party collections, and contributes both directly and indirectly to improved clinical quality. The local I/T/U multidisciplinary team approach to accreditation and ongoing quality management has been the mainstay of success in this important activity. During FY 2005, seven IHS hospitals were evaluated by JCAHO, CMS, or AAAHC. All seven maintained full accreditation. In addition, six ambulatory health centers participated in accreditation visits from JCAHO and AAAHC and all were accredited.

The IHS met measure 21, Medication Error Improvement, in FY 2005. During FY 2005, all direct care facilities were using the NCCMERP nationally recognized medication error definition, and have implemented a non-punitive multi-disciplinary medication error reporting system. Through the implementation of a new online medical error reporting system, patient safety staff at the local site, area office and national level will be able to trend errors looking for areas to prevent future errors, through policy changes, product changes or training opportunities. In FY 2006, the target calls for IHS to establish and evaluate a medical error reporting system at 3 Areas; in FY 2007, the target calls for IHS to maintain operation of this system at 3 Areas.

(22) Customer Satisfaction Measure: Eliminated in FY 2005, subsumed by Measure 20.

Measure	FY	Target	Result
(42) Scholarships: Proportion of Health Professional Scholarship recipients placed in Indian health settings within 90 days of graduation. [Outcome]	2007	increase	Oct/2007
	2006	32%	Oct/2006
	2005	22%	30%
	2004	Baseline	20%
	2003	Develop nurse retention plan	Nurse retention plan developed
	2002	No Measure	
Data Source: Scholarship program data system			
Data Validation: Clinic employment records			
Cross Reference: HHS Strategic Goals 3, 8			

The FY 2005 target was to increase efficiency in placing Health Profession Scholarship recipients in Indian health settings within 90 days of graduation by 2% over the established FY 2004 baseline. This target was met, with 30% of graduates placed in Indian health settings within 90 days of graduation. This represents an increase of 10% overall from the baseline rate of 20% in FY 2004. Increased efficiency in placing health profession scholarship recipients can and will help improve the health care delivery system at I/T/U facilities.

Prevention Measures: Public Health Nursing Measure

Measure	FY	Target	Result
(23) Public Health Nursing: Address the number of public health nursing services (primary and secondary treatment and preventive services) provided by public health nursing. Measure changes in FY 2006 to: Implement a data system capable of recording the time spent and nature of public health activities other than one-on-one patient care, with an emphasis on activities that serve groups or the entire community [outcome]	2007	Baseline	Oct/2007
	2006	Data system	Oct/2006
	2005	423,379	438,376
	2004	359,089	423,379
	2003	343,844	359,089
	2002	375,918	343,844
Tribally-Operated Health Programs	2007	Baseline	Oct/2007
	2006	N/A	Oct/2006
	2005	Maintain	140,599
	2004	N/A	126,744
	2003	N/A	134,705
	2000	N/A	124,691
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases			
Data Validation: CRS			
Cross Reference: HHS Strategic Goals 1, 3, 5			

The purpose of this measure is to improve the health status of AI/AN people through maintaining access to services associated with improved health outcomes. Public health nurses provide health assessment, health promotion, disease prevention, and infectious disease management. The total number of visits in all settings was 438,376 in FY 2005, compared to 423,379 visits reported in FY 2004. In FY 2006, this measure will change to implement a data system capable of recording the time spent and nature of public health activities other than one-on-one patient care, with an emphasis on activities that serve groups or the entire community. This change will more accurately reflect this range of services provided by public health nurses. In FY 2007, the target is to establish a baseline of time spent and nature of public health activities performed by public health nurses using this data system.

Prevention Measures: Immunization Group

Measure	FY	Target	Result
(24) Combined* immunization rates for AI/AN children patients aged 19-35 months. **Prior to 2005, vaccination rates reported for children ages 3-27 months [outcome]	2007	75%	Oct/2007
	2006	75%	Oct/2006
	2005	72%	75%
	2004	82%	81%/72%**
	2003	80%	80%
	2002	84%	80%
Tribally-Operated Health Programs *First year immunization data electronically collected and reportable.	2007	54%	Oct/2007
	2006	54%	Oct/2006
	2005	N/A	54%*
	2004	N/A	N/A
	2003	N/A	N/A
	2000	N/A	N/A
Data Source: Measures 25 and 26: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; Measure 24: quarterly Immunization Reports – 2002 through 2005.			
Data Validation: Immunization Program reviews			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3, 5			

Routine immunizations represent a cost-effective public health measure that significantly improves the health of children. The FY 2005 target for childhood vaccination was met and exceeded, with the percentage of children ages 19-35 months receiving recommended vaccines at 75%, up 3% from the FY 2004 baseline of 72%. Immunization rates for GPRA are calculated using the Immunization Report, not CRS. *Includes coverage with 4 doses of DTaP, 3 doses of IPV, 1 dose of MMR, 3 doses of Hep B and 3 doses of Hib (4:3:1:3:3 series) **Until FY 2004, vaccination rates reported were for children ages 3-27 months old. In FY 2004, a baseline rate for children ages 19-35 months old was established, and from FY 2005 forward, only coverage rates for children ages 19-35 months will be reported.

Measure	FY	Target	Result
(25) Influenza vaccination rates among adult patients aged 65 years and older. <i>Measure on hold in FY 2005 due to influenza vaccine shortage.</i>	2007	59%	Oct/2007
	2006	59%	Oct/2006
	2005	On Hold	Hold(59%)
	2004	51%	54%
	2003	51%	51%
	2002	35.8%	51%
[outcome]			
Tribally-Operated Health Programs	2007	54%	Oct/2007
	2006	54%	Oct/2006
	2005	On Hold*	54%
	2004	51%	53%
	2003	51%	51%
	2000	65%	49%
(26) Pneumococcal vaccination rates among adult patients aged 65 years and older.	2007	76%	Oct/2007
	2006	72%	Oct/2006
	2005	69%	69%
	2004	65%	69%
	2003	64%	65%
	2002	Baseline	64%
[outcome]			
Tribally-Operated Health Programs	2007	64%	Oct/2007
	2006	63%	Oct/2006
	2005	69%	62%
	2004	65%	69%
	2003	64%	66%
	2000	65%	60%
Data Source: Measures 25 and 26: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; Measure 24: quarterly Immunization Reports – 2002 through 2005.			
Data Validation: Immunization Program reviews			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3, 5			

Elders who get influenza are also at increased risk of hospitalization and death from heart disease and stroke. Influenza vaccination reduces that risk. In FY 2005, 59% of eligible patients received influenza vaccine, 5% higher than FY 2004. However, due to vaccine shortages, this measure was placed “on hold”.

Vaccination of the elderly against pneumococcal disease is one of the few medical interventions found to improve health and save on medical costs. In FY 2005, 39,368 patients had received pneumococcal vaccinations, compared to 32,002 patients in FY 2004, representing a relative 23% increase in one year. This measure is included in the “One HHS” 10 Department-wide Management Objectives to attain a 10% relative increase by FY 2007. While the number of patients over age 65 with pneumococcal vaccinations kept pace with the increase in the number of patients, the agency will need to refocus its efforts to reach the 10% increase by 2007.

Prevention Measures: Injury Prevention Group

Measure	FY	Target	Result
(27) Injury Intervention: Number of community-based injury prevention programs (measure will reflect number of projects per area starting in FY 2007). [output]	2007	3 projects per area	Oct/2007
	2006	Implement web system	Oct/2006
	2005	37	37
	2004	36	37
	2003	36	36
	2002	25	25
(28) Unintentional Injury Rates: Unintentional injuries mortality rate in AI/AN people. [outcome]	2007	88.8	Dec/2011
	2006	88.8	Dec/2010
	2005	88.8	Dec/2009
	2004	88.8	Dec/2008
	2003	88.8	Dec/2006
	2002	95.8	88.8
Data Source: National Center on Vital Health Statistics			
Data Validation: Statistics Branch, IHS			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3, 5; IHS Strategic Goal 1			

Injury prevention interventions are projects that address a specific injury pattern; employ a multiple-strategy approach; are based on a proven, effective injury prevention strategy; or are identified epidemiologically from local data and design based on a proven prevention approach. Examples of projects include Sleep Safe Project sites, national IHS Part II Injury Infrastructure Grants, and Injury Prevention Specialist Fellowships. The FY 2005 target for community based injury was to maintain at least 37 community-based, proven injury prevention intervention projects across I/T/U settings. IHS funded 37 injury prevention cooperative agreement grantee projects in FY 2005, meeting the target. The FY 2006 target is to implement web-based reporting. The FY 2007 target is for each area to conduct at least three community injury prevention projects and report them using an automated tracking system.

For measure 28, no data is currently available to report on the 2005 target for unintentional injuries, which is to maintain the mortality rate for unintentional injuries at the same rate as the previous year. Data is generally available three years later. IHS expects that we will be able to report results for FY 2005 by 2008. The most current unintentional injury mortality rate is extracted from FY 2002, 88.8 per 100,000. IHS met the 2002 target by reducing unintentional injury mortalities below 95.8 per 100,000. IHS has proposed a decrease in unintentional injury rates for both FY 06 and FY 07.

Prevention Measures: Suicide Prevention Measure

Measure	FY	Target	Result
(29) Suicide Surveillance: Collection of comprehensive data on the incidence of suicidal behavior. In 2006 measure changes to incidence of suicidal behavior. [Changes to outcome in FY 2006]	2007	Maintain	Oct/2007
	2006	Baseline	Oct/2006
	2005	Integrate tool	Integrated (met)
	2004	Plan	Plan
	2003	+5%	+30%
	2002	+10%	+10%
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases.			
Data Validation: Division of Behavioral Health			
Cross Reference: Healthy People 2010; HHS Strategic Goals 3, 5			

This measure is part of an expanding systematic effort at reducing the prevalence of suicide in the AI/AN population. The suicide death rate for the AI/AN population increased in the 1990s and is currently 72 percent greater than the national average.

In FY 2005 the target for this measure was to integrate the Behavioral Health suicide reporting tool into RPMS. This target was met. Suicide surveillance data can currently be entered electronically into the RPMS Behavioral Health System (BHS) by behavioral health providers. Medical providers can complete a paper-based suicide reporting form for data entry into BHS. An electronic version of the suicide reporting form in the RPMS Electronic Health Record was released for beta testing late Q4 FY05. Baseline data will be collected in FY 2006.

Prevention Measures: Developmental Prevention and Treatment

Measure	FY	Target	Result
(30) CVD Prevention: Cholesterol: Proportion of patients ages 23 and older who receive blood cholesterol screening. (Prior to FY 2005 measure was: Number of community-directed pilot cardiovascular disease prevention programs.) In FY 2007 measure changes to CVD Comprehensive Assessment: Proportion of at risk patients who have a comprehensive assessment for all CVD-related risk factors. [outcome]	2007	New baseline	Oct/2007
	2006	44%	Oct/2006
	2005	Baseline	43%
	2004	1 site	2 sites
	2003	1 site	4 sites
	2002	3 sites	4 sites
Tribally-Operated Health Programs	2007	Baseline	Oct/2007
	2006	N/A	N/A
	2005	N/A	N/A
	2004	N/A	N/A
	2003	N/A	N/A
	2000	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3			

Cardiovascular disease represents the leading cause of death for AI/AN people above 45 years of age. The target for Measure 30 in FY 2005 was to establish the proportion of patients ages 23 and older that receive blood cholesterol screening and the agency met this target. The baseline rate was set at 43%. In FY 2006 the target is to increase the rate to 44%. In FY 2007, this measure will focus on comprehensive cardio-vascular disease assessment.

Measure	FY	Target	Result
(31) Obesity Assessment: Proportion of patients for whom BMI (Body Mass Index) data can be measured. (Prior to FY 2004 measure was: Develop and implement pilot obesity prevention programs.) In FY 2006 measure changes to: Childhood weight control: Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher. [outcome]	2007	Maintain	Oct/2007
	2006	Baseline	Oct/2006
	2005	65%	64%
	2004	Baseline	60%
	2003	Implement plan	Met
	2002	Establish plan	Met
Tribally-Operated Health Programs	2007	Maintain	Oct/2007
	2006	Baseline	Oct/2006
	2005	65%	63%
	2004	Baseline	59%
	2003	Pilot sites	N/A
	2000	Pilot sites	N/A
(32) Tobacco Use Assessment: Proportion of patients ages 5 and above who are screened for tobacco use. (Prior to FY 2004, measure was: Support local level initiatives directed at reducing tobacco usage). In FY 2006 measure changes to Tobacco Cessation Intervention: Proportion of tobacco-using patients that receive tobacco cessation intervention. [outcome]	2007	Maintain	Oct/2007
	2006	Baseline	Oct/2006
	2005	27%	34%
	2004	Baseline	27%
	2003	Plan	Met
	2002	Commence	Met
Tribally-Operated Health Programs	2007	Maintain	Oct/2007
	2006	Baseline	Oct/2006
	2005	27%	34%
	2004	Baseline	28%
	2003	N/A	N/A
	2000	N/A	N/A
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3			

Obesity is a risk factor for type 2 diabetes, high blood pressure, asthma, arthritis, coronary heart disease, stroke, colon cancer, post-menopausal breast cancer, endometrial cancer, gall bladder disease, and sleep apnea. Rates of obesity among AI/AN populations exceed the national averages. The target for this measure was to raise the proportion of patients who have BMI (Body Mass Index) calculated from 60% to 65%. This represented an ambitious 5% increase over FY 2005. Despite a significant increase in the rate and overall number of BMI assessments, the agency was unable to achieve a 5% overall increase in one year because of the rise in the overall active user population. In FY 2006, this measure will establish the proportion of children, ages 2-5 years, with a

BMI of 95 percent or higher, with the goal of planning an effective program for childhood weight control.

The use of tobacco represents the second largest cause of preventable deaths for AI/AN people. 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. In FY 2006, this measure changes to measuring rates of tobacco cessation intervention, aimed at reducing tobacco usage in the AI/AN community.

Prevention Measures: HIV / AIDS Group

Measure	FY	Target	Result
(33) HIV Screening: Proportion of pregnant women screened for HIV. (Prior to FY 2005, measure was: Screen for HIV infections in high risk groups at designated sites.) [outcome]	2007	55%	Oct/2007
	2006	55%	Oct/2006
	2005	Baseline	54%
	2004	10 sites	Not Met
	2003	5% increase	.1% increase
	2002	Baseline	Met
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases.			
Data Validation: CRS quality control			
Cross Reference: Healthy People 2010			

The HIV/AIDS epidemic represents a growing threat to American women of childbearing age. HIV infections in newborn children are one potential consequence of higher HIV infection rates among women of childbearing age. Routine prenatal HIV testing of all pregnant women is the best way to avoid transmission of HIV from mother to infant. The IHS has developed guidance regarding universal prenatal HIV testing using the “opt-out” approach, consistent with CDC guidance. Information regarding HIV is included as part of a patient’s prenatal education. As more practitioners adopt opt-out testing, prenatal HIV screening rates should increase.

The target for Measure 33 in FY 2005 was to establish the proportion of pregnant women screened for HIV. The baseline rate was set at 54%. The target for 2006 is to increase this rate.

Prevention Measures: Environmental Surveillance Measure

Measure	FY	Target	Result
(34) Number of tribal programs with automated web-based environmental health surveillance data collection system (webEHRS). [output]	2007	29	Oct/2007
	2006	18	Oct/2006
	2005	12	12
	2004	15	15
	2003	22	22
	2002	10	19
Data Source: Web-based Environmental Health Reporting System (WebEHRS)			
Data Validation: Site inspection			
Cross Reference: HHS Strategic Goals 3, 4			

This measure is directed at reducing environmental threats to health by collecting community information for decision-making. Community environmental health status traditionally has 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.

The FY 2005 target was to have 12 environmental health programs reporting regionally appropriate environmental health priorities based on current community data into webEHRS. This target was met. In FY 2006, the target is for 50 percent more to do so. In FY 2007, the target is for 60 percent more environmental health programs above FY 2006 level to have reported priorities (a total of 29 programs for FY 2007).

Capital Programming / Infrastructure Measures

(35) Sanitation Improvement: Number of new or like-new and existing AI/AN homes provided with sanitation facilities.	2007	22,500	Oct/2007
	2006	22,000	Oct/2006
	2005	20,000	24,072
	2004	22,000	24,928
	2003	15,255	22,750
	2002	15,255	21,225
(35A) Percent of existing homes served by the program at Deficiency Level 4 or above as defined by 25 USC 1632.	2007	20%	Oct/2007
	2006	20%	Oct/2006
	2005		38%
	2004		
	2003		
	2002		
(36) Health Care Facility Construction: Number of health care facilities construction projects completed.	2007	3	Oct/2007
	2006	3	Oct/2006
	2005	21*	15*
	2004	4*	4*
	2003	12*	12*
	2002	10*	10*
Data Source: The SFC Sanitation Deficiency System (SDS) and Project Data System			
Data Validation: Site inspection			
Cross Reference: Healthy People 2010; HHS Strategic Goal 3			

Improved sanitation 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. AI/AN homes are twelve times more likely to be without clean water than other homes in the rest of the U.S.

The FY 2005 target for measure 35 to provide sanitation facilities to 20,000 homes was exceeded by servicing 24,072 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. The targets for FY 06 and 07 assume a 3% increase each year.

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 percent over the old facility. New healthcare facilities help contribute to improved quality of care.

The FY 2005 target for construction was not met. Approximately 80% of the planned health care facilities construction facilities for which funding was provided was completed. Six project phases out of 21 did not meet their 100% target goal in FY 2005 because of delays in the 638 Contract negotiations and the site acquisition process. The timelines have been rescheduled to meet those goals in FY 2006. The Central Southern California Youth Regional Treatment Center project serves several tribes, and no consensus could be reached on a site. The Wagner South Dakota quarters project had its

site removed from consideration by the tribe. The government is working with the tribe(s) to set new target dates on acquiring suitable sites.

*Target and result numbers reflect the number of construction projects being tracked for GPRA purposes. However, because the projects vary dramatically in terms of complexity, cost, and timeline, these numerical targets alone do not provide a meaningful picture of the work represented by this measure. A complete list of projects for any given year is available upon request. Until FY 2005, this measure tracked completion of construction phases on numerous projects. Starting in FY 2006, this measure is simplified to track final completion of projects, which means all phases are completed.

(37) Consultation Improvement Measure: Eliminated in FY 2005.

(38) CHS Procurement Improvement Measure: Eliminated in FY 2005.

Administrative Efficiency, Effectiveness, and Accountability Group

Measure	FY	Target	Result
(39) Public Health Infrastructure: Assess appropriate administrative and public health infrastructure in the Areas. Measure eliminated effective FY 2006; infrastructure review completed in FY 2005. [output]	2007	Eliminated	N/A
	2006	Eliminated	N/A
	2005	Assess 3 additional Areas	Not met
	2004	Add 1 Area	4 th Area assessed
	2003	Assess HQ & 6 areas	Assessed HQ & 3 Areas
	2002	No measure	
Data Source: Data collected by survey instruments developed, tested, and validated by CDC's National Public Health Performance Standards Program (NPHPSP) and adapted for IHS use.			
Data Validation: Collected data will be reviewed against benchmarks developed, tested, and validated by NPHPSP.			
Cross Reference: HHS Strategic Goals 2, 3			

The IHS did not meet this measure in FY 2005. The FY 2005 measure committed to complete a systematic assessment of the public health infrastructure for three additional Area Offices. Assessments have been completed for Headquarters and the Aberdeen, Albuquerque, Tucson, and Navajo Area Offices. This measure will be eliminated in FY 2006 due to limited resources.

(40) Compliance Plans Measure: Eliminated in FY 2004.

(41) Tribal SD Process Measure: Eliminated in FY 2004.

(42) Scholarship Measure: See Treatment Measures.

Health Care Facilities Construction Group

Long Term Goals: Increase proportion of patients with diagnosed diabetes with ideal blood sugar control (H _g A _{1c} <7) within 7 years of opening a new facility. Reduce the YPLL rate within 7 years of opening a new facility.			
Measure	FY	Target	Result
(36A) Diabetes: Ideal Glycemic Control: Proportion of patients with diagnosed diabetes with ideal glycemic control. [outcome]	2007	increase	Oct/2006
	2006	increase	Oct/2006
	2005	baseline	Mar-06
	2004	N/A	N/A
	2003	N/A	N/A
	2002	N/A	N/A
(36B) Pap Smear Rates: Proportion of eligible women who have had a Pap screen within the previous three years. [outcome]	2007	increase	Oct/2006
	2006	increase	Oct/2006
	2005	baseline	Mar-06
	2004	N/A	N/A
	2003	N/A	N/A
	2002	N/A	N/A
(36C) Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. [outcome]	2007	increase	Oct/2006
	2006	increase	Oct/2006
	2005	baseline	Mar-06
	2004	N/A	N/A
	2003	N/A	N/A
	2002	N/A	N/A
(36D) Alcohol Screening (FAS Prevention): Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients. [outcome]	2007	increase	Oct/2006
	2006	increase	Oct/2006
	2005	baseline	Mar-06
	2004	N/A	N/A
	2003	N/A	N/A
	2002	N/A	N/A
(36E) Immunization rates for AI/AN children patients aged 19-35 months. [outcome]	2007	increase	Oct/2006
	2006	increase	Oct/2006
	2005	baseline	Mar-06
	2004	N/A	N/A
	2003	N/A	N/A
	2002	N/A	N/A
(36F) Influenza vaccination rates among adult patients aged 65 years and older. <i>Measure on hold in FY 2005 due to influenza vaccine shortage.</i> [outcome]	2007	increase	Oct/2006
	2006	increase	Oct/2006
	2005	baseline	Mar-06
	2004	N/A	N/A
	2003	N/A	N/A
	2002	N/A	N/A
(36G) Pneumococcal vaccination rates among adult patients aged 65 years and older. [outcome]	2007	increase	Oct/2006
	2006	increase	Oct/2006
	2005	baseline	Mar-06
	2004	N/A	N/A
	2003	N/A	N/A
	2002	N/A	N/A
(36H) Proportion of patients ages 5 and above who are screened for tobacco use. (Prior to 2004, measure was	2007	increase	Oct/2006
	2006	increase	Oct/2006

Support local level initiatives directed at reducing tobacco usage). In 2006 measure changes to Tobacco Cessation Intervention: Proportion of tobacco-using patients that receive tobacco cessation intervention.	2005	baseline	Mar-06
	2004	N/A	N/A
	2003	N/A	N/A
	2002	N/A	N/A
[outcome]			
Data Source: Clinical Reporting System (CRS) extraction of data from local Resource Patient Management System (RPMS) databases; diabetic registries; yearly IHS Diabetes Care and Outcome Audit.			
Data Validation: Annual comparison of New Facility Construction CRS data			
Cross Reference: Healthy People 2010; HHS Strategic Goal 3			

FY 2005 serves as the baseline year for performance measures which document increases in access to services associated with the construction of new health care facilities. Thus FY 2006 will be the first year to document proposed improvements.

Healthcare Cost and Utilization Measures: Efficiency Measures

Efficiency Measure	FY	Target	Result
(43) Urban Indian Health Programs: Cost per service user in dollars per year.	2007	N/A	N/A
	2006	\$601	Oct/2006
	2005	\$579	\$776
	2004	N/A	\$557
	2003	N/A	\$571
	2002	N/A	\$483
(44) Tribally Operated Health Programs: Hospital admissions per 100,000 diabetics per year for long-term complications of diabetes.	2007	129	5/2009
	2006	130.3	5/2008
	2005	N/A	N/A
	2004	N/A	N/A
	2003	baseline	131.6
	2002	N/A	N/A
Data Source: (43) Urban Indian Health Program Common Reporting Requirements (UCRR) data; (44) National Health Disparities Report			
Data Validation: (43) UIH Program; (44) Division of Program Statistics Team			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3			

The target cost per service user in 2005, \$579 was not met. The cost per service user increased to \$776 in 2005 because the number of services needed/rendered/provided active users increased. Many Urban Indian Health Programs leveraged their IHS funding. They received additional funding from other sources such as State, County, and local funding, and they increased patient billing and third party collections.

Tribally Operated Health Programs established a baseline rate for hospital admissions per 100,000 diabetics per year for long-term complications of diabetes. This measure targets the effectiveness of diabetic care indirectly, by assessing hospitalizations for diabetic

complications. The FY 2006 target represents a commitment to reduce admissions by one percent and ultimately reduce the cost of managing diabetic patients.

Quality Assurance of Measures: Tribally Operated Health Programs (TOHP)

Long Term Goal: By 2010 decrease Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) populations served by tribal health programs.			
Measure	FY	Target	Result
(45) Percentage of TOHP’s clinical user population included in GPRA data. [output]	2007	87%	Oct/2006
	2006	86%	Oct/2006
	2005	83%	85.4%
	2004	baseline	78%
	2003	N/A	N/A
	2002	N/A	N/A
(46) Number of designated annual clinical performance goals met.	2007	14/17	Oct/2007
	2006	11/13	Oct/2006
	2005	11/14	11/14
	2004	baseline	7/10
	2003	N/A	N/A
	2002	N/A	N/A
Data Source: Clinical Reporting System			
Data Validation:			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3			

TOHP demonstrated significant improvements between FY 2004 and FY 2005 in two important performance areas. First, the proportion of the AI/AN population served by TOHP for which performance data is voluntarily submitted increased from 78% in FY 2004 to 85.4% in FY 2005. This increase documents the strong commitment to performance management in TOHP.

The second area of improved performance for TOHP is in the actual accomplishment of performance targets. Between FY 2004 and FY 2005, TOHP increase the number of performance measures they were reporting on and increased the success rate in accomplishing the performance measure’s targets by 13%. Some of the improved performance is attributed to a reduction in the growth of the user population from 2.3% in FY 2004 to 1.5% in FY 2005.

Data Measures: Resource Patient Management System (RPMS)

Long Term Goals: Deploy Electronic Health Record (EHR) to all direct sites by 2008.			
Measure	FY	Target	Result
(47) Develop comprehensive electronic health record (EHR) with clinical guidelines for select chronic diseases. [output]	2007	Maintain All	Oct/2006
	2006	Cardiovascular	Oct/2006
	2005	Obesity	met
	2004	HIV/AIDS	not met
	2003	ER/Asthma	met
	2002	N/A	N/A
(48) Number of clinical measures derived from RPMS/number of sites from which this data is available. [output]	2007	38/12	Oct/2006
	2006	38/12	Oct/2006
	2005	37/12	41/12
	2004	37/12	37/12
	2003	34/12	34/12
	2002	18/10	18/10
(49) Number of sites to which electronic health record is deployed. [output]	2007	40	Oct/2006
	2006	40	Oct/2006
	2005	20	20
	2004	N/A	N/A
	2003	N/A	N/A
	2002	N/A	N/A
Data Source: RPMS			
Data Validation:			
Cross Reference: Healthy People 2010; HHS Strategic Goals 1, 3			

The Office of Information Technology was able to meet and surpass the performance goals for RPMS. IHS continues to emphasize the continued development and deployment of the electronic health record. In addition, the suite of RPMS applications has expanded to include additional case management tools, as well as the Clinical Reporting System (CRS). CRS was nationally recognized with the receipt of the Davies Award for Excellence in public health software applications during 2005.

IHS Sanitation Facilities Group

Long Term Goals: By 2010 increase the percent of American Indian/Alaska Native (AI/AN) homes with potable water to 90 percent.			
Measure	FY	Target	Result
Sanitation Facilities Construction: Percentage of AI/AN homes with sanitation facilities. [output]	2007	N/A	N/A
	2006	N/A	N/A
	2005	N/A	88%
	2004	N/A	88%
	2003	N/A	88%
	2002	N/A	92.5
Data Source: The SFC Sanitation Deficiency System (SDS) and Project Data System (PDS).			
Data Validation: Site inspection			
Cross Reference: Healthy People 2010; HHS Strategic Goal 3			

Improved sanitation 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% since 1973. American Indian and Alaska Native homes are twelve times more likely to be without clean water than other homes in the rest of the U.S.

Since 2002, the percentage of homes served with sanitation facilities including potable water facilities annually has generally increased. The 2010 goal of 90% of AI/AN homes being served will depend on the level of funding the program receives relative to the number of new homes constructed throughout Indian Country and stability in the regulatory environment. Changing regulations resulted in the negative change from 2002 to 2003, this along with increased housing construction activity and increasing AI/AN populations since 2003 have resulted in less than 90% of the AI/AN homes having sanitation facilities, although the results for the past three years do not represent progress toward the goal.

CHANGES AND IMPROVEMENTS OVER PREVIOUS YEARS

FY 2007 Performance Plan

The FY 2007 Performance Plan represents our ongoing linkage of annual performance measures to the long-term health outcome goals of the IHS Strategic Plan. This plan and its performance measures are based on our ability to continue to address key external factors influencing success, the level of attainment of related FY 2006 performance measures, and the current proposed funding level.

The FY 2007 Performance Plan includes a total of 35 measures, two of which are efficiency measures. In addition, the number of outcome measures increased by two from the FY 2005 Performance Plan. Although the FY 2006 and FY 2007 performance plans include the same number of measures, recent revisions to the FY 2006 Performance Plan eliminated two measures that were included in the FY 2006 Congressional Justification.

In FY 2007, IHS has included a comprehensive sentinel measure for cardiovascular disease (CVD). By 2010, comprehensive sentinel measures should account for the majority of the proposed budget plan

Revisions to FY 2006 Performance Plan

The change table below shows that this plan reduces the total number of planned measures by one. The table that follows summarizes significant changes in content or magnitude to FY 2006 measures originally submitted with the FY 2006 budget.

Table of Changes to the FY 2006 IHS Performance Measures

Original FY 2006 Measure	Revised FY 2006 Measure	Rationale for Change
<p><u>Diabetes: Ideal Glycemic Control:</u> During FY 2006, maintain the proportion of patients with diagnosed diabetes that have demonstrated ideal glycemic control at the FY 2005 level.</p>	<p><u>Diabetes: Ideal Glycemic Control:</u> During FY 2006, increase the proportion of patients with diagnosed diabetes that have demonstrated ideal glycemic control to 32% (as measured by the Clinical Reporting System).</p>	<p>The FY 2005 target assumed no improvement between FY 2004 and FY 2005, but the results were a 3% increase over FY 2004. The revised FY 2006 target assumes IHS will continue this rate of progress and puts the agency on track to meet its long-term goal of increasing the rate to 40% by 2010.</p>
<p><u>Diabetes: Dyslipidemia Assessment:</u> During FY 2006, maintain the proportion of patients with diagnosed diabetes assessed for dyslipidemia (LDL cholesterol) at the FY 2005 level.</p>	<p><u>Diabetes: Dyslipidemia Assessment:</u> During FY 2006, increase the proportion of patients with diagnosed diabetes assessed for dyslipidemia (LDL cholesterol) to 56% (as measured by the Clinical Reporting System) and 72% (as measured by the Diabetic Audit).</p>	<p>The measure has been changed from maintain to increase and specifies the targeted increase over the 2005 level. IHS has committed to achieve a 10 percent increase in this measure by FY 2007 as part of the "One HHS" 10 Department-wide Management Objectives.</p>

Original FY 2006 Measure	Revised FY 2006 Measure	Rationale for Change
<p><u>Diabetic Nephropathy:</u> During FY 2006, maintain the proportion of patients with diagnosed diabetes assessed for nephropathy at the FY 2005 level.</p>	<p><u>Diabetic Nephropathy:</u> During FY 2006, increase the proportion of patients with diagnosed diabetes assessed for nephropathy to 50% (as measured by the Clinical Reporting System).</p>	<p>The original target assumed no improvement. The revised target will help put IHS on track to meet its long-term goal of increasing the rate to 70% by 2010.</p>
<p><u>Diabetic Retinopathy:</u> During FY 2006, maintain the proportion of patients with diagnosed diabetes who receive an annual retinal examination at the FY 2005 level.</p>	<p><u>Diabetic Retinopathy:</u> During FY 2006, maintain the proportion of patients with diagnosed diabetes who receive an annual retinal examination at designated pilot sites at the FY 2005 level and establish the baseline of patients with diagnosed diabetes who receive an annual retinal examination at all sites.</p>	<p>The original 2006 measure did not specify that the goal was to maintain the proportion of patients receiving an examination at designated pilot sites. The revised measure also adds a target to establish a baseline for screening patients with diagnosed diabetes at all sites.</p>
<p><u>Alcohol Screening (FAS Prevention):</u> During FY 2006, increase the screening rate for alcohol use in females ages 15 to 44 over the FY 2005 rate.</p>	<p><u>Alcohol Screening (FAS Prevention):</u> During FY 2006, increase the screening rate for alcohol use in females ages 15 to 44 to 12%</p>	<p>IHS committed to achieve a 10% increase in this measure over three years as part of the “One HHS” 10 Department-wide Management Objectives. Based on 2005 results of 11%, this measure’s target has been changed to 12%.</p>
<p><u>Fluorides:</u> During FY 2006, increase by 1 percent (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 level.</p>	<p><u>Fluorides:</u> During FY 2006, maintain the number of American Indian and Alaska Native patients receiving at least one topical fluoride application at the FY 2005.</p>	<p>The National Oral Health Council has determined that measuring the number of patients receiving one or more fluoride applications will provide an adequate measure of fluoride program efficacy. The FY 2006 target is also changed to maintain rather than increase the 2005 rate in light of population growth and budgetary considerations</p>
<p><u>Diabetes: Dental Access:</u> Address the proportion of patients diagnosed with diabetes who obtain access to dental services.</p>	<p><u>Diabetes: Dental Access:</u> Eliminated.</p>	<p>The National Oral Health Council has recommended eliminating this measure. The Council determined that the measure Dental Access, which includes diabetic patients, is an adequate measure of access.</p>
<p><u>Domestic (Intimate Partner) Violence Screening:</u> Increase the proportion of women who are screened for domestic (intimate</p>	<p><u>Domestic (Intimate Partner) Violence Screening:</u> Increase the proportion of women who are screened for domestic</p>	<p>IHS committed to achieve a 10% increase in this measure over three years as part of the “One HHS” 10 Department-wide Management</p>

Original FY 2006 Measure	Revised FY 2006 Measure	Rationale for Change
partner) violence at health care facilities over the FY 2005 level.	(intimate partner) violence at health care facilities to 14%.	Objectives. Based on 2005 results of 13%, this measure's target has been changed to 14%.
<u>Behavioral Health:</u> This measure was not defined in the final FY 2006 Congressional Justification.	<u>Behavioral Health:</u> During FY 2006, establish a baseline rate of annual screening for depression in adults ages 18 and over collected from the behavioral health and other RPMS software packages.	This revision meets the stated objective for a new 2006 measure by utilizing the enhanced functionality in the IHS Integrated Behavioral Health software application to reflect patient outcomes.
<u>Urban IS Improvement:</u> During FY 2006, IHS will establish baseline participation in urban data sharing.	<u>Urban IS Improvement:</u> During FY 2006, increase the number of urban sites reporting clinical GPRA performance measures through the national clinical reporting process from 2005 levels.	IHS analyzed GPRA 2004 and 2005 results and identified urban programs that submitted data, establishing a baseline level from which to track progress.
<u>Scholarships:</u> During FY 2006, 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.	<u>Scholarships:</u> During FY 2006, IHS will increase its efficiency in placing Health Profession Scholarship recipients in Indian Health setting within 90 days of graduation to 2% over the FY 2005 level.	The revision corrects the basis of comparison from 2004 to 2005 results and specifies the amount of increase over the 2005 level that is the target for 2006.
<u>Public Health Nursing:</u> This measure was not defined in the final FY 2006 Congressional Justification.	<u>Public Health Nursing:</u> During FY 2006, implement a data system capable of recording the time spent and nature of public health activities other than one-on-one patient care, with an emphasis on activities that serve groups or the entire community.	This measure has been modified to emphasize the Public Health Nursing contribution to public health in terms of communities and groups, which has a broader impact on health promotion and disease prevention than provision of one-on-one patient care.
<u>Adult Immunizations:</u> <u>Influenza:</u> In 2006, maintain the rate for influenza vaccination levels among adult patients ages 65 years and older.	<u>Adult Immunizations:</u> <u>Influenza:</u> In 2006, maintain the rate for influenza vaccination levels among adult patients ages 65 years and older at the 2005 rate of 59%	The 2006 target has been changed from maintain to a specific target of 59%, which is the rate reporting clinics achieved in 2005, although the measure was "on hold" due to a vaccine shortage.
<u>Adult Immunizations:</u> <u>Pneumovax:</u> In 2006, maintain the rate for pneumococcal vaccination levels among adult	<u>Adult Immunizations:</u> <u>Pneumovax:</u> In FY 2006, increase the rate for pneumococcal vaccination levels among adult patients	The 2006 target has been changed in order to achieve a 10 percent increase over three year as part of the "One HHS" 10 Department-

Original FY 2006 Measure	Revised FY 2006 Measure	Rationale for Change
patients ages 65 years and older.	ages 65 years and older to 72 percent.	wide Management Objectives.
<p><u>CVD Prevention: Cholesterol:</u> In 2006, increase the proportion of patients ages 23 and older who receive blood cholesterol screening over the FY 2005 rate.</p>	<p><u>CVD Prevention: Cholesterol:</u> In 2006, increase the proportion of patients ages 23 and older who receive blood cholesterol screening to 44%.</p>	<p>The 2005 target for this measure was to establish a baseline. Now that the baseline of 43% has been established, this target has been changed to a specific target of 44%.</p>
<p><u>Obesity Assessment:</u> During FY 2006, decrease the obesity rates in children, ages 2-5 years.</p>	<p><u>Childhood Weight Control:</u> During FY 2006, establish a baseline for children, ages 2-5 years, with a BMI of 95 percent or higher.</p>	<p>The final FY 2006 Congressional Justification stated that this measure was under review. The revision provides a more accurate name and reflects the need to establish the size of the target population, in order to plan an effective program for childhood weight control.</p>
<p><u>Prenatal HIV Screening:</u> In FY 2006, increase the proportion of pregnant female patients screened for HIV.</p>	<p><u>Prenatal HIV Screening:</u> In FY 2006, increase the proportion of pregnant female patients screened for HIV to 55%.</p>	<p>The 2005 target for this measure was to establish a baseline. Now that the baseline of 54% has been established, this target has been changed to include a specific target of 55%.</p>
<p><u>Sanitation Improvement:</u> During FY 2006, provide sanitation facilities projects to 20,000 Indian homes with water, sewage disposal, and/or solid waste facilities.</p>	<p><u>Sanitation Improvement:</u> During FY 2006, provide sanitation facilities projects to 22,000 Indian homes with water, sewage disposal, and/or solid waste facilities.</p>	<p>The original target for FY 2006 projected serving 12% fewer homes than were served in FY 2005. The new target represents a 10% improvement in the goal.</p>
<p><u>Health Care Facility Construction:</u> 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:</p> <ul style="list-style-type: none"> 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, 	<p><u>Health Care Facility Construction:</u> During FY 2006, complete construction of replacement health centers at Red Mesa, AZ, St. Paul, AK, and Metlakatla, AK.</p>	<p>The previous 2006 measure tracked completion of construction phases on numerous projects. The revised measure is simplified to track final completion of projects, which means all phases are completed.</p>

Original FY 2006 Measure	Revised FY 2006 Measure	Rationale for Change
<p>Komatke, AZ – complete planning and commence design of new satellite health center.</p> <p>d. Barrow, AK – complete site acquisition and design of replacement hospital.</p> <p>e. Red Mesa, AZ – complete construction of new health center and supporting staff quarters.</p> <p>f. St. Paul, AK – complete construction of replacement health center and supporting staff quarters.</p> <p>g. Metlakatla, AK – complete construction of replacement health center and supporting staff quarters.</p> <p>h. Sisseton, SD – continue construction of a replacement health center and supporting staff quarters.</p> <p>i. Clinton, OK – continue construction of replacement health center.</p> <p>j. Eagle Butte, SD – commence design of replacement health center.</p> <p>k. Kayenta, AZ – prepare to commence design of replacement health center.</p> <p>l. San Carlos, AZ – prepare to commence design of replacement health center.</p> <p>m. Zuni, NM – complete design and construction of staff quarters supporting existing health care facility.</p> <p>n. Wagner, SD – continue design and construction of staff quarters supporting existing health care facility.</p> <p>o. Ft. 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> <p>p. Phoenix-Nevada Youth Regional Health Center (YRTC) – continue construction of this satellite YRTC.</p> <p>q. Central-Southern California YRTC – continue site acquisition.</p> <p>r. Northern California YRTC –</p>		

Original FY 2006 Measure	Revised FY 2006 Measure	Rationale for Change
<p>continue site acquisition.</p> <p>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.</p>		

THIS PAGE LEFT BLANK INTENTIONALLY