# Alaska Area

# 2004

# Annual Performance Contract

## P.L. 93-638 Area

U.S. Department of Health & Human Services
Indian Health Service
Alaska Area Native Health Service
Christopher Mandregan, Jr., MPH, Director
4141 Ambassador Drive, Suite 300
Anchorage, Alaska 99508

| Alaska Area IHS; Christopher Mandregan. Jr., MPH, Area Director | | FY 2003 Performance | FY 2004 Performance/Accomplishment | N/A | Met/Partially Met/Not Met |
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| **A. MAXIMIZE TOTAL RESOURCES** Provide leadership and support to Area Indian health programs so that systems are in place and efforts are directed to maximize total resources available to the Agency to carry out its mission and goals. | | | | | |
| A1. | Facilitate and support systems and manpower necessary for tribal collections of M/M/PI resources. | In accordance with the terms of the CMS/IHS mutual operating agreement, the Alaska Area IHS maintains a list of facilities that are eligible for 100% FMAP. The State of Alaska Division of Medical Assistance gives Medicaid billing privileges to Alaska tribes only if their facilities are on the CMS/IHS list. During FY 2004 negotiations, the Alaska Area collaborated with the Alaska tribes, IHS Headquarters and the State of Alaska to define and minimize the impact of P.L. 93-638, Section 505 on the ability of tribes to collect 100% FMAP. There are 324 facilities on the Alaska CMS/IHS list, while other IHS areas have between 19 and 89 facilities on their lists. | | | |
| A2. | Demonstrate active efforts and actual accomplishments to increase total contributions from external sources made to Area ITU health programs. | Collaboration between the Alaska Area IHS and other agencies have made the following funds available for tribes: $11,320,874 for 18 Environmental Protection Agency Safe Drinking Water Act and Clean Water Act projects; $50,111,840 for 41 State of Alaska Village Safe Water Program projects; $6,482,114 for 3 Department of Transportation projects. The Alaska FY 2004 baseline for contributions from external sources is $67,914,828. | | | |
| A3. | Describe activities and efforts to share information and collaborate with the Veterans Health Administration as described in the 2/25/2003 MOU. | The Alaska Area IHS orders pharmaceuticals for 16 tribally managed hospitals and clinics through VHA's AmeriSource Corporation prime vendor contract. This contract provides for on-line ordering and next day delivery, including the most rural areas of Alaska, at considerable savings to tribes. Pharmaceuticals ordered through the VHA prime vendor contract totaled $21 million in FY 2003 and $26 million in FY 2004. The Alaska Area Director escorted the VHA Under Secretary for Health on a tour of IHS-funded programs in rural Alaska, and conducted orientation on the Alaska Native health system and a tour of the Alaska Native Medical Center for VHA's VISN 20 Director. | | | |
| A4. | Support and participate in DHHS regional consultations and other DHHS activities to support increased resources to address the health needs of Indian communities. | The Alaska Area IHS and 26 Alaska Tribes participated in a DHHS tribal consult in Portland on March 23 and 24, 2004. The FY 2004 Tribal/Alaska Area budget formulation session was held at that time. Alaska tribal participants created two lists of budget priorities to acknowledge the split between "budget line item priorities" and "health priorities". Contract health services and sanitation facilities were moved to the new "budget line item" priority list, while diabetes and mental health care stayed on the "health" priority list. The Alaska Area IHS is also represented on the Alaska Medicaid Task Force to consult with the Centers for Medicare and Medicaid Services (CMS) and tribal business office managers. | | | |

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| A5. Demonstrate efforts to identify alternative resources and financing mechanisms to address Area facility and equipment needs. | The Barrow and Norton Sound Hospital replacement projects both received $500,000 in design funds from the Denali Commission. The Denali Commission asked the Alaska Area IHS to be the reviewing authority for the hospital plans. Technical advice and assistance from Alaska Area staff helped get the funding for the Barrow hospital site into the Senate Mark for FY 2005. The Alaska Area IHS succeeded in getting a delegation of authority from the ASH, DHHS, to accept a gift of real property, thereby facilitating construction of the Community Mental Health Center in Dillingham, AK funded by the Denali Commission and HUD. IHS Tribal Equipment funds totaling $3.8 million were committed to 23 tribal locations building new health facilities. Construction costs totaled $29.6 million in non-IHS funds. The Alaska Area IHS facilitated the leveraging of IHS biomedical equipment funding to encourage the building of health facilities in rural Alaska using non-IHS funds. For every $1 in IHS funds, $8 in construction funds were identified. | | | |
| **B. IMPROVE HEALTH SYSTEMS**<br>Facilitate and support Area Indian health programs so that systems are in place to provide high-quality, easily accessible, preventive and primary health care services and that there is ongoing focus on improving the delivery of health care. | | | | |
| B1. Facilitate and support activities that assist Area Indian health programs to achieve objectives similar to the following objectives for IHS programs: | | | | |
| B1a. Improve the level of CHS procurement of inpatient and outpatient hospital services for routinely used providers by at least 1% over the 2003 level of the total dollars paid to contract providers or rate quote agreements at the IHS-wide reporting level. | Since January 1999, all Alaska Area CHS programs have been tribally managed. All current CHS providers have contracts with Alaska tribes. A number of the programs have contracts with frequent providers, and some programs have provider agreements modeled on IHS rate-quote agreements. | | | |
| B1b. Ensure that Medicare and Medicaid Compliance Plans are in place in 100% of IHS-operated hospitals and clinics to ensure that claims are processed in accordance with CMS payment requirements. | Compliance plans are in place at all tribal hospitals in Alaska. Most tribal clinics have compliance staff, committees, structure and written plans to meet the compliance guidelines for physician clinics. Clinic sites are at different phases of implementation. | | | |

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| B1c. | In Areas with IHS hospitals with low average daily patient levels, demonstrate active efforts to explore alternative delivery mechanisms to achieve cost savings. | The Alaska Area IHS has explored, with Headquarters and tribal staff, the design and staffing specifications for two small rural hospitals in Barrow and Norton Sound. The current hospital models do not seem to be a good fit for either of those hospitals, and we have provided our input into the new IHS health system planning modules for small rural hospitals. | | | |
| **Actions in Support of IHS Initiatives** | | | | | |
| B2. | Enhance personnel performance and address future personnel needs by demonstrating an investment of at least 2.5% of the cost of salaries and benefits in appropriate training to enhance current performance and to ensure required competencies in the future. | The Alaska Area spent 2.8% of the cost of salaries and benefits during FY 2003 for training. | The Alaska Area spent 3.17% of the actual cost of salary and benefits on training during FY 2004. A spreadsheet from the Alaska Area Office of Finance is available to further document these expenditures and costs. | | |
| B3. | Facilitate, support and where possible, invest in efforts to improve information infrastructure and describe the resulting enhancement to the health care system. | With the assistance of the Alaska Area, the IHS Headquarters Statistics Team met with Alaska tribal organizations that have been allowed adjustments to their user populations in past years. Some tribal organizations were given individual technical assistance in fixing their RPMS data system, and/or in preparing data interfaces with the IHS systems. All tribal organizations were invited to an IHS consultation on Dr. Grim's decision that user population adjustments will no longer be granted. | | | |
| B4. | Complete an Area Health Services and Facility Master Plan. | The Alaska Native Tribal Health Consortium published a draft of the Alaska Area Health Services Master plan in July 2004. It is expected that the final document including both the services plan and a measure of unmet need for health facility space in Alaska will be completed by the end of the fiscal year. The plan will vastly exceed the minimum standards established by IHS Headquarters. | | | |
| B5. | Facilitate and support activities that enhance the physical capacity of health care facilities in the Area (inclusive of GPRA Indicator #35). | In July 2004, the DHHS Secretary delegated to the IHS Director the authority to accept the gift of a mental health facility from the Bristol Bay Area Health Corporation (BBAHC). The Area Director's intervention prevented a loss of these funds, which almost resulted from delays in getting the delegation of authority. The Alaska Area's work on developing awareness of the need for such delegations and a process for expediting them will continue to pay dividends in the expansion of facility capacity. Many such "gifts" will continue to be proposed by tribal organizations. | | | |
| B6. | Provide support to Area programs so that systems and programs are in place to maintain 100% accreditation of Area IHS-operated health care facilities (GPRA Indicator #19). | All of the seven (7) tribally-managed hospitals in Alaska are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). One Alaska tribal clinic is accredited by JCAHO, and two tribal clinics are accredited by the Accreditation Association for Ambulatory Healthcare (AAA). | | | |

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| B7. Provide leadership and assistance to support compliance with HIPAA requirements for 100% of Area Indian health programs. | The Alaska Area IHS coordinates the dissemination of HIPAA related information to Alaska tribes. There are no Indian Health Service direct care facilities in the Alaska Area, and tribes has responsibility for HIPAA compliance. | | | |
| B8. Support the use of telemedicine at, at least, one site. | The Alaska Federal Health Care Access Network has worked with Alaska's private sector to support 8 new telemedicine projects in Alaska during FY 2004. There are now 248 federal health care sites in Alaska. The network includes the IHS, US Coast Guard and Dept of Defense. | | | |
| **C. PROVIDE LEADERSHIP AND DIRECTION ON PRESIDENTIAL, DEPARTMENT, AND AGENCY INITIATIVES WHICH SUPPORT IMPROVEMENTS TO MANAGEMENT SYSTEMS.** Support and promote all major One-Department Management Goals, and in particular will provide assistance and support to Area Indian health programs to enable them to meet the following objectives: | | | | |
| C1.1. Support the IHS Workforce Plan objectives by providing assistance to Area Indian health programs to reduce position vacancy rates of the high priority occupations (Dental, Optometry, Pharmacy, Nursing, Physicians) by 5%, reduce the time-to-hire to 120 days, and improve to 20% the number of hires retained after 6 months. | Since FY 2001, the Alaska Area Office has recruited dentists, dental hygienists, physicians, physician assistants and nurse practitioners to work for tribal health organizations under federal personal service contracts (PSC's). This process meets the needs of providers who are unsure of their interest in rural Alaska, and are unwilling to undergo the State licensure process. Forty-four (44) high priority PSC's were awarded in FY 2003 and forty-nine (49) in FY 2004. An additional 14 volunteer dentists were placed with tribal health organizations through federal volunteer contracts negotiated by the Alaska Area IHS. Also during FY 2004, the Alaska Area hosted "Operation Arctic Care" in conjunction with the Departments of the Army, Navy and Air Force to provide care to the medically underserved villages in the Kotzebue and Norton Sound regions. Operation Arctic Care provided 1,412 medical encounters, 922 dental encounters, 746 optometry encounters and 6,487 veterinary encounters to 15 villages. | | | |
| C1.2. Support and promote recruitment and retention activities to increase by 12% the number of Commissioned Officers in the Area. | The Alaska Area IHS increased the number of Commissioned Officers assignments from 298 on October 1, 2003 to 304 on September 1, 2004. | | | |
| C2. Cascade appropriate portions of the FY04 Performance Contract into the performance elements of the Area Office and Service Unit staff with expected outcomes that support the Director's Performance Contract and other performance objectives. | Appropriate portions of the FY 2004 Area Director's Performance Contract were cascaded into the performance objectives of all forty-one (41) Alaska Area staff. | | | |

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| C3. | Demonstrate support for public affairs activities that provide public visibility for the accomplishments of the IHS. | The Alaska Area IHS successfully fulfilled the Office of the Secretary (OS), DHHS, request for logistical coordination of Secretary Thompson's July 2004 visit to Alaska. Alaska Area planned and coordinated logistics with OS, tribal and community leaders, and notified local press of the Secretary's press conferences. The Area Director coordinated a Tribal Leader's breakfast in which Secretary Thompson met with tribal leaders to discuss priorities and needs. Hotels and charter aircraft for 18 Departmental senior staff were procured by the Area. These tasks were previously performed by OS, DHHS. The Area Director served as ceremonial co-chair of the 2004 National Commissioned Officers Association Conference in Anchorage. Alaska Area IHS arranged a ceremony in which the Director, IHS promoted 8 Commissioned Officers and presented awards to 6 Commissioned Officers. The Alaska Area Director and Lead Negotiator were quoted in news stories about the effects of IHCIA 813(b) on tribal health programs. Stories were carried by the Alaska Public Radio Network, the Anchorage Daily News, the Fairbanks News Miner and the Sitka Daily Sentinel. | | | |
| C4. | Implement restructuring within the Area to implement the Agency plan for consolidation of Human Resource activities. | Alaska Area IHS continued its intra-agency agreement with the Portland Area for consolidation of Commissioned Officer personnel services. The Alaska, California and Portland Area Directors and Human Resource Officers all met in February 2004 to develop and implement a plan to regionalize the HR function. The resulting "Western Region-HR" plan was the first to be implemented in the IHS. The Western Regional HR Director position has been advertised and interviews are imminent. | | | |
| C5. | Support the efficient, effective and equitable transfer of the management of health programs to tribes under the Indian Self-Determination Act by providing technical assistance to 100% of tribes submitting letters of intent or contract/compact proposals, and with specific technical assistance provided in determining Contract Support Costs. | No new PL 93-638 proposals were received during FY 2004 because of the moratorium on Title I contracting by individual tribes in Alaska. The moratorium (Section 326 of PL 105-83) remains in effect through September 30, 2004, and is proposed to be made permanent in the FY 2005 Senate Mark. Alaska continues to set the agency standard in tribal self-governance, having negotiated new Title V funding agreement language, with national implications, under the Alaska Tribal Health Compact (ATHC). This language enables tribes to operate or pay for nursing home services under funding agreements with the IHS. Other language was successfully removed from ATHC funding agreements that described programs, services, functions and activities not authorized for inclusion in funding agreements under PL 93-638, Title V, Section 505. The Alaska Area continues to provide personnel and PL 93-638 expertise to the Navajo Area IHS for assistance with Title I renewal negotiations, contract support cost negotiations and the negotiation of a new Title I contract award with the Navajo Health Foundation (Sage). | | | |

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| | | In FY 2004 Alaska Area staff consulted with 40 Title I and Title V tribes and tribal organizations regarding preparation of the FY 2003 Shortfall Report. This consultation included the sharing of drafts, revisions and discussions regarding the applicability of indirect rates, bases and exclusions. Area staff negotiated and reviewed indirect type costs with 6 organizations that do not have formally negotiated indirect rates. Several tribal organizations consulted with the Area regarding treatment of contract support costs when programs transfer from one entity to another. Area staff participated in negotiation of a revised base and rate for one tribal consortia where there was a need to offset for duplication between program funding and contract support costs. Alaska Area IHS continued to provide expertise to the Navajo Area IHS on contract support cost negotiations. | | | |
| C6. | Ensure that audit findings for tribal and urban programs brought to the Area's attention by the office of Nation External Audit Review (NEAR) are addressed within required timelines, and that letters of determination are issued and technical assistance provided to tribes and correct against future findings. | Alaska Area IHS received 19 Title I audits and 21 Title V audits during FY 2004. Letters of determination were issued within the required timelines. For the three (3) audits that were not received, audit resolution staff sent letters to each tribe or tribal organization advising them that sanctions might be imposed if audits were not submitted. | | | |
| C7. | Ensure that by the end of FY04, at least one performance-based contract is in place in the Area. | All Alaska Native programs, services, functions and activities are managed by tribes pursuant to P.L. 93-638. Consequently, there have been no procurement requirements conducive to awarding commercial contracts subject to performance based contracting criteria. | | | |
| C8. | Contribute to the successful outcome of the FY04 IHS Accountability Report by ensuring that administrative systems and internal controls are in place for sound fiscal management including the following: | Alaska Area IHS conducted 20 self-assessments, and IHS Headquarters staff conducted two (2) reviews during FY 2003. Two (2) corrective action plans were submitted. | Alaska Area IHS conducted 17 self-assessments during FY 2004. One assessment resulted in three (3) deficiencies requiring a corrective action plan. The deficiencies were all related to senior contracting officer audit resolution training and have been addressed in a single CAP. | | |

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| C8.1. | Ensure that complete and current real and personal property management records are in place and that inventories of personal property are performed annually at all IHS facilities. | **Personal Property**. Alaska Area IHS has some 500 vehicles in its personal property inventory, all of which are in the possession of, and used by, Alaska tribal organizations. Virtually all of these vehicles are physically located in remote Alaska villages, for use in sanitation facilities projects. On September 23, 2004, the Office of General Counsel issued a legal opinion that government vehicles in the Alaska are not subject to reporting requirements, with the exception of 20+ vehicles in Anchorage. **Real Property**. As part of its funding agreement, the Alaska Native Tribal Health Consortium (ANTHC) receives maintenance and improvement (M&I) funds in support of eligible IHS and tribally owned facilities. In a joint effort during FY 2004, the ANTHC and the Alaska Area IHS developed a tribal reporting process for capital improvements. Since acceptance of the process by all parties, the ANTHC has reported $5 million in capital improvements and is continuing to submit final closeouts reports. | | | |
| C8.2. | Ensure that the Area as a whole, and all IHS direct operated Area facilities operate within FY04 allowances and budgeted fiscal targets including those for travel and Contract Health Services. | Alaska Area IHS will close the fiscal year within its FY 2004 allowances. Most funds allocated to the Area are awarded and paid to tribes via Title I contracts and Title V compacts. Contract Health Services funds are paid directly to tribal organizations in Alaska, and managed at each location. In addition to operating within its allowances, the Alaska Area IHS reduced its operating budget by consolidating office space. Savings of $598,331 in rental expenses were transferred to Alaska tribes, and used to increase funds available for tribal programs, services, functions and activities. | | | |
| C9. | Provide technical assistance and support to Area Indian health programs to utilize insure that systems are in place in IHS facilities so that necessary background checks and the checking of credentials is completed for all health care provider candidates to prevent employment of unsuitable individuals. | Background checks were completed to ensure that all federal personal service contractors meet the requirements of P.L. 101-630, the Indian Child Care Protection Act. The Alaska Native Tribal Health Consortium added several positions to their list of positions covered under P.L. 101-630. This prompted additional CNACI background investigations, which in turn, identified three (3) individuals as ineligible for employment in their positions. After attempts to reassign them failed, they were separated from employment. | | | |
| **D. MAXIMIZE TOTAL RESOURCES**<br>Provide leadership and support to Area Indian health programs so that systems are in place and efforts are directed to maximize total resources available to the Agency to carry out its mission and goals. | | | | | |
| Indicator 2 | Increase the proportion of patients with diagnosed diabetes that have demonstrated improved glycemic control by 1% over the FY03 level. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 36.6% of Alaska Native diabetic patients had good glycemic control, and 9% had poor glycemic control in FY 2003. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 36.3% of Alaska Native diabetic patients had good glycemic control, and 8% had poor glycemic control in FY 2004. | | |

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| Indicator 3 | Increase the proportion of patients with diagnosed diabetes that have achieved blood pressure control by 1% over the FY03 level. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 36.1% of Alaska Native diabetic patients achieved blood pressure control in FY 2003. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 36.1% of Alaska Native diabetic patients achieved blood pressure control in FY 2004. | | |
| Indicator 4 | Increase the proportion of patients with diagnosed diabetes assessed for dyslipidemia by 1% over the FY03 level. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 61.8% of Alaska Native diabetic patients were assessed for LDL cholesterol in FY 2003. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 60.5% of Alaska Native diabetic patients were assessed for LDL cholesterol in FY 2004. | | |
| Indicator 5 | Increase the proportion of patients with diagnosed diabetes assessed for nephropathy by 1% over the FY03 level. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 51.1% of Alaska Native diabetic patients were assessed for nephropathy in FY 2003. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 49.1% of Alaska Native diabetic patients were assessed for nephropathy in FY 2004. | | |
| Indicator 6 | At designated sites, the proportion of patients with diagnosed diabetes who receive an annual diabetic retinal examination will increase by 3% over the FY03 rate. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 55.2% of Alaska Native diabetic patients had a retinal exam in FY 2003. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 52.3% of Alaska Native diabetic patients had a retinal exam in FY 2004. | | |
| Indicator 7 | Maintain the proportion of eligible women patients who have had a Pap screen within the previous three years at the FY03 level. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 69.7% of Alaska Native women had a Pap screening during FY 2003. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 66.3% of Alaska Native women had a Pap screening during FY 2004. | | |
| Indicator 8 | Maintain the proportion of eligible women patients who have had mammography screening within the last two years at the FY03 level. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that, in FY 2003, 55.9% of Alaska Native women had a mammogram within the last two years. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that, in FY 2004, 56.1% of Alaska Native women had a mammogram within the last two years. | | |
| Indicator 12 | Maintain the proportion of patients that obtain access to dental services at the FY03 level. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 37.2% of Alaska Native patients received dental services during FY 2004. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 35.6% of Alaska Native patients received dental services during FY 2004. | | |
| Indicator 13 | Maintain the number of sealants placed per year in AI/AN children at the FY03 level. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 11,682 dental sealants were placed during FY 2003. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 10,380 dental sealants were placed during FY 2004. | | |

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| **D2** | **Provide leadership and support to assist Area Indian health programs to meet the following GPRA indicators which measure preventive health interventions:** | | | | |
| Indicator 10 | Establish a baseline rate for alcohol screening in a defined group of female patients of childbearing age. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 9.2% of eligible Alaska Native women were screened for alcohol in FY 2003. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 13.7% of eligible Alaska Native women were screened for alcohol in FY 2004. | | |
| Indicator 11 | Increase the proportion of AI/AN population receiving optimally-fluoridated water by 1% over the FY03 levels of all IHS Areas. | In FY 2003, 46,957 Alaska Natives had access to fluoridated community water systems. | In FY 2004, 47,047 Alaska Natives had access to fluoridated community water systems. | | |
| Indicator 15 | Address domestic violence, abuse and neglect by screening at least 15% of eligible women patients between the ages of 16-24 for domestic violence at direct care facilities. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 2.2% of eligible Alaska Native women were screened for domestic violence in FY 2003. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 7.2% of eligible Alaska Native women were screened for domestic violence in FY 2004. | | |
| Indicator 20 | Establish baseline data for medication error reporting for all IHS Areas, and pilot test a standardized medication error reporting system in two additional Areas. | Alaska Area is not a pilot test for a standardized medication error reporting system. | | | |
| Indicator 23 | Establish baseline FY04 rates for recommended immunizations for AI/AN children 19-35 months, and increase 3-27 month rates by 2% over FY03. | This information is not available through the GPRA+ (CRS) software. The Alaska Native Tribal Health Consortium immunization coordinator keeps her own records of childhood immunization rates, and shares that information with the IHS immunization coordinator. | | | |
| Indicator 24 | Maintain FY03 influenza vaccination rates among non-institutionalized adult patients aged 65 years and older. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that the influenza vaccination rate for Alaska Native elders was 50.2% in FY 2003. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that the influenza vaccination rate for Alaska Native elders was 50.2%. | | |
| Indicator 25 | Maintain the FY03 rate for pneumococcal vaccination levels among non-institutionalized adult patients age 65 years and older. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that the pneumococcal vaccination rate for Alaska Native elders was 83.8% in FY 2003. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that the pneumococcal vaccination rate for Alaska Native elders was 85.7% in FY 2004. | | |

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| Indicator 26 | Maintain at least 36 community-based, proven injury prevention projects across ITU settings. | The Alaska Native Tribal Health Consortium had four (4) community-based proven injury prevention projects in both FY 2003 and 2004. The programs are: 1) Child Passenger Safety Initiative - 1,000+ car seats distributed in both years; 2) Safe Firearm Storage - 200 gun safes distributed through tribal/state collaboration; 3) Kids Don't Float - child floatation jackets available at all harbors/boat launches for public use; 4) Smoke Alarm project - 750 smoke alarms installed each year. | | | |
| Indicator 27 | Reduce death rates caused by unintentional injuries to no higher than the FY03 level. | This rate is determined by the Headquarters GPRA coordinator. | | | |
| Indicator 29 | Support clinical and community-based cardiovascular disease prevention initiatives through the addition of one pilot site and appropriate evaluation of the pilot projects. | An IHS funded cardiovascular disease prevention program is provided in Dillingham, Alaska (Bristol Bay). Other tribal funded cardiovascular disease programs are provided by Southcentral Foundation and Southeast Alaska Regional Health Consortium. | | | |
| Indicator 30 | Establish baseline omission rates for BMI on children and adults. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that the BMI omission rate for Alaska Natives was 58% in FY 2003. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that the BMI omission rate for Alaska Natives was 50.1% in FY 2004. | | |
| Indicator 31 | Establish baseline screening rates for tobacco use. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 54.7% of Alaska Native patients were assessed for tobacco use in FY 2003. | The Area Aggregate GPRA+, Version 3.1 (August 2004) indicates that 63.3% Alaska Native patients were assessed for tobacco use in FY 2004. | | |
| Indicator 33 | Increase the number of active tribal user accounts for the automated Web-based environmental health surveillance system by 15% over the FY03 level for American Indian and Alaska Native tribes not currently receiving direct environmental health services. | Five (5) Alaska Tribes used the web-based surveillance system in FY 2003. | Six (6) Alaska Tribes used the web-based surveillance system in FY 2004. | | |
| Indicator 34 | Contribute to the national goal of providing sanitation facilities projects (water, sewage disposal, and/or solid waste facilities) to 20,000 Indian homes. | In FY 2003, Alaska's tribally operated DEHE provided 4,093 homes with water and 3,004 homes with wastewater facilities. | In FY 2004, Alaska's tribally operated DEHE provided 1,268 homes with water facilities and 1,749 homes with wastewater facilities. | | |

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| D3. | Encourage and support Tribal development and implementation of an Area health promotion/disease prevention plan that identifies long term goals and objectives, and incorporates activities identified as prevention benchmarks by the IHS Preventive Taskforce. | Funds to support the Alaska Native Tribal Health Consortium (ANTHC) Health Promotion and Wellness Coordinator position have been approved by the IHS HP/DP coordinator. The scope of work was added to the ANTHC FY 2005 funding agreement. The Alaska Area Director served as moderator of the IHS HP/DP Summit in Washington, D.C., and secured co-sponsorship of the Summit from a private organization. | | | |
| D4. | Provide support in the Area for Headquarters activities to achieve the following national GPRA indicators and performance contract objectives: | | | | |
| Indicator 16 | Implement a national program to improve the quality, accuracy, and timeliness of RPMS Patient Care Component (PCC) data to support the Agency's GPRA clinical measures by providing data quality training in each Area. | Basic training to meet the objective of "improving the information infrastructure for IHS initiatives" was provided to 30 Alaska tribal individuals in October 2003. The training was financed by the IHS Information Technology Service Center (ITSC) and provided by Pat Ramsey and Associates. Since then, members of the Alaska Area GPRA Pilot Project, the Area Office, the IHS ITSC, and Pat Ramsey and Associates have designed an advanced "train the trainer" data quality class, which was offered to 15 tribal individuals in September 2004. There is a perpetual need for data quality training due to high turnover of data entry and medical records staff, and the class is designed to create a self-sustaining Area data quality training team. | | | |
| Indicator 17 | Improve the Behavioral Health Data System by assuring at least an additional 5% of the programs will report minimum agreed to behavioral health related data warehouse. | Maniilaq Association in Kotzebue is using the IHS Behavioral Health Data System. Other Alaska Tribes use a behavioral health data system required by the State of Alaska. | | | |
| D5. | Encourage and support the installation and implementation of the electronic health record system at a minimum of two beta test sites. | The electronic health record system (EHR) has been installed at two Alaska tribal facilities, the Maniilaq Medical Center in Kotzebue and the Chief Andrew Isaac Health Center in Fairbanks. The EHR will be implemented in those two sites in the first quarter FY 2005. Alaska Area IHS provided $85,000 to Chief Andrew Isaac, and $120,000 to Maniilaq in support of their EHR implementation. Corresponding spending plans have been submitted. | | | |

Status Report on Performance Contract Achievements and Progress - Alaska Area Indian Health Service

**Significant Accomplishments for FY 2004**

**Christopher Mandregan, Jr., MPH, Alaska Area Director**

With DHHS and IHS initiatives and performance plans as a basis, the Alaska Area IHS worked in partnership with the Alaska Native Tribes it serves to achieve significant accomplishments in providing primary and preventive health care services to support the DHHS' commitment to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the sovereign rights of Tribes.

**Accomplishment** 1: The Director, Alaska Area IHS is a national leader in the Department's implementation of the Indian Self Determination and Education Assistance Act, PL 93-638, as amended. As such, the Alaska Area Director demonstrates *executive leadership* that is *proactive and customer-responsive*. For example, the Alaska Area Director used a high degree of *business acumen* to successfully complete extremely difficult Alaska Tribal Health Compact (ATHC) negotiations. The ATHC not only sets forth terms for utilization of over $450 million in agency resources in Alaska, they also directly impact subsequent negotiations with American Indian tribes nationwide. Citing recently promulgated regulation and Office of General Counsel, DHHS opinion, IHS refined its position on what program descriptions are allowable in tribal funding agreements. This required the Alaska Area Director to seek removal from tribal funding agreements, all programs, services, functions and activities (PSFA) which are not PSFAs of the IHS. The potential financial consequences for both parties were great because PSFAs must be in the funding agreement to receive Federal Tort Claims Act coverage. The Alaska Area IHS negotiating team succeeded through intense negotiation and *coalition building/communication*, in removing and clarifying unallowable and ambiguous program descriptions. Negotiations were conducted externally with tribes, and internally with IHS program officials and HHS attorneys, and illustrate this Director's ability to *lead people* to a "win-win" solution for tribal and federal officials alike. In one highlighted example, the Alaska Area IHS secured agreement from tribes, IHS program officials, and DHHS attorneys, to include specific reference to Nursing Home Services and Long Term Care in tribal funding agreements, where appropriate. This agreement recognizes tribes' success in redesigning IHS programs by adding services IHS was heretofore unable to provide, while staying within Congressional authority granted by the Indian Health Care Improvement Act. It illustrates the Alaska Area Director's ability to *lead change* while *building coalitions and communication*, because the agreed upon language serves as the model for all of Indian Country. Such a *results driven* accomplishment fulfills the IHS' role as stewards of federal resources, while maximizing the health benefits of IHS-funded programs to American Indian and Alaska Native people.

**Accomplishment 2:** Working closely with the Office of the Secretary, IHS Headquarters, and Alaska Native tribes, the Director, Alaska Area IHS used his *coalition building and communication* skills, and ability to *lead people*, to help garner Departmental support for increased program funding for American Indians and Alaska Natives in Alaska and throughout the United States. For three years including FY 2004, the Alaska Area IHS provided logistical and programmatic planning and support for Alaska site visits by the Secretary of Health and Human Services, Departmental OPDIV Heads, and HHS Senior Staff. Based in part upon what he learned in Alaska about the health needs of American Indians and Alaska Natives, the Secretary requested additional funding for the national

IHS Sanitation Facilities Construction program, Alcohol Program, and for the Community Health Aide/Practitioner (CHA/P) program. Included in the President's IHS budget request for FY 2005 is $10 million for Sanitation Facilities Construction, and $2 million for the Alaska CHA/P program. The Alaska Area Director's role in coordinating the Secretary's visits has helped to vastly improve working relationships between Alaska Native tribal leaders, the Secretary, and HHS senior staff. The availability of program data to substantiate need was instrumental in gaining Secretary Thompson's support, and illustrates the Alaska Area Director's *balance measure of results* approach to public health in Alaska. In his comments to tribal leaders during the 2004 IHS Health Promotion/Disease Prevention Summit, Secretary Thompson identified Sanitation Facilities as one of his highest priorities for Indian Country.

**Accomplishment 3:** The Director, Alaska Area IHS executed an intra-agency agreement with the Portland and California Area IHS, forming the Western Regional Office of Human Resources. This 3-Area region is the first in the IHS, formed in fulfillment of the IHS Director's plan for consolidation of the IHS Human Resources function. This inter-Area collaboration will meet the HR support needs of the Alaska, California, and Portland Area Offices while eliminating duplication of effort, maintaining economies of scale, and meeting the Department's HR staffing metric of 1 HR staff per 87 employees. Furthermore, the *results driven* Alaska Area Director exceeds this metric, providing HR support to Alaska's federal employees on a 1 per 100 ratio. The Western Regional Office of Human Resources is already functioning and has made significant progress toward implementation of the Electronic OPF. A Western Regional HR Director position has already been advertised and interviews will commence shortly. This proactive initiative is a demonstration of this incumbent's *business acumen* and ability to *lead people*, *lead change*, and *build coalitions/communication*.

**Accomplishment 4:** Data submitted into IHS' GPRA+ reporting system by IHS-funded programs in Alaska has improved IHS national averages for many health indicators. While the Government Performance and Results Act (GPRA) does not legally apply to tribes, the Alaska Area IHS succeeded in gaining participation by Alaska Native tribes, in the GPRA+ reporting system thus illustrating this Director's ability to *lead people* and *lead change* in a *results driven* manner. In FY 2004, it was revealed that FY 2003 data submitted by 4 Alaska tribal organizations improved IHS data averages. In FY 2004, the Alaska Area IHS brought an additional 3 tribal organizations into the GPRA+ reporting system. GPRA+ training, targeted at improving data quality, has been provided to Alaska Native tribal programs. Preliminary FY 2004 data indicates that data submitted by 7 Alaskan tribal entities will again raise national averages for IHS-funded programs. Such success in program accountability was realized in part by this incumbent's development and maintenance of strong working relationships with tribal leaders, i.e., *building coalitions/communication*.

**Accomplishment 5:** This incumbent *builds coalitions* with federal, state and tribal partners, thereby maximizing health resources for IHS beneficiaries. With IHS providing considerable technical advice and assistance to the Denali Commission and cognizant tribes, the Barrow and Norton Sound Hospital replacement projects both received $500,000 in design funds from the Denali Commission,

and the Barrow hospital is slated for $4 million in the FY 2005 Senate Mark. The Alaska Area secured a delegation of authority from the ASH, DHHS, to accept a gift of real property, thereby facilitating construction of a $3 million Community Mental Health Center in Dillingham, AK funded by the Denali Commission and HUD. IHS Tribal Equipment funds totaling $3.8 million were committed to 23 tribal locations building new Alaska Native health facilities funded with $29.6 million in non-IHS funds. For every $1 in IHS funds, $8 in health facility construction funds was identified. Similarly, in Sanitation Facilities Construction, the Alaska Area IHS supplements $16.4 million in IHS funds with $67.9 million in contributions through interagency agreements with the EPA, State of Alaska (EPA and HUD), and DOT. Such *results driven* efforts serve to maximize access to care for Alaska Natives state-wide.

**Executive Leadership – Critical Element:** The above highlighted accomplishments illustrate that the Alaska Area Director leads in a proactive, customer-responsive manner consistent with Agency vision and values, effectively communicating program issues to external audiences. This incumbent has served to present issues to internal and external leadership in a manner which, in spite of contentious compact negotiation issues, has improved the relationship between the Department and Alaska Native tribes. The Alaska Area Director succeeds in gaining tribal support for, and participation in, federal program reporting systems such as the IHS Sanitation Deficiencies System, and GPRA+ health data reporting systems. The Alaska Area Director serves as an employee advocate for IHS-funded programs in which there are at least 3 personnel systems, i.e., civil service, USPHS Commissioned Officers, and tribal direct-hires. The accomplishments outlined above are the product of teamwork and 2-way communication in an equal opportunity environment that values fair and equitable treatment of employees.

# Alaska Area IHS: Christopher Mandregan, Jr. MPH, Area Director
# FY 2004 -- Reporting Dr. Grim's Accomplishments to DHHS

| Program Objectives | Accomplishment | What Quarter? | Significant Progress for FY05 Objectives |
|---|---|---|---|
| 1. Build infrastructure and capacity to support implementation and evaluation, as appropriate, of the Director's Health Promotion/Disease Prevention (HPDP) initiative by the end of FY05. | • Funds to support the Alaska Native Tribal Health Consortium (ANTHC) Health Promotion and Wellness Coordinator position have been approved by the IHS HP/DP coordinator. The scope of work was added to the ANTHC FY 2005 funding agreement.<br>• The Alaska Area Director served as moderator of the IHS HP/DP Summit in Washington, D.C., and secured co-sponsorship of the Summit from a privately-owned Alaskan organization. | (4th) Quarter. | |
| 2. Apply earmarked dollars to fund cooperative agreements among American Indian/Alaska Native (AI/AN) communities to build injury programs by the end of FY05. | • The Alaska Area IHS has an interagency agreement with the NIOSH to pilot test a new occupational injury surveillance and investigation system. | | |
| 3. Maintain 100% accreditation of hospitals and clinics during FY04 and FY05. | • All of the seven (7) tribally-managed hospitals in Alaska are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).<br>• One Alaska tribal clinic is accredited by JCAHO, and two Alaska tribal clinics are accredited by the Accreditation Association for Ambulatory Healthcare (AAA). | | |

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|---|---|---|---|
| 4. Develop the electronic health record during FY04 to enable clinical practitioners to make safer more informed decisions and diagnoses. Deploy the electronic health record in 20 facilities by Q4 FY05. | • The electronic health record system (EHR) has been installed at two Alaska tribal facilities, the Maniilaq Medical Center in Kotzebue and the Chief Andrew Isaac Health Center in Fairbanks. The Alaska Area provided $85,000 to Chief Andrew Isaac, and $120,000 to Maniilaq in support of their EHR implementation during FY 2004. Corresponding spending plans have been submitted. | 4th Quarter | The EHR will be implemented in two Alaska sites in the first quarter FY 2005. |
| 5. Develop and deploy an interim behavioral health management information system software (GUI) to improve technology access, data trending and research capabilities by Q2 FY04. | N/A | | The Maniilaq Association in Kotzebue is using the behavioral health management information software beginning lst Quarter, FY 2005 |
| 6. Develop and deploy the integrated behavioral health component of the electronic health record in FY05. | • The Maniilaq Association in Kotzebue is using the integrated behavioral health component of the electronic health record in FY 2005. | | Implemented in first quarter, FY 2005. |
| 7. Complete deployment of a standardized medication-error reporting system in Q4 FY04 as part of a comprehensive patient safety program. Develop a plan by the end of FY05 for the deployment of a medical-error reporting system as part of a comprehensive patient safety program. | N/A | 4th Quarter | |

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|---|---|---|---|
| 8. Develop the national suicide surveillance system for AI/AN by the end of FY04 and deploy system by the end of FY05. This will drive specific programming and longer-term reduction of suicide. | • The Maniilaq Association in Kotzebue has been using a suicide surveillance system funded by SAMSHA for approximately two (2) years. | | |
| 9. Develop strategies and tools to increase the capacity in AI/AN communities to increase the quality of care for chronic disease (e.g., diabetes, obesity, heart disease) regarding long-term care management, case management, and treatment management during FY04 and FY05. | • As has often been the case, new Title V funding agreement language, with national implications, was negotiated under the Alaska Tribal Health Compact. The new language enables a tribe to operate or pay for the services of a nursing home under its funding agreement with the IHS. | 4th Quarter | |
| 10. Design an injury data system by the end of Q4 FY04 to track injury prevention activities and projects in order to identify impact and results of activities and projects in AI/AN communities. Begin to implement system in FY05. | The Alaska Native Tribal Health Consortium had four (4) community-based injury prevention projects in both FY 2004.<br>• The programs are: 1) Child Passenger Safety Initiative - 1,000+ car seats distributed in both years; 2) Safe Firearm Storage - 200 gun safes distributed through tribal/state collaboration; 3) Kids Don't Float - child floatation jackets available at all harbors/boat launches for public use; 4) Smoke Alarm project - 750 smoke alarms installed each year. | All Quarters | |

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|---|---|---|---|
| 11. Increase the number of Headquarters partnerships, alliances, and collaborations by 10% above FY03 in the areas of disease prevention, health disparities and health infrastructure by the end of FY05. | N/A | | |
| 12. Establish baselines for partnership, alliances and collaborations for each Area by the end of FY04 and increase by 10% by the end of FY05. | • The Alaska Area had 13 partnerships, alliances and collaboration in FY 2004. | All Quarters | |
| 13. Validate all HQ and Area office location emergency management plans by the end of FY04. Develop and implement hospital and clinic emergency management plans by the end of FY05. | • The Alaska Area set in place an emergency management circular, has held several continuity of operations training sessions, and has performed a desk top disaster exercise and simulation. | 3rd Quarter | |
| 14. Exceed FY03 third party collections through collaboration with CMS. | • In accordance with the terms of the CMS/IHS mutual operating agreement, the Alaska Area Office maintains a list of facilities that are eligible for 100% FMAP.<br>• The State of Alaska, Division of Medical Assistance gives Medicaid billing privileges to Alaska tribes only if their facilities are on the CMS/IHS list.<br>• During FY 2004 negotiations, the Alaska Area collaborated with the Alaska tribes, IHS Headquarters and the State of Alaska to define and minimize the impact of P.L. 93-638, Section 505 on the ability of tribes to | All Quarters | |

| Program Objectives | Accomplishment | What Quarter? | Significant Progress for FY05 Objectives |
|---|---|---|---|
| | collect 100% FMAP. There are 324 facilities on the Alaska CMS/IHS list, while other IHS areas have between 19 and 89 facilities on their lists. | | |
| 15. Ensure accountability for IHS business plan implementation during FY04 and FY05. | N/A | | |
| 16. Establish a seamless infrastructure between HQ and area offices by the end of FY05 for the development, transition, and contractual oversight of tribal administered programs so that IHS meets its responsibilities under the Self Determination Act. | • During the FY 2004 negotiations, the IHS successfully removed from Alaska Tribal Health Compact funding agreements descriptions of programs, services, functions and activities that are not authorized to be included in a funding agreement under P.L. 93-638, Title V, Section 505.<br>• In FY 2004 the Alaska Area continued to provide personnel and PL 93-638 expertise to the Navajo Area for assistance with Title I renewal negotiations, contract support cost negotiations and the negotiation of a new Title I contract award for FY 2005 with the Navajo Health Foundation (Sage). | 4th Quarter | |

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| Management Objectives | Accomplishment | What Quarter? | Significant Progress for FY05 objectives |
|---|---|---|---|
| 1. Support the Department in the development of the IHS HR center in Q2 FY04 and begin operating according to the HR metrics, staffing ratios and automated systems. | • Alaska Area Office of Human Resources is operating at a ratio of 1 personnelist to 100 employees. This ratio has been included in the funding agreements for the Title V tribes since FY 1998, and it exceeds the ratio of 1 to 82 that is now required by the DHHS. Alaska Area manages 41 residual, 470 civil service "intergovernmental personnel agreements" and 304 commissioned officer mutual operating agreements. | 2nd Quarter | Training for supervisors in the electronic official personnel file (EOPF) will be provided during FY 2005 with separate sessions for Tribal and residual supervisors |
| 2. Create meaningful, results-oriented performance contracts for all senior executives that meet new SES requirements from OPM in Q4 FY04. | N/A | | |
| 3. Develop and implement a plan to streamline at least one organizational structure and reduce management layers to no more than 4 to meet the Department's restructuring and delayering objective in Q4 FY04. | N/A | | |
| 4. Assess HR structure and implement the regional concept by the end of FY04. Assess the potential for streamlining/regionalizing other administrative functions (e.g., Finance, Procurement and Property and Supply) in FY05. | • The Alaska, California and Portland Area human resource offices all met in February 2004 to develop a plan to merge the three (3) offices into one. The plan was sent forward to the Executive Committee for review. The "Western Region-HR" plan was the first to go forward in this process. | 2nd Quarter | |

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| 5. Develop strategies to assess the workforce mix and competencies in Headquarters, the Area offices and service units to achieve proper staffing and succession planning, while respecting/honoring tribal preferences by Q4 FY04. Implement in FY05. | • The Alaska Area IHS negotiates residual and transitional-residual staffing each year as it updates the funding agreements for tribes in the Alaska Tribal Health Compact. | All Quarters | |
| 6. Establish the 2004 baseline for vacancies for critical health care provider positions in Q4 FY04. Use existing recruitment and retention tools and strategies to reduce the vacancy rate for critical positions by 1% by the end of FY05. | • Since FY 2001, the Alaska Area Office has recruited dentists, dental hygienists, physicians, physician assistants and nurse practitioners to work for tribal health organizations under federal personal service contracts. This process meets the needs of providers who are unsure of their interest in rural Alaska, and are unwilling to go through the State licensure process. It allows time for the provider to develop a relationship with the tribal organization and complete licensure. Forty-four (44) high priority personal service contracts were awarded in FY 2003 and forty-nine (49) in FY 2004. An additional 14 volunteer dentists were placed with tribal health organizations through federal volunteer contracts negotiated by the Alaska Area Office.<br>• Also during FY 2004, the Alaska Area hosted "Operation Arctic Care" in conjunction with the Departments of the Army, Navy and Air Force to provide care to the medically | All Quarters | |

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| | underserved villages in the Kotzebue and Norton Sound regions. Operation Arctic Care provided 1,412 medical encounters, 922 dental encounters, 746 optometry encounters and 6,487 veterinary encounters to 15 villages. | | |
| 7. Assess and formulate plans to receive electronic grant applications in Q4 FY04. Post all grant announcements on grants.gov in Q1 FY05. Implement receipt of electronic grant applications in Q4 FY05. | N/A | | |
| 8. Load grants data on the Administration for Children and Families' GATES (HHS service grants system) by Q2 FY05 and begin testing. | N/A | | |
| 9. Report to the Department in Q2 FY04 an inventory of positions identified in the annual FAIR Act Inventory. Report conversions quarterly, or as requested. | • Alaska Area IHS has no positions to add to the FAIR Act Inventory. | | |
| 10. Implement by Q2 FY05 an industry standard model to improve third party billing. | N/A | | |
| 11. Support the transformation to "One Department" regarding IT functions by initiating implementation of products, services, and policy directives yielded by the Enterprise initiatives as defined by HHS. | N/A | | |

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|---|---|---|---|
| 12. Support and comply with the transformation to "One Department" regarding the Financial Management functions during FY04 and FY05. | • During FY 2004, Alaska Area finance staff attended training and demonstrations on the new DHHS accounting system. We are hoping to send additional staff members to training in FY 2005. | 2nd Quarter | |
| 13. Meet HHS Small Business and Performance-Based Contracting Goals in FY04 and FY05. | • All Alaska IHS programs, services, functions and activities are managed by tribes pursuant to P.L. 93-638. Consequently, there have been no procurement requirements conducive to awarding commercial contracts subject to performance-based contracting criteria. | | |
| 14. Participate and support the Department-wide effort for program evaluation and corrective strategies during FY04 and FY05. | • The Alaska Area IHS continues to update and refine its strategic plan. | All Quarters | • An office director's retreat on program evaluation will be held in the first quarter, FY 2005. |

**Finally, what is the greatest accomplishment, in your mind, for IHS? (in two sentences or less)**

In FY 2004 the IHS re-examined its authority under the Indian Health Care Improvement Act, and in recognition of tribal health program improvement and redesign, authorized the inclusion of long term care and skilled nursing facilities in PL 93-638 Compact Funding Agreements.