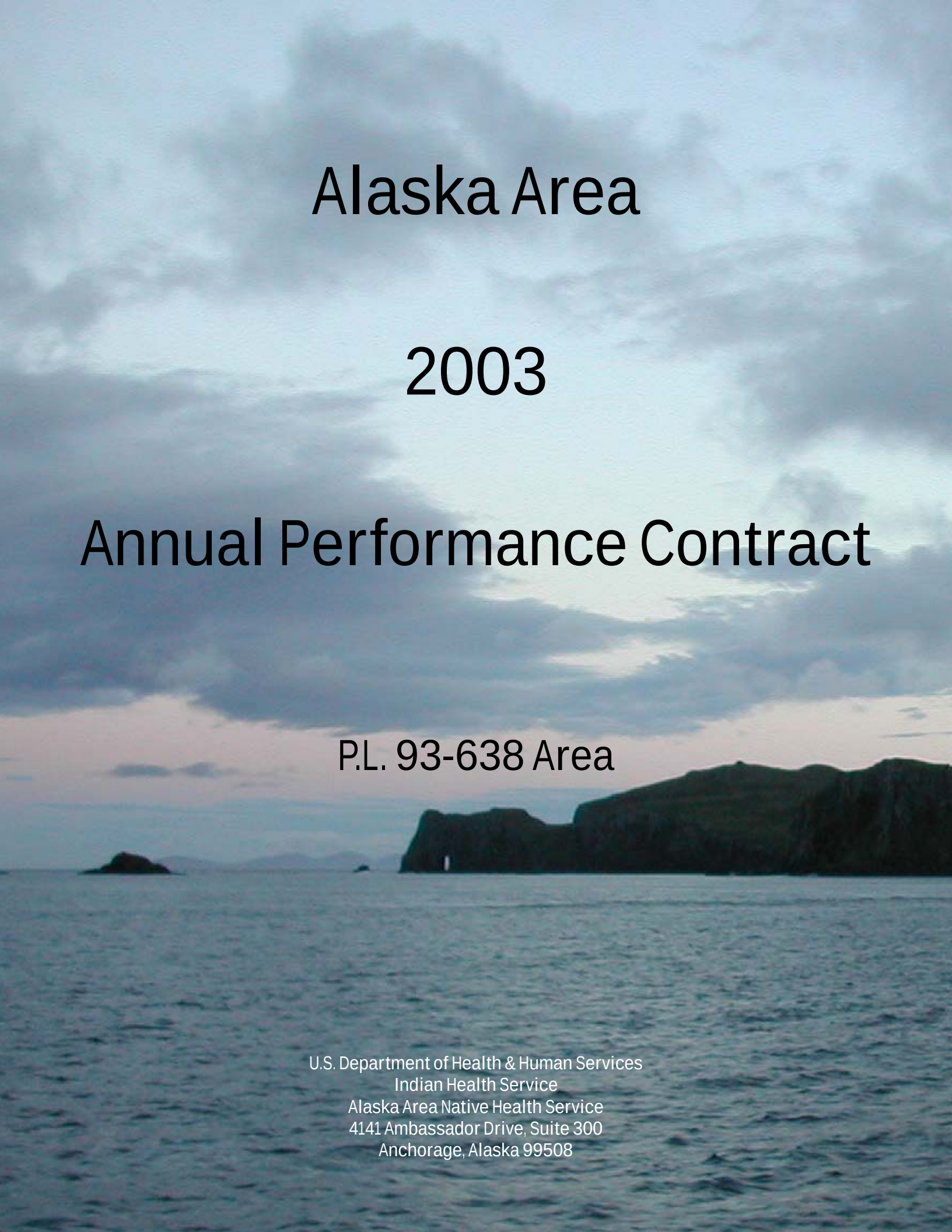

Alaska Area

2003

Annual Performance Contract

P.L. 93-638 Area

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

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Alaska Area 2003 Annual Performance Contract

P.L. 93-638 Area Report Summary

A. Area Vision:

Provide the name of the Area and the Area's vision statement.
The Alaska Area vision statement is: "to be recognized as a highly professional health organization, leading the IHS in support of tribal self-governance, with the best health consultants and technical support staff available to Alaska Native organizations."

B. Indian Health Care Population (location and numbers):

1. **Identify the location of the Area including numbers and names of States comprising the Area.**
   The Alaska Area Native Health Service, Indian Health Service office is located in Anchorage, Alaska, and is comprised of one state.

2. **Identify the number of Federally recognized Indian Tribes and Alaska Native Villages and urban Indian programs in the service Area.**
   There are 228 federally recognized tribes in the Alaska Area. There are no urban Indian programs.

3. **Identify the total service area American Indian and Alaska Native user population and service population.**
   The FY 2002 count of Indian Active Users in Alaska Area was 121,009. The 2000 Census count was 119,241.

C. Facilities and Accreditation:

1. **Indicate total number of hospitals, health centers, health stations and village clinics and urban clinics for each of the following components: Indian Health Service, Tribal Title I Contract and Title V Compact, and Urban (I/T/U).**
   There are seven (7) tribal hospitals, 25 tribal health centers and 176 tribal community health aide clinics in the Alaska Area. There are no IHS or urban facilities.

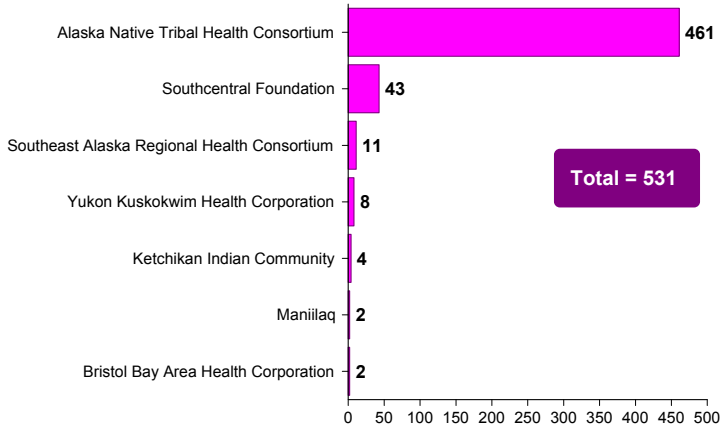
2. **Identify types of accreditation and number of facilities accredited under each type.**
   Alaska Area has 8 tribally managed facilities that use the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and two tribal facilities that use the Accreditation Association for Ambulatory (AAA) Healthcare.

D. Human Resources:

Indicate the total number of Federal employees by types of employees: civil service and U.S. PHS Commissioned Corps.

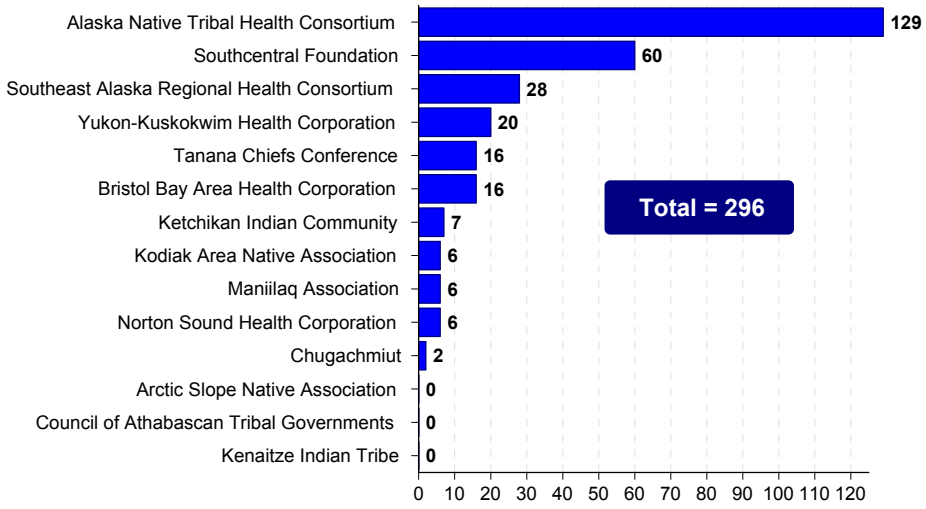
There are 36.25 civil service employees in the Alaska Area Office and 5 U.S. PHS Commissioned Corps. There are 531 civil service Intergovernmental Personnel Agreements (IPAs) and 296 U.S. PHS Commissioned Corps Memorandum of Agreements (MOAs) detailed to Alaska tribes.

Alaska Area
Intergovernmental Personnel Agreements (IPA)
October 1, 2002 - September 2, 2003



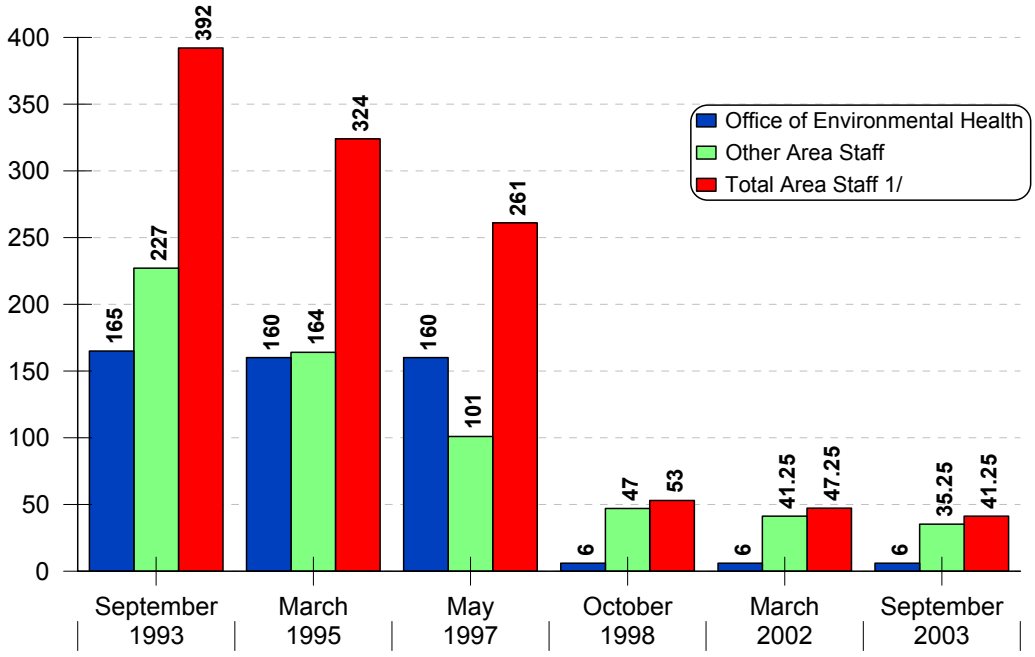
source: IHS, Alaska Area Native Health Service, Human Resources Department

Alaska Area
Memorandum of Agreements (MOA)
October 1, 2002 - September 3, 2003



source: IHS, Alaska Area Native Health Service, Human Resources Department

Since 1993, the Alaska Area Office has downsized from 392 to 41.25 employees, a reduction of 90%, by achieving greater efficiencies and by transferring functions.



1/ Includes 23 residual, 13.25 transitional residual, 3 buyback, 1 Portland intra-agency agreement, and 1 personal services contract.

E. Highlights of FY 2003 Achievements

Identify and highlight three FY 2003 Area accomplishments.

- On October 1, 2002, the Yakutat Tlingit tribe became the 21st co-signer of the Alaska Tribal Health Compact.
- The Alaska Area negotiated 21 Title V annual funding agreements and 19 Title I contracts during FY 2003.
- All 288 tribal governments in Alaska have exercised their authorities under the Indian Self-Determination and Education Assistance Act during FY 2003.

F. FY 2004 Key Focus Areas

Using FY 2003 accomplishments, identify three key areas of focus for FY 2004.

- Negotiate Title V annual funding agreements and Title I contracts.

- Assist tribes in transitioning from Title I contracts to Title V annual funding agreements.

- Provide a federal mechanism for certifying Community Health Aides/Practitioners.

G. Area Budget:

Provide a breakout of the FY 2003 Area budget by categorical amounts in the table below:

Budget Category	IHS	Tribal		Non 638		Total
		Title I	Title V			
Services:						
Hospitals & Health Clinics	5,099,498	5,115,776	207,114,577	309,734		217,639,585
Dental Services	14	154,004	15,230,596	231		15,384,845
Mental Health	16	55,084	5,321,399	753		5,377,252
Alcohol & Substance Abuse	6,295	1,189,255	9,725,753	277,400		11,198,703
Contract Health Services	19	1,059,445	48,071,508	-		49,130,972
Clinical Services Total:	6,330	7,573,564	285,463,833	588,118	1/	298,731,357
Public Health Nursing	10	4,431	3,036,800	64		3,041,305
Health Education	6	18,588	1,548,506	59		1,567,159
Community Health Representatives	12	198,737	3,745,858	204		3,944,811
Immunization	6	771	1,545,013	96		1,545,886
Prevention Health Total:	34	222,527	9,876,177	423	1/	10,099,161
Urban Health						-
Indian Health Professions			22,332			22,332
Tribal Management						-
Direct Operation	40	13,682	5,866,595	570	1/	5,880,887
Self Governance	1,745		146,635			148,380
Contract Support Costs		2,596,787	83,884,706			86,481,493
Services Total:	8,149	10,406,560	385,260,278	589,111		401,363,610
Facilities:						
Maintenance & Improvement		275,518	11,271,992			11,547,510
Sanitation Facilities			17,917,900			17,917,900
Health Care Facilities Construction			4,967,500	6,801,919	2/	11,769,419
Facilities & Environmental Health Support	443,127	6,769	16,056,912	38,000	2/	16,544,808
Equipment		34,289	1,568,351	16,593	1/	1,619,233
Facilities Total:	443,127	316,576	51,782,655	6,856,512		59,398,870
Area Total	451,276	10,723,136	437,042,933	7,445,623		460,762,480
Collections:						
Medicare			342,278			342,278
Medicaid						-
Private Insurance						-
Quarters	1,508		31,649			33,157
Area Collection Total	1,508	-	373,927	-		375,435
Advance Transfer Appropriation:						
Diabetes						
Area Program Level Total	452,784	10,723,136	437,416,860	7,445,623		461,137,915
1/ North Slope Borough						
2/ Certified to Engineering Services-Seattle						

FY 2003 Area Director Performance Contract - P.L. 93-638 Area Report Summary

FY 2003 Performance Contract Element	Achieved		Performance		Change from FY 2002	Page #
	Yes	No	Goal	Actual		
Element A (20 points) Maximize Total Resources						
The Area Director will 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 carry out the Agency's mission and goals.						
Performance Objective A.1 – The Area Director will facilitate and support systems and manpower necessary for tribal collections of third party resources.	X			X		15
Performance Objective A.2 – The Area Director will demonstrate active efforts and actual accomplishments to increase by 1% total contributions from external sources made to Area IHS, tribal and urban Indian health programs.	X			X		17
Element B (25 points) Improve Health Systems						
The Area Director will 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.						
Performance Objective B.1 - The Area Director will facilitate and support activities that assists Area Indian health programs to meet the following Government Performance Results Act (GPRA) indicators:						19
Indicator 40: During the FY 2003 reporting period, the IHS will have improved the level of Contract Health Services (CHS) procurement of inpatient and outpatient hospital services for routinely used providers to at least 1% over the FY 2002 level of the total dollars paid to contract providers or rate quote agreements at the IHS-wide reporting level.	All Alaska Area contract health service progams became tribally managed effective January 1999.					19
Indicator 43: By the end of FY 2003, the IHS will increase by 10% over the FY 2002 level the proportion of I/T/Us who have implemented Hospital and Clinic Compliance Plans to assure that claims meet the rules, regulations, and medical necessity guidance for Medicare and Medicaid payment.	All tribal hospitals and most tribal health clinics in Alaska have compliance plans. Tribal clinics are at varying stages of implementation.					19
Performance Objective B.2 - The Area Director will enhance personnel performance and address future personnel needs by demonstrating an investment of at least 3% of the cost of salaries and benefits in appropriate training to enhance current performance and to ensure required competencies in the future.	X			X		19
Performance Objective B.3 - The Area Director will facilitate and support efforts to improve information infrastructure and describe the resulting enhancement to the health care system.	X			X		20
Performance Objective B.4 - The Area Director will facilitate and support activities that enhance the physical capacity of health care facilities in the Area.	X			X		21
Performance Objective B.5 - The Area Director will facilitate and support systems and programs to maintain 100% accreditation of Area Indian health care facilities (GRPA Indicator #20).	X			X		24
Performance Objective B.6 - The Area Director will provide leadership and assistance to support the implementation of HIPAA privacy requirements in all Area Indian health care facilities.	X			X		24
Performance Objective B.7 - The Area Director, in collaboration with the Director, will describe the Area Vision with a schedule of outcomes and assessment methodology to achieve the Agency mission.	X			X		25
Performance Objective B.8 - The Area Director will provide leadership and support to Area Indian health programs to assist the Agency achieve the measurements prescribed in the OMB Program Assessment Rating Tool (PART) process.	Not applicable in FY 2003 (Handled entirely by Headquarters)					25

FY 2003 Area Director Performance Contract - P.L. 93-638 Area Report Summary

FY 2003 Performance Contract Element	Achieved		Performance		Change from FY 2002	Page #
	Yes	No	Goal	Actual		
Element C (25 points) Improve Management Systems						
The Area Director will provide leadership and direction on Presidential, Department, and Agency initiatives which support improvements to management systems.						
Performance Objective C.1 - The Area Director will support and promote all major One-Department Management Goals, and in particular for FY 2003 the following objectives:						**27**
1. Ensure at least 20% of IHS contracted service dollars are subject to performance-based contracting criteria.	Since all Alaska Area programs are managed by tribal organizations, there are no longer any opportunities for awarding commercial contracts subject to performance based contracting criteria.					**29**
2. Support IHS Human Capital Plan by assisting in meeting specific recruitment and retention targets for specific skill areas and position types.	The Alaska Area assists the tribal organizations retain their physicians by maintaining the physicians' comparability allowance and physicians' special pay contracts.					**29**
3. Support the IHS Workforce Plan objectives by reducing position vacancy rates of the high priority occupations (Medical Imaging, Podiatry, Dental, Optometry, Pharmacy, Nursing, Physician and Physical Therapy) by 5%, reduce the time-to-hire to 120 days, and improve to 20% the number of hires retained after 6 months.	The Alaska Area prepares personal services contracts for intermittent providers to work temporarily while they decide whether to stay and obtain Alaska licensure.					**29**
Performance Objective C.2 - The Area Director will have in place performance contracts with lead Area Office and service unit staff with expected outcomes that support the Director's Performance Contract and other performance objectives.	**X**			**X**		**30**
Performance Objective C.3 - The Area Director will demonstrate support for public affairs activities that provide public visibility for the accomplishments of the IHS.	**X**		**X**			**31**
Performance Objective C.4 - The Area Director will implement within the Area restructuring to support Department, Restructuring Initiative Workgroup (RIW), and Headquarters initiatives.	**X**		**X**			**34**
Performance Objective C.5 - The Area Director will demonstrate successful performance of GPRA Indicator #44 to support P.L. 93-638 contracting by tribes of Agency programs in order to contribute to Agency outsourcing requirements.	**X**		**X**			**35**
GPRA Indicator 44: During FY 2003, the IHS will support the efficient, effective and equitable transfer of management of health programs to tribes submitting proposals or letters of intent to contract or compact IHS programs under the Indian Self-Determination Act by:	**X**		**X**			**35**
a. Providing technical assistance to all tribes (100%) submitting proposals or letters of intent based on identified areas of need and with specific technical assistance in the area of calculating contract support costs.	**X**		**X**			**35**
b. Reviewing all initial contract support cost requests submitted using the IHS Contract Support Cost Policy Protocol to assure the application of consistent standards in order to assure equitable and approvable requests.	**X**		**X**			**35**
Performance Objective C.6 - The Area Director will contribute to the accomplishment of the Accountability Report by ensuring that administrative systems and internal controls are in place for sound fiscal management.	**X**		**X**			**35**

FY 2003 Area Director Performance Contract - P.L. 93-638 Area Report Summary

FY 2003 Performance Contract Element	Achieved		Performance		Change from FY 2002	Page #
	Yes	No	Goal	Actual		
Performance Objective C.7 - The Area Director will implement the activities identified in the IHS Business Plan as priorities for FY 2003.	X		X			39
Performance Objective C.8 - The Area Director will facilitate and support Area Indian health programs to insure that systems are in place so that necessary background checks on health care provider candidates are done to prevent hiring of unqualified individuals.	X		X			39
Element D (30 points) Maximize Health Returns						
The Area Director will provide leadership and support to assist Area Indian health programs to utilize the human and physical resources of the Area to maximize health returns for patients served.						
Performance Objective D.1 - The Area Director will encourage and support efforts by Area Indian health programs to meet the following GPRA indicators which measure clinical treatment interventions:	Four (4) tribal health facilities have shared their GPRA+2003 results with the Alaska Area. Those tribes asked that they remain anonymous and that the IHS follow HIPAA guidelines for use of their data.					42
Indicator 2: During FY 2003, maintain the FY 2002 performance level for glycemic control in the proportion I/T/U patients with diagnosed diabetes.	X		X		2.6%	42
Indicator 5: During FY 2003, maintain the proportion of I/T/U patients with diagnosed diabetes assessed for nephropathy.	X		X		0%	44
Indicator 7: During FY 2003, maintain the proportion of eligible women patients who have had a Pap screen within the previous three years at the FY 2002 level.		X	X		-2.4%	44
Indicator 8: During FY 2003, maintain mammography screening of eligible women patients at the FY 2002 rate.		X		X	-8.7%	45
Indicator 14: During FY 2003, maintain the number of sealants placed per year in AI/AN children at the FY 2002 level.	The GPRA+2003 logic for dental sealants was determined to be invalid.					45
Indicator 16: During FY 2003 the IHS will address domestic violence, abuse, and neglect by assuring that:	Alaska Area surveyed 29 health clinics.					46
i. At least 85% of I/T/U medical facilities (providing ER and urgent care) will have written policies and procedures for routinely identifying and following: • intimate partner abuse (IPV) • child abuse and/or neglect • elder abuse and/or neglect	X X X X		X X X X			46
ii. At least 60% of I/T/U medical facilities (providing direct patient care) will provide training to the direct clinical staff on the application of these policies and procedures.	X		X			46
iii. (IHS Headquarters responsibility).	IHS Headquarters responsibility.					
Performance Objective D.2 - The Area Director will provide leadership and support to assist Area Indian health programs to meet the following GPRA indicators that measure preventive health interventions:						46
Indicator 12: During FY 2003, increase the proportion of AI/AN population receiving optimally fluoridated water by 1% over the FY 2002 levels for all IHS Areas.	X			X		46
Indicator 23: During FY 2003, maintain the total number of public health nursing services (primary and secondary treatment and preventive services) provided to individuals in all settings and the total number of home visits at the FY 2002 workload levels.	The number of public health nurse visits increased by 16.2% , but the number of public nurse home visits decreased by 83.2%. The decrease may represent a change in reporting practices.					47

FY 2003 Area Director Performance Contract - P.L. 93-638 Area Report Summary

FY 2003 Performance Contract Element	Achieved		Performance		Change from FY 2002	Page #
	Yes	No	Goal	Actual		
Indicator 24: In FY 2003, maintain FY 2002 levels in the proportion of AI/AN children who have completed all recommended immunizations for ages 3-27 months, as recommended by the Advisory Committee on Immunization Practices.	X		X		0%	48
Indicator 25: In FY 2003, maintain FY 2002 influenza vaccination rates among non-institutionalized adult patients aged 65 years and older.	X		X		1.80%	48
Indicator 26: In FY 2003, maintain the FY 2002 rate for pneumococcal vaccination levels among non-institutionalized adult patients age 65 years and older.	X		X		0%	49
Indicator 27: During FY 2003, implement at least 36 community-based, proven injury prevention intervention projects across I/T/U settings.	Alaska tribes have implemented three (3) community-based proven injury prevention projects.					49
Indicator 29: During FY 2003, increase by 5% over the FY 2002 level, the proportion of I/T/Us that have implemented systemic suicide surveillance and referral systems which include:	One systemic suicide surveillance and referral system in Alaska is described in this report. The project depends on SAMSHA funding.					50
i. Monitoring the incidence and prevalence rates of suicidal acts (attempts and completions).	The Alaska Native Tribal Health Consortium Injury Prevention Program has begun tracking information on incidence and prevalence.					50
ii. Assuring appropriate population-based prevention and interventions are available and services are made accessible to individuals identified at risk.	The Alaska Native Tribal Health Consortium Injury Prevention Program has begun tracking prevention and intervention services.					51
Indicator 30: During FY 2003, the IHS will continue collaboration with NIH to assist three AI/AN communities to implement culturally sensitive, community-directed pilot cardiovascular disease prevention programs and initiate expansion into at least one new AI/AN site. (Applies to Alaska, Oklahoma City, Albuquerque)	The Bristol Bay Health Consortium has received IHS funds for a cardiovascular disease prevention program. Mary Wachaca, the IHS lead on Indicator 30, prepared a progress report in September 2003.					51
Indicator 37: During FY 2003, Areas will contribute to the national goal of providing sanitation facilities projects to 15,255 Indian homes (estimated 3,800 new or like-new homes and 11,455 existing homes) with water, sewage disposal, and/or solid waste facilities.	Alaska Area tribes served 4,093 homes with water facilities, and 3,004 homes with wastewater facilities in FY 2003.					52
Performance Objective D.3 - The Area Director will facilitate and support within the Area a comprehensive preventive health strategy to address increases in chronic diseases.						52
Indicator 31: During the FY 2003, begin implementation or continue implementation of all components of the Indian health system obesity prevention and treatment plan developed in FY 2002 that include:						52
i. A multidisciplinary stakeholder obesity prevention and treatment planning group.	The Alaska Native Tribal Health Consortium is represented on a multidisciplilnary state-wide planning group.					52
ii. A staff development and IT development plan to assure securing height and weight data for all system users to monitor AI/AN population obesity.	Height and weight measures are recorded for about 40% of all active clinical users in Alaska tribal facilities.					52
iii. An infrastructure to collect, interpret and diffuse the approaches from obesity related demonstration projects and studies to IHS Areas and I/T/Us.	There is not currently an obesity prevention demonstration project in the Alaska Area.					52

FY 2003 Area Director Performance Contract - P.L. 93-638 Area Report Summary

FY 2003 Performance Contract Element	Achieved		Performance		Change from FY 2002	Page #
	Yes	No	Goal	Actual		
Performance Objective D-4 - The Area Director will provide leadership and support to Area Indian health programs so that systems and programs are in place to enable the Area to track health outcomes by completing the following GPRA indicators.						53
Indicator 17: During FY 2003, the IHS will continue the development of automated approaches for deriving performance information by:						53
i. Completing collection of baseline data for any performance measures where electronic data collection was implemented in FY 2002 and continue collection into measurement years.	Several Alaska tribes use the GPRA+ 2003 as an automated approach to monitor performance.					53
ii. Implementing additional electronically derived performance measures as their accuracy is proven to be sufficient.	Several Alaska tribes use ORYX software for accreditation requirements.					53
iii. Distributing semi-automated LOINC mapping tool for IHS's clinical information systems to all (100%) I/T/U sites; achieve full local LOINC mapping at 5 sites in addition to the 5 pilot sites.	The Alaska tribal information technology staff assume they have loaded LOINC in the latest RPMS software patch.					53
Indicator 35: During FY 2003, the IHS will increase the number of active tribal user accounts for the automated Web-based environmental health surveillance system by 15% over the FY 2002 level for American Indian and Alaska Native tribes not currently receiving direct environmental health services.	X			X	0%	53

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Financial Reconciliation

The annual financial reconciliation of P. L. 93-638 Indian Self-Determination and Education Assistance Act, as amended Title 1 contracts and Title V, compacts is identified as a best practice for the Alaska Area Native Health Service. The annual reconciliation was developed by the Area Finance Office to provide documented assurance that 638 entities and the federal government agreed on the total funding obligated and paid under their annual funding agreements and that any disputes or differences in charges assessed to individual Buyback accounts were resolved and all charges agreed upon. Those benefiting from the annual reconciliation include the tribal entities, the federal government, the Alaska Area Office, potentially other Area Offices and the beneficiaries of the AI/AN healthcare system.

The annual reconciliation requires collaboration between the Area Finance Office, the Area Office of Tribal Programs and the customer tribal organization. Financial Analysts prepare copies of the local fund distribution document, the Operating Resources Detail (ORD); the Cumulative Funding Report for each funding agreement detailing the total funding authorized for each location for the fiscal year; spreadsheets showing the amount paid for each amendment including a summary total; detail for all transactions included in the Buyback account; an invoice (if funds are owed to IHS); and, a worksheet summarizing all transactions with space for tribal and federal signatures upon agreement. The information is electronically transmitted to the customer organization for their review and comments. Area staff works through discrepancies with the tribal finance staff. Once there is agreement on all data, a corrected summary sheet is prepared for the tribal representative to sign indicating their agreement with the information, the Area Office of Tribal Programs representative signs indicating their agreement with the amendment totals and the Area Finance Officer signs indicating agreement on fund distribution totals and the total charges in the Buyback account.

A copy of the signed reconciliation for each tribal compact and contract is retained in Area Finance. Copies of Title V reconciliations are forwarded to the Office of Tribal Self Governance (IHS-OTSG). The signed reconciliation allows OTSG to close out the compact for the year. The Area has a record of agreement that at a specific point-in-time, the tribe agreed on the ORD totals (recurring and non-recurring), agreed on the total funding amended and paid for their compact for a given fiscal year, and agreed on the charges in the Buyback account. The tribes have confidence in the totals used in their funding agreements year after year. They have also developed confidence in the Area Office, knowing that we will work with them to resolve differences in amounts due or charges assessed.

The Alaska Area has twenty-one Title V compacting tribes, nineteen Title I tribes and one commercial contract for health services. We use the same process for reconciling

all 638 funding agreements and payments under the commercial contract. The reconciliation clearly addresses the issue of amounts authorized and owed to contractors, eliminating the possibility of claims for non-payment after the fiscal year closes. The reconciliation has contributed to the positive relationship between the Area Office and the Title V co-signers and eliminated the issue of claims against the government for non-payment. We have had no formal claims or informal complaints pertaining to non-payment for the years reconciled.

Since we implemented the current reconciliation process, the Alaska Area has had only two complaints pertaining to funding that resulted in formal claims. The tribal organizations that filed complaints had not completed reconciliations for the year for which the claim was filed.

The Alaska Tribal Health Compact FY 2004 IHS/Tribal Negotiation Open Items and FY 1998-FY 2003 Unresolved Issues list updated on May 12, 2003 cites the FY 1999 Full Year Invoice Reconciliation (and subsequent years). The list shows that there is one cosigner who has not reconciled for FY 1999. The same cosigner has not completed a reconciliation for FY 2000. The Alaska Area Native Health Service has provided to this co-signer all information necessary for reconciliation. All other tribal organizations within the Alaska Area have completed a reconciliation of funding agreements from FY 1998-FY 2002.

The cost to implement this best practice is minimal. The preparation of documentation requires staff time, a commitment to provide quality customer service and the determination to follow up with customers to complete the reconciliation. The reconciliation process could be used by any Area Office for Title I or Title V funding agreements. Initially, we chose to meet personally with the customer organizations to resolve the differences. After the first year, there was enough confidence between the tribes and the finance staff to do most of the reconciliation electronically. We made sure that our customers knew that we would sit down with them at the table at any time to work through issues. Tribes expect to receive the reconciliation data every year. The tribes in Alaska expect it within 45 days of the close of the fiscal year.

For additional information, contact:

Sharon A. Miller, Financial Management Officer
Alaska Area Native Health Service, IHS
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samiller@akanmc.alaska.ihs.gov

Negotiation and Management of the Buyback Account

The negotiation and management of the Buyback account is a best practice for the Alaska Area. The summary monitoring reports issued by Headquarters Finance dated April 30, 2003 shows the total unobligated balance in the Buyback account for Indian Health Service at a negative $1.3M. Alaska has an unobligated (available) balance of $15.6M while other Areas have negative balances, some in excess of $9M. The monitoring report dated August 30, 2003 shows Alaska with an unobligated balance of $2.6M. Another Area on the report has a negative balance of over $12M. The balance in our account is due to consideration of our fiduciary responsibility when negotiating annual funding agreements under Title V of the Indian Self-Determination and Education Assistance Act, as amended.

Each of the 21 Alaska Tribal Health Compact (ATHC) cosigners has a separate funding agreement. As an appendix, the Buyback/Withhold Agreement between the Indian Health Service and the Alaska Tribal Health Compact cosigners is incorporated into each funding agreement by reference. The "Buyback Agreement", as it is commonly called, outlines the terms under which the tribes may use services, personnel or other resources of the Federal Government as negotiated and agreed upon. Also, the Title I contractors with IPA/MOA personnel or General Services Administration (GSA) vehicles have agreed to buyback terms and have incorporated such into their funding agreements.

The funding agreements include the terms of the withholding agreement. The funds to pay salary for staff serving under an Interpersonal Agreement (IPA) or a Memorandum of Agreement (MOA) may be withheld in total or in an amount equal to the current month and the last three monthly payments based on the mutually agreed upon estimate of the annual IPA/MOA salary costs. Funds are withheld from the lump sum payment and retained by the Area pending final disbursement for the last three months of the fiscal year. In short, negotiating our compacts in this manner allows us to avoid a violation of the Anti-Deficiency Act.

Whether the Area is processing the initial lump sum payment or payment under a series of Continuing Resolutions (CR), we withhold the agreed amount or a percentage of the total estimated cost of salary. Transactions for the withheld amounts are processed into the accounting system, followed by a request for an Advice of Allowance from Headquarters Finance. The Advice is issued for the entire withheld amount even though it will not be obligated until the last quarter of the fiscal year. There are flaws in the current system, primarily due to changes in estimated costs.

During the CR period, the Alaska Area was overobligated in the Buyback account. The overobligation was due to the cosigners spending at a higher rate than originally estimated.

After receiving the FY 2003 annual allocation and processing lump sum payments, the (Headquarters) monitoring reports showed that we had "available" funds every month. We seek agreement on total estimated costs with each tribal location, but changes that occur during the year, such as an increase in the number of customers who purchase pharmaceuticals, has not been optimally addressed. We have plans to review the estimated annual costs every quarter starting next fiscal year.

The government, the tribes and the AI/AN health system patients benefit from the way the withheld amounts are negotiated. The Federal Government benefits by having funds on-hand to cover the cost of salaries and other services; the tribes benefit because they have a choice of either paying the full amount of the estimated cost of salary or paying only a fraction of the total and investing the remainder. The beneficiaries of the native health system ultimately benefit by receiving enhanced healthcare services made available through tribal returns-on-investments.

The Alaska model for negotiating Buyback/Withheld can be replicated at every Area Office. The cost would vary from place to place, depending on the relationship between the Area Office and the tribal organizations served. There is no material cost, but negotiations featuring this best practice could be lengthy. The obstacles to successful implementation of this best practice may be:

a) Tribes that want to invest more of their money to maximize interest income
b) Disagreement on the total estimated costs for services or salaries
c) Changing conditions that either decrease the estimated costs or increase it, causing the withheld amount or the monthly remittance amounts to be low
d) Receiving monthly amounts due in a timely manner.

As stated above, the Alaska Area's negotiation and management of the Buyback Account is not perfect. We are working with estimates and often with unknowns. The Best Practice portion of the process is that we are working to ensure that the Federal Government is not held liable for tribally procured services and that the Alaska Area serves the needs of their customers. We can only do so in concert with the customer.

If you have questions, please address them to:

Mr. Jim Armbrust, Director, Office of Tribal Programs
Alaska Area Native Health Service, IHS
4141 Ambassador Drive, Suite 300
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Introduction. The Secretary of the Department of Health and Human Services, through the IHS, tribes and tribal organizations in Alaska first entered into the Alaska Native Health Compact in 1995. The Compact began with 13 individual funding agreements, and now consists of 21 annual funding agreements. Tribes and tribal organizations have assumed all programs of the Alaska Area Native Health Service, except certain residual functions. The programs, functions, services and activities of the Area Office were assumed by the Alaska Native Tribal Health Consortium (ANTHC) under the authority of section 325 of P.L. 105-83 and P.L. 93-638 as amended on October 1, 1998. There are 41.25 federal full time equivalent (FTE) residual and transitional residual positions remaining in the Alaska Area Office.

Since 1993, the Alaska Area Office has downsized from 392 to 41.25 employees, a reduction of 90%, by achieving greater efficiencies and by transferring functions.

	9/93	3/95	5/97	6/98	10/98	3/02	9/03
OEH Staff	165	160	160	149	6	6	6
RSCC Staff[1]	20	13	15	13	0	0	0
Other FTEs	207	151	86	57	47	41.25	35.25
Total Federal FTEs[2]	392	324	261	219	53	47.25	41.25[2]

[1] Regional Supply Service Center transferred to tribal management October 1999.

[2] Includes 23 residual, 13.25 transitional residual, 3 buyback, 1 Portland intra-agency agreement, and 1 personal services contract.

Element A. Maximize Total Resources

The Area Director will 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 carry out the Agency's mission and goals.

Performance Objective A.1. **The Area Director will facilitate and support systems and manpower necessary for tribal collections of third party resources.**

Maintenance of IHS/Tribal Facility List for 100% Federal Medical Assistance Program (FMAP). Approximately 20% of eligible Medicaid patients in Alaska are American Indian/Alaska Native (AI/AN), compared to about 1% of eligible Medicaid patients nation-wide. The FMAP is an important factor in the Medicaid budget for the State of Alaska. The State receives 100% federal reimbursement for Native Medicaid patients who are treated in IHS or tribal facilities, compared to 60% reimbursement in other facilities. Under the 1996 Memorandum of Agreement between the Indian Health Service and the Centers for Medicaid and Medicare Assistance (CMS), the Alaska Area maintains a list of facilities that are eligible for 100% FMAP. The State Division of Medical Assistance grants Medicaid billing privileges to tribal clinics only if they are on the IHS

list. There are 328 facilities on the Alaska Area list compared to between 19 and 89 facilities for other IHS areas.

Technical Assistance to State of Alaska and Tribes, to Maximize Tribal 3rd Party Collections. The Alaska Area Director, together with the Acting Director of Headquarters Operations, and the Senior Public Health Advisor, OPH, IHS met with the Commissioner of Health and Social Services, State of Alaska, to discuss strategies for maximizing 100% FMAP in Alaska. This unprecedented meeting included representatives from Alaska Native tribes and tribal organizations operating IHS-funded programs pursuant to PL 93-638. Dialogue with the State of Alaska and tribes will continue in FY 2004.

Additionally, the Alaska Area Director; Director of Headquarters Operations, IHS; and, the Senior Public Health Advisor, OPH, IHS met with Alaska Native held an Alaska state-wide meeting with Alaska Native tribal leaders and their finance/business office staff, to provide technical assistance in the areas of Medicare Cost Reporting; and, evaluation of whether it is in the tribes' best interest to convert to Critical Access Hospital (CAH) status. This technical assistance included financial analysis of each Alaska hospital, with recommendations on whether it may be advantageous to convert to CAH status. Technical assistance to tribes on CAH will continue in FY 2004.

Alaska Medicaid Task Force. Representatives of the Alaska Area meet with CMS, the State Division of Medical Assistance and tribal business office representatives four times a year in Alaska Medicaid Task Force meetings. The issues addressed by the task force this year are:

- IHS/CMS list of tribal facilities
- Community health aide/practitioner chap standards and procedures
- Dental health aide (DHA) curriculum
- CHA/P visit reimbursements by Medicaid
- Gaining approval of third party payment for telemedicine visits

All-inclusive Rate. The most challenging issue for tribal third party billing systems is the use by state Medicaid agencies of an all-inclusive rate published by IHS and used by CMS to reimburse services. The all-inclusive rate was developed over twenty years ago to address the inability of IHS facilities to prepare Medicare cost reports. Because of overall changes in Medicaid payment methodologies (shifting away from cost-based payment systems), and a growing diversity in the nature of IHS and tribal 638 facilities, CMS is questioning whether the all-inclusive rate is viable. The Alaska Area sponsored a meeting between IHS headquarters, the CMS and the Alaska tribes in Anchorage on June 19, 2003 to discuss Medicare cost reports and reimbursements under the all-inclusive rate.

Performance Objective A.2 **The Area Director will demonstrate active efforts and actual accomplishments to increase by 1% total contributions from external sources made to Area IHS, tribal and urban Indian health programs.**

The Alaska Area distributes through its budget the following contributions from external sources for improvements to tribal health programs:

- Department of Transportation/Federal Emergency Management Administration for various city and school districts: funding for 6 projects in the amount of $4,153,278.
- Environmental Protection Agency (EPA) Safe Drinking Water Act and Clean Water Act in the amount of $11,598,171.
- State of Alaska Village Safe Water program: funding for 37 projects in the amount of $47,000,600.
- Department of Defense funding for one solid waste project $4,000,000.
- Denali Commission funding for washeteria improvements $633,356.
- DHHS, Health Resource Services Administration (HRSA) for a research and evaluation grant $86,000.

Inter-agency Agreements for Service.

- The Alaska Federal Health Care Partnership Interagency agreement was renewed again this year. All sub-agreements were also renewed. The Office of Awards & Administrative Services (OAAS) Director continued her position as Chairperson of the Planning Committee.

- An interagency agreement was developed between the Alaska Native Tribal Health Consortium and the Alaska Arctic Care Military Readiness Training Program. The agreement provides at least a five-year agreement to address when and where the readiness team will practice in Alaska. This direct access to the military medical system will fill a much needed niche in many of the villages in Alaska that do not have physicians, dentists, nurses, nor clinics at their disposal.

- Tribal contractors/compactors in the Alaska Area showed interest in participating in the records management storage and service provided by the National Archives and Records Administration (NARA). The Alaska Area OAAS Director worked with NARA Headquarters and Pacific Alaska Region to establish a tri-party agreement that covers records belonging to members of the Alaska Native Tribal Health Consortium. Services for records will be used according to the agreement worked out between each compactor or contractor. Services include storage, accessioning, disposal, reference requests, refiles and interfiles, quality assurance and training. These are the same services received by all federal agencies, and charged accordingly by NARA to the participating agencies. To date seven Alaska tribes are participating in the NARA agreement, with one new tribe and the other six renewing their collaborative agreements for FY 2003.

- The transfer of equipment from AANHS to ANTHC for the ANMC/SCF assumption is complete. A final report of the survey is done and transferred to ANTHC.

- The OAAS Director is working with the ANTHC Division of Environmental Health to establish their own property management procedures. Final transfer of all DEHE property is also being scheduled for FY 2004.

Element B. Improve Health Systems

The Area Director will 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.

Performance Objective B.1. **The Area Director will facilitate and support activities that assists Area Indian health programs to meet the following Government Performance Results Act (GPRA) indicators:**

Indicator 40: During the FY 2003 reporting period, the IHS will have improved the level of Contract Health Services (CHS) procurement of inpatient and outpatient hospital services for routinely used providers to at least 1% over the FY 2002 level of the total dollars paid to contract providers or rate quote agreements at the IHS-wide reporting level.

Effective January 1, 1999, all Alaska Area IHS contract health service (CHS) programs became tribally managed. All current contracts with CHS providers are between individual providers (e.g. physicians, dentists and hospitals) and individually tribally operated CHS programs. A number of the programs have contracts with frequent providers, and some programs have provider agreements modeled on IHS rate-quote agreements.

Indicator 43: By the end of FY 2003, the IHS will increase by 10% over the FY 2002 level the proportion of I/T/Us who have implemented Hospital and Clinic Compliance Plans to assure that claims meet the rules, regulations, and medical necessity guidance for Medicare and Medicaid payment.

All of the tribal hospitals in Alaska have compliance plans. Most tribal clinics have compliance staff, committees, structure and written plans to meet the compliance guidelines for physician clinics. The clinic sites are at different phases of implementation.

Performance Objective B.2. **The Area Director will enhance personnel performance and address future personnel needs by demonstrating an investment of at least 3% 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 Native Health Service substantially met this requirement by spending $51,624 or 2.8% of the area average salary on training. In FY 2004, the Alaska Area will require a training plan from managers to ensure the full 3% requirement is met.

Performance Objective B.3. **The Area Director will facilitate and support efforts to improve information infrastructure and describe the resulting enhancement to the health care system.**

Contract with Alaska Native Tribal Health Consortium (ANTHC) for Information Services. The Alaska Area has an $85,470 contract with the ANTHC to provide computer support services to Area Office employees. The ANTHC repairs and replaces computer equipment that we have purchased, maintains our connection to the ANMC campus network and updates our computer software. Responsibility and support for data quality, computer training, and system security are under the control and responsibility of ANTHC and the local tribes. The ANTHC maintains RPMS related software, RISC systems, network services, telecommunications, and telemedicine. The ANTHC and local tribes have ownership of the data. At our request, the ANTHC has provided a report of their information technology services in the "Addendum A."

User Population Adjustments. The Area Office worked with several tribes and tribal organizations to adjust their user populations. Adjustments were needed at some small facilities who lack the capacity to operate RPMS. Other facilities needed adjustments due to data problems with existing RPMS operations. In particular, ANMC lost some 40,000 visits from the interface between RPMS and their new billing package MS4. We have continued to work with Southcentral Foundation and the ANTHC throughout the year to improve that interface.

For the last four years, the ANTHC has dedicated one information technologist position to develop RPMS capacity in small facilities. For the first time in FY 2003, the ANTHC received a Community Access Program (CAP) grant to register patients at non-RPMS small facilities. After registration is complete, an ANTHC technologist sets up the hardware needed to operate RPMS and trains the local RPMS coders. The process has resulted in one small tribe coming on line to RPMS. The addition of the CAP grant assistance is expected to speed the process.

Environmental Health & Engineering Partnerships. The following are partnerships maintained by the Alaska Area with the tribes, State and local health departments, and other federal agencies to improve the information infrastructure.
Activity: Representatives of the Area Office provide feedback to the Headquarters component to create information capacity on health facility improvement and expansion projects in the IHS Facilities Data System for the tracking of asset value and dates of occupancy.
Outcome: The database has the capacity to provide accurate and timely data resulting in better information for basing decisions and meeting accounting standards. The data is used in the distribution of maintenance and improvement and equipment replacement funds.

Activity: Representatives of the Area Office participated in steering committee to direct the development of a web based Sanitation Deficiency System (SDS) and Project Data System database.
Outcome: These two databases provide sanitation facility unmet need and current project status information for reports to Congress. The SDS database was originally pilot tested in Alaska and has now been implemented nationwide.

Performance Objective B.4. **The Area Director will facilitate and support activities that enhance the physical capacity of health care facilities in the Area.**

Staffing New Facilities. Two small Alaska tribes will open new health clinics in FY 2005 or early FY 2006. The Metlakatla Indian Community (MIC) will open a health center in Metlakatla, and the Aleutian Pribilof Islands Association (APIA) will open a health center in St. Paul. Even though the Alaska tribes compacted the facility planning function, it became necessary that the Alaska Area assist these two small tribes in completing the budget Health Systems Planning (HSP) software and the Resource Requirement Methodology Needs Assessment (RRMNA). Our residual Continuing Services Agreement stipulates that we validate the RRMNA prepared by the tribe; however, there was no tribal facility planner to prepare the documents. Tribal organizations and their contractors are still working to develop proficiency in completing the RRMNA and HSP. Alaska Area is attempting to represent both the tribal and headquarters interests in the staffing of these two new facilities.

Environmental Health & Engineering Activities.
Activity: A representative of the Area Office distributes information to the tribes in Alaska regarding the IHS Tribal Equipment program and interfaces with IHS Headquarters personnel.
Outcome: Tribal Equipment funds are made available to eligible tribally constructed health facility expansion projects.

Activity: A representative of the Alaska Area serves as a member of the IHS National Environmental Remediation Steering Committee.
Outcome: The committee makes policy decisions for environmental issues and allocates funds for submitted project requests.

Activity: Representatives of Alaska Area serve on the M&I Resource Allocation Committee.
Outcome: M&I funds are distributed to eligible tribal health corporations to maintain and expand health care facilities.

Activity: A representative of the Alaska Area provides information to Alaskan Tribal Health Corporations seeking to build health facilities on federal lands in Alaska.
Outcome: Additional health care space is provided for IHS and other funded health programs to improve and expand the health services available.

Activity: A representative of the Alaska Area serves as assistant chair to the IHS Health Facilities Advisory Committee.
Outcome: Improves communication and coordination of technical matters concerning national health care facilities engineering issues and policies.

Activity: A representative of the Alaska Area participated in a committee to review Denali Commission Proposals for allocation of construction funding for washeteria improvements (4-day event).
Outcome: Additional sanitation improvement funding was made available to Alaska rural communities.

Activity: A representative of the Alaska Area participated on the review and scoring of the National Solid Waste workgroup application process (2-day event).
Outcome: Input into selection of the grant recipients for Solid Waste Funding in Alaska was provided.

Activity: A representative of the Alaska Area participated on the Denali Commission review committee for funding rural Health Clinics (4-days).
Outcome: Additional funding for improvements to health facilities was provided to Alaska rural communities.

Activity: A representative of the Alaska Area attends meetings to organize the expanded Alaska Health Facilities Advisory Committee.
Outcome: The operating guidelines are being developed and the expanded mission defined for this Alaska based tribal committee.

Activity: A representative of the Alaska Area serves as a reviewer on the Denali Commission's evaluation committee for statewide Alaska Rural Primary Care Facilities Construction Program.
Outcome: Project proposals were reviewed and prioritized and $28.35 million dollars in small clinic planning, design and construction funding was provided in FY 2003.

Activity: A representative of the Alaska Area attends multi-agency coordination meetings concerning the provision of sanitation facilities for Housing and Urban Development funded housing construction for Native Americans.
Outcome: Improved communication and coordination and project planning among the native housing entities, regional housing authorities and funding agencies.

Activity: A representative of the Alaska Area attends teleconference calls on the IHS National Environmental Remediation Steering Committee.
Outcome: The committee made policy decisions for environmental issues and allocated appropriated funds to submitted project requests.

Activity: A representative of the Alaska Area participates in teleconference calls and meetings of the IHS Health Facilities Advisory Committee.
Outcome: Improved communication and coordination of technical matters concerning national health care facilities engineering issues and policies.

Activity: A representative of the Alaska area participates in meetings of the Sustainable Utilities Steering Committee sponsored by the USDA Rural Development and Department of Environmental Conservation.
Outcome: Communication between 18 Federal, State, Utility, Non-for-Profit and State legislature participants was improved. A report outlining activities and responsibilities of the participants for furthering sustainable public health utilities was developed. The committee utilizes this report on an ongoing basis to coordinate activities of the server agencies that are participating.

Activity: A representative of the Alaska Area serves as a member of the University of Alaska Anchorage Engineering and Science Management Graduate Program advisory committee.
Outcome: The committee provides advice to the department chair on degree programs with the goal of building engineering and project management education and training capacity for the Pacific Rim region. Currently there are six IHS employees who are detailed to Tribes and are working part-time on a engineering masters degree program.

Activity: A representative of the Area Office participated in a meeting of the Governor's Water and Waste Water Advisory Board this fiscal year.
Outcome: The Board provides oversight and guidance to the State of Alaska water and wastewater treatment operator certification program.

Performance Objective B.5. **The Area Director will facilitate and support systems and programs to maintain 100% accreditation of Area Indian health care facilities (GPRA Indicator #20).**

The following tribal facilities provide us with their accreditation scores.

	Score	Last Survey	Next Survey
Alaska Native Medical Center (H), Anchorage	95	11/2000	11/2003
Samuel Simmonds Memorial Hospital (H), Barrow	96	9/2000	9/2004
Chief Andrew Isaac Health Center (C), Fairbanks	P [1]	1/2003	10/2006
Kanakanak Hospital (H), Dillingham (Bristol Bay)	86 [2]	10/2001	10/2004
Ketchikan Indian Health Center (C), Ketchikan	P [1]	11/2002	11/2005
Maniilaq Health Center (H), Kotzebue	94	9/2000	9/2003
Norton Sound Hospital (H), Nome	84	9/2000	9/2003
SEARHC Medical/Dental Clinic (C), Juneau	94	9/2001	9/2004
SEARHC Mt. Edgecumbe Hospital (H), Sitka	91	9/2001	9/2004
Yukon Kuskokwim Delta Regional Hospital (H), Bethel	98 [3]	10/2003	10/2006

[1] The Accreditation Association for Ambulatory Health Care (AAA) scores pass or fail.

[2] Bristol Bay Area Health Corporation's score is an average of three scores (hospital 82; home health 83; behavioral health 94).

[3] Yukon Kuskokwim Health Corporation's score is an average of three scores (hospital 96; home care 100; behavioral health 99)

NOTE: H = Hospital; C = Clinic

Performance Objective B.6. **The Area Director will provide leadership and assistance to support the implementation of HIPAA privacy requirements in all Area Indian health care facilities.**

A representative of the Alaska Area participates in the Alaska Native Tribal Health Consortium Statewide HIPAA Task Force, which has been a forum for P.L. 93-638 Title I and V organizations to develop and implement plans for HIPAA requirements. Although compactors and contractors have assumed responsibility for such programs, functions, services and activities, the Area Office has a liaison to funnel information, policies, procedures, training opportunities that have come out of IHS or other external sources to this group.

Performance Objective B.7. **The Area Director, in collaboration with the Director, will describe the Area Vision with a schedule of outcomes and assessment methodology to achieve the Agency mission.**

Alaska Area Office managers are currently undergoing a series of strategic planning meetings to update the Area Office Mission, Vision and Values. They will then update the Area Strategic Plan. These strategic planning activities will continue in FY 2004. A copy of the draft Mission, Vision and Values is included.

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Alaska Area Native Health Service

MISSION, VISION and VALUES
Progress Report as of
August 2003

MISSION:

The mission of the Alaska Area Native Health Service is to promote the health of Alaska Native and American Indian beneficiaries by providing assistance to tribes and tribal organizations.

VISION:

To lead the IHS in support of tribal self-governance, earning recognition as a highly professional and critical component of the Alaska Native health care delivery system with the best health consultants and technical support staff available for Alaska Native organizations.

OR;

To be recognized as a highly professional health organization, leading the IHS in support of tribal self-governance, with the best health consultants and technical support staff available to Native organizations.

(As compared to the following 1994 version);

To be recognized as a highly professional health organization with the best health consultants and technical support staff available for Alaska Native organizations.

VALUES:

Honesty – We are truthful in our dealings with internal and external customers.
Willingness – We have a dedicated, enthusiastic, and positive attitude.
Professionalism – We seek and demonstrate expert knowledge in our employees.
Service – Our customers' needs and expectations are critically important to us.
Quality – We efficiently deliver responsive support to our customers.
Caring – We are sensitive to the well being of Native communities and people.
Resourcefulness and Creativity - We value all ideas as potential improvements.
People – We are grateful for our employees' abilities, diversity, aspirations, and contributions.
Listening – We listen respectfully and thoughtfully with our ears, our eyes and our hearts.
Teamwork – We work together knowing that we can do together, what we cannot do alone.

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Performance Objective B.8. **The Area Director will provide leadership and support to Area Indian health programs to assist the Agency achieve the measurements prescribed in the OMB Program Assessment Rating Tool (PART) process.**

Not applicable in fiscal year 2003. [Handled entirely by Headquarters]

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Element C. Improve Management Systems

The Area Director will provide leadership and direction on Presidential, Department, and Agency initiatives which support improvements to management systems.

Performance Objective C.1. **The Area Director will support and promote all major One-Department Management Goals, and in particular for FY 2003 the following objectives.**

"One Department" Management Goals
Alaska Area/IHS Collaboration With HRSA to Fund Research and Evaluation Grant Proposals.
Because Alaska tribes compacted their shares of the IHS budget line item "Research and Evaluation", they are no longer eligible to compete for research and evaluation grants. Historically, Alaska tribes submit between one and five proposals for research and evaluation projects each year. The Alaska Area had submitted five tribal research and evaluation proposals in early 2003 that needed alternative funding sources. Both Alaska Area and Headquarters planning officers are working to find alternative funds for research and evaluation projects.

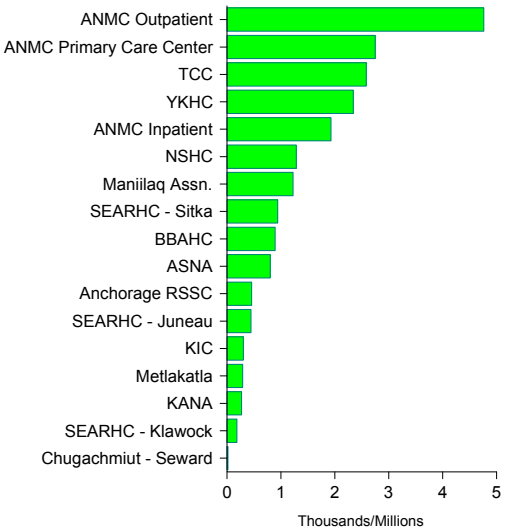
In August 2003, the Health Resource and Service Agency (HRSA) committed funding for one of the proposals submitted by the Southeast Alaska Regional Health Consortium (SEARHC). The project is entitled a "Rural Integrated Health Delivery System Evaluation". An interagency agreement between the Indian Health Service and the Health Resources and Services Administration was signed in August 2003.

On September 10, 2003, Alaska Area met with HRSA representatives, National Rural Health Service Center representatives, and SEARHC representatives to work out the details of the IHS/HRSA collaboration:

- The funding will come from HRSA to IHS Headquarters, through the Alaska Area Office, and finally to SEARHC.
- The Alaska Area will provide project officer support.
- IHS reporting requirements will still be in place.
- SEARHC will agree to work with the National Rural Health Service Center on a similar HRSA funded project.

The Alaska Area continues to administer several long-term contracts in support of the Alaska Native Medical Center (ANMC) for which termination was not practical or cost effective when management of the ANMC was transferred. The Alaska Area additionally provides support to the ANMC through the purchase of a variety of medical supplies and equipment, available through contracts with the Department of Veterans Affairs (VA) and for which tribal organizations are not authorized to make purchases.

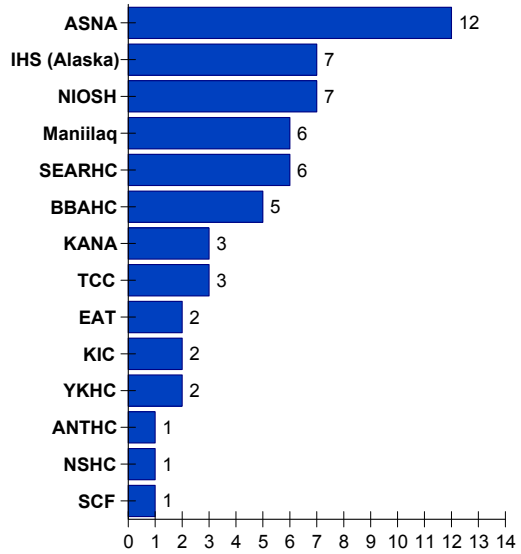
Alaska Area Native Health Service
Acquisition of $21 Million in Pharmacy Products
for Alaska Tribal Health Organizations
FY 2003



ANMC=Alaska Native Medical Center; TCC=Tanana Chiefs Conference; YKHC=Yukon Kuskokwim Health Corporation; NSHC=Norton Sound Health Corporation; SEARHC=Southeast Alaska Regional Health Consortium; BBAHC=Bristol Bay Area Health Corporation; ASNA= Arctic Slope Native Association (Barrow); RSSC=Regional Supply Service Center; KIC=Ketchikan Indian Community; KANA=Kodiak Area Native Association
Source: Alaska Native Tribal Health Consortium, Finance Department.

These purchases, which are reimbursed to the IHS through the buy-back system, represent a considerable savings to the ANMC. The Alaska Area also continues to purchase pharmacy products for 16 tribally managed clinics and hospitals within the Alaska Area through a Prime Vendor Contract awarded by the VA. This contract provides for on-line ordering and next day delivery, including the most rural areas of Alaska, and at a considerable savings to the tribal organizations.

Alaska Area Non-Pharmacy Contracts
with Alaska Tribal Health Organizations
and NIOSH
October 1, 2002 - September 25, 2003



ASNA = Arctic Slope Native Association, NIOSH = National Institute for Occupational Safety & Health, SEARHC = Southeast Alaska Regional Health Consortium, IHS = Indian Health Service, KANA = Kodiak Area Native Association, ANTHC = Alaska Native Tribal Health Consortium, SCF = Southcentral Foundation, BBAHC = Bristol Bay Area Health Corporation, KIC = Ketchikan Indian Community, NSHC = Norton Sound Health Corporation, TCC = Tanana Chiefs Conference, EAT = Eastern Aleutian Tribes, YKHC = Yukon Kuskokwim Health Corporation.
Source: AANHS, Office of Acquisition Management

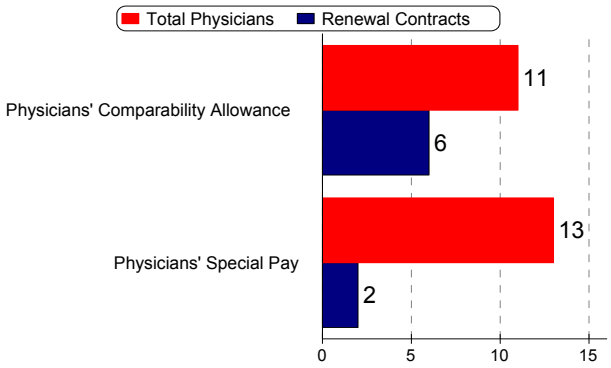
C.1.1. Ensure at least 20% of IHS contracted service dollars are subject to performance-based contracting criteria.

Since the Alaska Area has all programs managed through P.L. 93-638 contracts with tribal organizations, there are no longer any opportunities for awarding commercial contracts which are subject to performance based contracting criteria.

C.1.2. Support IHS Human Capital Plan by assisting in meeting specific recruitment and retention targets for specific skill areas and position types.

The Alaska Area Human Resources department assists the tribal organizations in retention of their physicians by advising on and maintaining the Physicians' Comparability Allowance and Physicians' Special Pay contracts.

Alaska Area
Total Number of Physicians
with Comparability Allowance and Special Pay
Fiscal Year 2003



Source: IHS, Alaska Area Native Health Service, Human Resources Department

C.1.3. Support the IHS Workforce Plan objectives by reducing position vacancy rates of the high priority occupations (Medical Imaging, Podiatry, Dental, Optometry, Pharmacy, Nursing, Physician and Physical Therapy) by 5%, reduce the time-to-hire to 120 days, and improve to 20% the number of hires retained after 6 months.

Tribal organizations in rural areas of Alaska have traditionally had difficulty in obtaining and retaining health care professionals to provide medical care to IHS beneficiaries, particularly dental services. This recruitment problem is derived in part from the difficulty of obtaining a license to practice in Alaska and a unwillingness by many health care providers to undertake the licensure process when they are unsure of their interest in rural Alaska. In FY 2001, the Alaska Area began a program to recruit and retain health care professionals and thereby increase the access for IHS beneficiaries. The program was expanded in FY 2002 and in FY 2003 and will continue into FY 2004. By working with tribal organizations and advertising nationally, the Alaska Area

has been highly successful in obtaining health care providers through personal service contracts with the IHS and assigning the health care provider to a tribally managed facility. This process allows time for the health care provider to develop a relationship with the tribal organization and complete the licensure requirements, at which time the personal services contract can be terminated and the health care provider hired directly by the tribal organization. Other health care provider awarded personal service contracts may have their own practice in another state or be semi-retired and only provide services to the IHS/tribal organization on an intermittent basis. Either way, this resulted in a substantial increase in care to IHS beneficiaries. The Alaska Area currently has in excess of 60 personal services contractors providing health care to tribal organizations, primarily dental services, but also including physicians, pharmacists, dental assistants, physician assistants and nurse practitioners. In FY 2003 the office awarded 58 new contracts, for 30 dentists, 8 physicians, 1 nurse practitioner, 3 dental hygienists, 2 physician assistants and 14 others to provide a variety of supplies and services. The Alaska Area continues to administer contracts awarded in previous fiscal years for which option year(s) were exercised. During FY 2003, several dentists and physicians providing service to tribal organizations under personal service contracts, obtained their license to practice in Alaska, and subsequently accepted direct hire employment with the tribal organization(s).

Performance Objective C.2. **The Area Director will have in place performance contracts with lead Area Office and service unit staff with expected outcomes that support the Director's Performance Contract and other performance objectives.**

All Alaska Area staff have performance contracts in place.

Performance Objective C.3. **The Area Director will demonstrate support for public affairs activities that provide public visibility for the accomplishments of the IHS.**

Visiting Dignitaries and Related Activities.
On October 2, 2003, Brigadier General Dunn, Regional Tri-Care Director, visited the Alaska Area Native Health Service, the Alaska Native Medical Center and the Southcentral Foundation Primary Care Center to acquaint himself with the health care programs offered to native beneficiaries and military beneficiaries through Tri-Care Inter Agency Agreements with the Alaska Federal Health Care Partnership.

During August 4 - 8th, 2003, Secretary Thompson visited the Alaska Area with his staff Alex Azar, Andy Knapp, Charlie Curie, Kerry Weems, Andy Bush, Harry Wilson, Michael Lonetto, Dave Boyer, Eric Broderick, Gena Tyner-Dawson and Stacey Ecoffee. Dr. Charles Grim also accompanied the Secretary on most of his visits. Secretary Thompson and Dr. Grim participated in tribal consultation with Alaska and Northwest tribes, and acquainted senior staff with Alaska tribal health organizations and their programs. Mr. Thompson traveled with his staff and the Alaska Area Director to the Bristol Bay Area Health Corporation (BBAHC) in Dillingham and met with the directors of the hospital and Native Association (BBNA). They toured the BBNA Family Center. The group flew to Barrow for a meeting with native community leaders and the hospital staff. A flight was arranged to Point Hope where the people had a planned luncheon of native foods in honor of Secretary Thompson. The next stop was Nome, Alaska for a visit to the proposed new hospital site.

Dr. Charles Grim, was sworn into the office of IHS Director during his trip to the Alaska Area on August 6, 2003. The ceremony was officiated by Secretary Thompson, and attended by U.S. Senator Lisa Murkowski, Congressional staff Liz Connell, Brian Gavitt and Cynthia Ahwinona, and State Commissioner of Health and Social Services, Joel Gilbertson. Ms. Sally Smith, President of ANHB participated in the ceremony by holding the Bible.

The Alaska and Portland Areas participated in an August 8th and 9th, DHHS tribal consultation with Alaska and Northwest Tribes at the Anchorage Sheraton Hotel. Representatives of each DHHS agency provided a separate one-hour session with tribal officials to discuss respective DHHS programs and answer questions. Region X Directors from CMS, SAMHSA, Office of Public Health & Science, CDC, Administration on Aging, Assistance Secretary for Budget, Technology and Finance; Asst. Sec. for Planning and Evaluation, Administration for Children and Families, Health care Research and Quality, National Institutes of Health, Office of Civil Rights were in attendance. The Portland Area Director, Alaska Area Deputy Director and Office of Engineering Services Director, Region 10, represented the IHS at the August 8th short sessions. Dr. Grim represented the Indian Health Service at an all-day general open consultation on August 9th.

Jay Lefkowitz, Deputy Assistant to the President for Domestic Policy, accompanied Mr. Mandregan, Area Director, AANHS on a site visit to Kasigluk, Alaska on August 28, 2003, at the encouragement of Secretary Thompson during a recent White House meeting. Mr. Lefkowitz had never before seen rural Alaska. Mr. Lefkowitz expressed his appreciation for the opportunity to see what he "couldn't have seen anywhere", had HHS and IHS not made the arrangements. He asked very insightful questions during the flight from Denali Park (where he had been on a sight visit with the Department of Interior), to Kasigluk. Mr. Mandregan gave a presentation on the IHS role in meeting the trust responsibility to Alaska Natives and American Indians; the HHS government-to-government relationship with tribes pursuant to Title V of PL93-638; the inherently federal role of the Alaska Area Native Health Service; the structure of the tribally managed health care delivery system; and health issues that affect Alaska Natives. Mr. Lefkowitz asked about infrastructure, health status/disparities, culture, religion, socioeconomic, education, and social issues of the kind that contribute to our extremely high death rates due to accidental injury, suicide and alcohol abuse.

Mr. Lefkowitz was openly amazed at the remoteness, the living conditions and lack of sanitation facilities. He visited for some time with the Community Health Aides, at what is yet a weathered and aged clinic. They told him of the most common reasons patients present for care, and of a recent outbreak of boils among villagers, attributing it to lack of adequate water supply in homes, and the consequential hygiene problems that ensue.

He visited the D-12 school, the only place in Kasigluk with running water and flush toilets. School was in session, and Mr. Lefkowitz enthusiastically took time and talked in the hallway between periods with several Native high-school aged kids. They said "holy cow" when they realized where he worked, and that he personally spoke with the President on a routine basis. He also visited with 2nd and 3rd graders, who were in a Yupik language immersion classroom. All the writing on the walls and lessons were in Yupik. The students and teacher spoke to him in Yupik, then translated to English. He reviewed the book selection in the school library. The Principal described the greatest challenge as overcoming the gap between the reality of their existence and what they read in books. They have no context from which to comprehend what they read in books.

Mr. Lefkowitz then crossed the Johnson River by boat to see "Old Kakigluk" where a sizable portion of the community still lives. He commented that he had seen poverty on such levels in Palestinian refugee camps, but that the Yupik people didn't exude the anger seen there.

Before departing Anchorage, Mr. Lefkowitz said he would tell the President what he saw - that we would tell lots of people what he saw. He said there was lot of work left to do. He expressed his opinion that folks from the Office of Management and Budget (OMB) should see what he saw, and that he would recommend that they do so.

Bev Clarno, Regional Director for the U.S. Department of Health & Human Services in Seattle, Washington, and Mr. Brian Gavitt, Legislative Aide to Senator Lisa Murkowski

visited the Alaska Area and toured the Alaska Native Medical Center, in Anchorage. Ms. Sharon Miller, Director of Finance AANHS, accompanied them to the Yukon Kuskokwim Health Corporation Offices in Bethel, and the Tundra Swan Inhalant Treatment Center in Bethel. They also visited the village of Kasigluk and a sub-regional clinic at St. Mary's Alaska. Ms. Clarno and Mr. Gavitt also visited the Tanana Chiefs Conference and Clinic in Fairbanks, Alaska with the AANHS Deputy Director, Kenneth Glifort, MD.

Jerry Farrell, Executive Director of the Commissioned Officers Association of the USPHS was in Anchorage during the first two weeks of September to review the scheduled location for the 2004 Commissioned Officer's Association national convention. During his visit here he met with the AANHS Director, Mr. Christopher Mandregan, Jr., MPH; Paul Sherry, CEO Alaska Native Tribal Health Consortium (ANTHC) and Ms. Katherine Gottlieb, CEO Southcentral Foundation (SCF) and Dr. Doug Eby Director of SCF Primary Care Center and members of the local branch of the Commissioned Officers Association. Mr. Farrell also toured the Alaska Native Medical Center.

On September 15 -19 2003, Dr. Frances Murphy, VA Deputy undersecretary for Health for Health Policy Coordination toured the Alaska Native Medical Center and traveled to Kotzebue to view the use of Maniilaq Health Association's tele-medicine equipment.

On September 3, 2003, Patricia S. Pearson, Human Resources Center Director, DHHS, Baltimore, visited the Alaska Area Native Health Service. Ms. Pearson met individually with the HR staff to discuss the HR consolidation, and then met with the Area Director and Office Directors to discuss the consolidation efforts, and how the process would work.

Presentations. Ms. Deborah Segelhorst, a 32 year employee of IHS was invited to speak at the Federal Women's Program on Equality Day, August 28, 2003. The topics of the program were to discuss the glass ceiling, women mentoring women and obstacles in the work place.

The Alaska Director, Mr. Christopher Mandregan, Jr., MPH gave a presentation on the Alaska Area Native Health Service/Indian Health Service Mission to the Alaska Federal Health Care Partnership Executives in Juneau on July 24, 2003. The AFHCP visited the Coast Guard Station in Juneau, to assess the health care and use of tele-health.

Federal Women’s Program. Ms. Deborah Segelhorst has been delegated the task of working as the Alaska Area Native Health Service, IHS Public Affairs Officer. In compliance with Executive Order 11375, the Area Director has made a concerted effort to ensure that a staff member participates in the Federal Women’s Program (FWP). The Area office conference room has been utilized for Federal Women’s Program planning committee meetings. The Area Director has appointed Ms. Deborah Segelhorst as a replacement for the FWP manager who transferred to another agency. The Area Director contributed funds towards ensuring FWP can provide training to federal employees in Alaska through its annual Career Challenges program. Ms. Segelhorst participated in the

Federal Women's Program Presentation on Women Mentoring Women as a panel member to talk about her experiences in the federal workforce, talking about her experiences as a female director working in the Indian Health Service.

Performance Objective C.4. **The Area Director will implement within the Area restructuring to support Department, Restructuring Initiative Workgroup (RIW), and Headquarters initiatives.**

Continuity of Operations Plan. As specified by DHHS and Homeland Security, we are required to have the capability of maintaining continuous operations in accordance with Executive Orders 12656 and 12472, during an emergency or threat. Ms. Deborah Segelhorst, Director, Office of Awards & Administration has volunteered to help establish the COOP for the Alaska Area. This project includes establishing a Circular, Training, Resource Documents and a desktop exercise and simulation.

Tribal Consult on IHS Restructuring. The Alaska Area held a tribal consult on the restructuring initiative on October 23, 2002 in Anchorage. There were 30 tribal representatives in attendance. The "Alaska Area Tribal Position Statement" regarding the restructuring initiative dated October 2002 is attached in section B of the Addendum.

The November 22, 2002, HDQ restructuring plan was presented to the Alaska Native Health Board (ANHB) and the Tribal Health Directors during a joint December 2, 2002 meeting in Anchorage. Due to logistical limitations, the formal consultation for the final draft was conducted primarily in writing and through teleconference.

Restructuring Initiative Workgroup. The Alaska Area Director serves as a member of the nation-wide Restructuring Initiative Workgroup (RIW).

Technical Advisory and Assistance Services on HHS Restructuring. The Area Director has provided technical assistance to the Director, IHS and the Office of the Secretary, DHHS on how to address Alaska Tribal Health Compact co-signer proposals in the context of the DHHS Human Resources consolidation initiative. This included management, political, contracting/compacting, and cost analysis of the tribes' proposal and implications thereof.

Additionally, the Alaska Area Human Resources Office and Financial Management Officer provided technical advisory and assistance services to the IHS National Council of Executive Officers and the Director, DHHS Baltimore Human Resources Service Center, on how best to implement the HHS HR consolidation in a seamless manner.

Performance Objective C.5. **The Area Director will demonstrate successful performance of GPRA Indicator #44 to support P.L. 93-638 contracting by tribes of Agency programs in order to contribute to Agency outsourcing requirements.**

Indicator 44: During FY 2003, the IHS will support the efficient, effective and equitable transfer of management of health programs to tribes submitting proposals or letters of intent to contract or compact IHS programs under the Indian Self-Determination Act by:

a. providing technical assistance to all tribes (100%) submitting proposals of letters of intent based on identified areas of need and with specific technical assistance in the area of calculating contract support costs.

No P.L. 93-638 proposals were received during FY 2003. The moratorium on Title I contracting by individual tribes in Alaska, first put into effect October 1, 1997 by section 326 of P.L. 105-83, remains in effect through September 30, 2004. Related to letters of intent, Title I mature contractor, Kenaitze Indian Tribe, indicated an interest in entering into a compact starting FY 2005. They were assisted in successfully applying for a compact planning grant.

b. reviewing all initial contract support cost requests submitted using the IHS Contract Support Cost Policy Protocol to assure the application of consistent standards in order to assure equitable and approvable requests.

Four (4) Indian Self-Determination contract support cost proposals were received and successfully negotiated in accord with the current contract support cost Policy Protocol including the delegated negotiation responsibility.

Performance Objective C.6. **The Area Director will contribute to the accomplishment of the Accountability Report by ensuring that administrative systems and internal controls are in place for sound fiscal management.**

Management Control Reviews.

Title I Contracting. In May 2003, the Alaska Area conducted a self-assessment of the Title I contracting management control area. No adverse findings were identified or reported.

Title V Compacting. In May 2003, the Alaska Area conducted a self-assessment of the Title V compacting management control area. No adverse findings were identified or reported.

Purchase Card Program. In May 2003, the Alaska Area conducted a self-assessment of the purchase card program. No adverse findings were identified or reported.

Contract Health Services. In May 2003, the Alaska Area conducted a self-assessment of the contract health services management control area. No adverse findings were identified or reported.

Sanitation Facilities Construction Program. In March 2003, the Alaska Area conducted a self-assessment of the Sanitation Facilities Construction Program. No adverse findings were identified or reported. In September 2003, IHS Headquarters conducted a review of Alaska Area sanitation facilities construction. Results are pending.

Real Property. In May 2003, the Alaska Area conducted a self-assessment of the real property management control area. Maintenance and improvement (M&I) funds are transferred each fiscal year to the Alaska Native Tribal Health Consortium (ANTHC) in support of eligible IHS and tribally owned health care and support facilities. Since 1998, when ANTHC entered into an Indian self-determination contract for management of statewide health services only 1.9 million of 24 million M&I funds were reported for capital improvement projects. In September 2003, IHS Headquarters conducted a review of Alaska Area real property. Results are pending.

Third Party Collections. In May 2003, the Alaska Area responded to the third party compliance plan with a negative response. The Alaska Area does not have a business office function and no federal facilities.

Contract Support Costs. In May 2003, the Alaska Area conducted a self-assessment of the contract supports management control area. No adverse findings were identified or reported.

Human Resources. In May 2003, the Alaska Area conducted a self-assessment of human resources. No adverse findings were identified or reported.

Travel. In May 2003, the Alaska Area conducted a self-assessment of travel. No adverse findings were identified or reported.

Records Management. In January 2003, the Alaska Area conducted a corrective action plan of the records management area. Alaska Area staff has been provided with the necessary storage requirements for electronic mail, which we now meet. In May 2003, the Alaska Area conducted a self-assessment of the records management area. No adverse findings were identified or reported.

Property and Supply Management. In May 2003, the Alaska Area conducted a self-assessment of property and supply management area. No adverse findings were identified or reported.

Information Systems Management. In May 2003, the Alaska Area conducted a self-assessment of the automated information system area. No adverse findings were identified or reported.

Audit Resolution. In May 2003, the Alaska Area conducted a self-assessment of the audit and resolution function. No adverse findings were identified or reported.

Gift Administration. In May 2003, the Alaska Area conducted a self-assessment of the gift administration. No adverse findings were identified or reported.

Personnel Security. In May 2003, the Alaska Area conducted a self-assessment of personnel security. No adverse findings were identified or reported.

Emergency Preparation. In May 2003, the Alaska Area conducted a self-assessment of the emergency preparation management control area. No adverse findings were identified or reported.

Health Insurance Portability and Accountability. The Alaska Area conducted a self-assessment of the health insurance portability and accountability (HIPAA) management control area. No adverse findings were identified or reported.

Quarters Management. In September 2003, IHS Headquarters conducted a review of the quarters management area.

Alaska Area Native Health Service
Management Control Reviews

Management Control Area	MCR	MCRR	CAP	CASR
Real Property	10/1/01; 5/19/03; 9/10/03	5/19/03	5/19/03	
Travel	8/22/97; 4/10/03	4/10/03		
Auto. Information Systems Security	4/29/98; 5/23/03	12/11/98	1/11/99; 3/17/99	6/30/99
Procurement and Purchasing	7/21/97; 5/15/03	5/15/03		
Grants				
Advisory and Assistance Services				
Hospital Accreditation (JCAHO)				
Admit. and Reimburse Procedure				
Privacy Act [HIPPA]	5/22/03	5/22/03		
Payment Management System	9/24/01			
Gift Admininstration	10/1/01; 5/10/02; 5/9/03	5/9/03		
Program User Fees				
Patents, Copyrights and Royalities				
Conference Management				
Quarters Management	9/10/03	9/10/03		
Health Promotion/Disease Prevention				
Alcohol and Substance Abuse Prgm				
Contract Health Services	9/20/01 *; 5/23/03	5/23/03		
Sanitation Facilities Construction	10/1/01; 3/28/03; 9/10/03	9/10/03		
M&M, Private Insurance Collection	5/12/03	5/12/03		
Program Fraud Civil Remedies				
Community Health Rep. Program				
Records Management	10/4/01; 5/23/03	5/23/03	1/29/03	
Urban Indian Health Programs Staff				
Administration of Agreements [AFAs]	7/21-25/97; 9/01			
Controlled Substances (Pharmacy)				
Personal Property Management	12/13/96; 9/26/01; 5/23/03	5/16/1997; 5/23/03	9/8/97	6/30/98
Management Control Sys. (FMFIA)				
Outside Activities/Conflict of Interest				
Freedom of Information				
Sensitive Material				
Supply/Warehouse	1/11/94; 5/23/03	4/28/97	6/30/97	
Audit Resolution and Cost Analysis	5/16/03			
Scholarships				
Personnel Security	6/14/02; 5/22/03	5/22/03		
Contract Support Costs	05/22/03			
Human Resources	05/23/03			
Emergency Preparedness	05/23/03			
Title I Conracting	05/22/03			
Title V Contracting	5/23/203			
Facility Construction	09/10/03			

* The survey, although limited in responses because the Area no longer conducts any CHS programs directly, had no criteria responded to with "non-compliance".

The Area Finance Office is finalizing a comprehensive review of the Buyback account. Charges continued to accumulate in the FY 2002 Buyback account after the close of the fiscal year. Upon review, it was determined that additional transactions had been charged to all the prior year Buyback accounts. Every year after fiscal year end close, we provide tribal locations with a reconciliation that includes the fund distribution totals, funding agreement (amendment) totals, details of payments processed for the agreements and information for the buyback account. The buyback account information includes the total income and the detail for expenses. Once the reconciliation is agreed by the tribal organization, no additional charges should be incurred for the account. (It is

possible that there are undelivered orders in the account after reconciliation, but increased obligations should be billed to tribes or transferred to the current fiscal year's buyback account.)

During the review, we identified several issues that impact the account: correct and timely posting of withheld amounts and checks remitted; retained shares; adjustments to original withheld amounts; external agreements; adjustments or corrections to obligations; multiple-year reconciliation (summary total or net); not requesting the correct amount for the advice; negotiated exclusions such as unemployment insurance; surcharge assessment; reimbursement of over-collected surcharge amounts and errors. Each of these items cause fluctuation in the account, contributing to charges above those originally reconciled.

The review has allowed us to balance the account by identifying amounts in excess of the reconciled amounts and transferring them to the appropriate fiscal year. It has also highlighted the need to put controls in place to prevent a recurrence of the problem in later years. The review has been used as an opportunity for training at all levels of staff, providing the knowledge, skills and confidence for managing the account for the future.

The Area Office works as a strong advocate of the Alaska Native health programs. Area Office personnel coordinate the efforts of Alaska tribes with the Indian Health Service and other health agencies. The following are partnerships maintained by Alaska Area Director with the tribes, State and local health departments, and other federal agencies to improve the quality and accessibility of services.

Performance Objective C.7. **The Area Director will implement the activities identified in the IHS Business Plan as priorities for FY 2003.**

Review of the document “A Business Plan” dated March 2003 reveals no activities clearly labeled “priorities for FY 2003.” In fact, the section Plan entitled “Next Steps” calls for adoption of the Plan, further refinement of the Action Plan, the development of a plan for implementation, and prioritization of action items into five annual work plans. The general activities of the Area demonstrate our commitment to the principles contained in the subject Plan, but it appears that this performance objective was set prematurely.

Performance Objective C.8. **The Area Director will facilitate and support Area Indian health programs to insure that systems are in place so that necessary background checks on health care provider candidates are done to prevent hiring of unqualified individuals.**

The Alaska Area Human Resources department works with the Alaska Area Contracting Officer on the Personal Services Contracts to assure that these contractors meet the investigative requirements of P.L. 101-630, the Indian Child Care Protection Act.

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Element D. Maximize Health Returns

The Area Director will provide leadership and support to assist Area Indian health programs to utilize the human and physical resources of the Area to maximize health returns for patients served.

Although we no longer administer any clinical programs, the Alaska Area continues to maintain a strong connection to tribal clinical activities and challenges. We meet periodically with the tribal Epidemiology Center and Alaska Native Health Board to increase their awareness of GPRA measures. As part of his membership in the Medical Services Networking Committee, the Alaska Area Deputy Director participates in ongoing discussions of health returns with tribal clinical directors.

Tribal Health Priorities. During the budget/GPRA consultation session in April 2003, the Alaska tribes reviewed their health priorities, and settled on the following sixteen priorities for the current year. The narrative justifications were updated to reflect the Alaska Native Health Board strategic planning objectives.

Health Priorities Identified by the Alaska Tribal Budget Formulation Work Session April 7, 2003

Ranked by Priority	Identified in Alaska Budget Formulation Process April 2003
1	Staffing Shortages/CHAP
2	Contract Health *
3	Diabetes
4	Sanitation Facilities
5	Mental Health/Suicide
6	Substance Abuse
7	Injuries
8	Dental Disease
9	Elder Care
10	Cancer
11	Domestic Violence
12	Heart Disease
13	Infectious Disease
14	Maternal & Child Health
15	Traditional Healing
16	Hearing Disease

* Contract Health includes the need for patient transportation

GPRA Pilot Project. The GPRA pilot project, which began in February 2001, received continuation funding of $146,635 for FY 2002 from the Indian Health Service's national GPRA pilot program. The program was funded above the limit of $42,000 per pilot project because it supports the development and implementation of the new GPRA+ software in six (6) Alaska sites. IHS Headquarters provides the funds for two (2) sites directly, while the grant provides the funds for the additional four (4) sites and provides for reimbursement of Project Team members meeting travel expenses. The pilot program has not received FY 2003 funding, but has remained active.

Two pilot project orientation/training sessions are being planned for the week of October 23, 2003 in Anchorage. Mike Gomez from the national ORYX project will train tribal administrators and information technicians on RPMS and ORYX data quality.

The activities of the GPRA project team have the added benefit of assisting the Area and Alaska tribes respond to reporting requirements in the new Title V amendments to the Indian Self-Determination Act, JCAHO reporting requirements and HRSA 330 grant reporting.

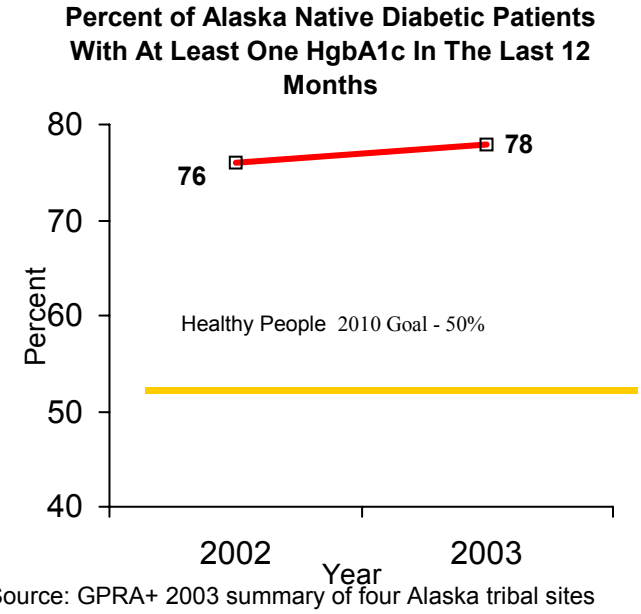
GPRA+ 2003 Software. The Alaska Native Tribal Health Consortium and individual Alaska tribes have ownership of RPMS data. The Alaska Area Office does not have access to local facility data.

In an attempt to increase GPRA+ capacity in FY 2003, the Alaska GPRA pilot program contracted with ANTHC and six local pilot sites to run GPRA+ software. After considerable discussion, four of the tribes agreed to share the local reports with IHS headquarters in mid-September. The Alaska Area Planning Officer was given permission to use the data base of four tribal facilities for purposes of responding to the Area Director's performance objectives in the SES Area Work Plan Report. The facilities would like to remain anonymous, but agree to have their data published on an Area-wide level. They ask that the Indian Health Service follow HIPAA and Privacy Act guidelines for use of the data.

Performance Objective D.1. **The Area Director will encourage and support efforts by Area Indian health programs to meet the following GPRA indicators which measure clinical treatment interventions:**

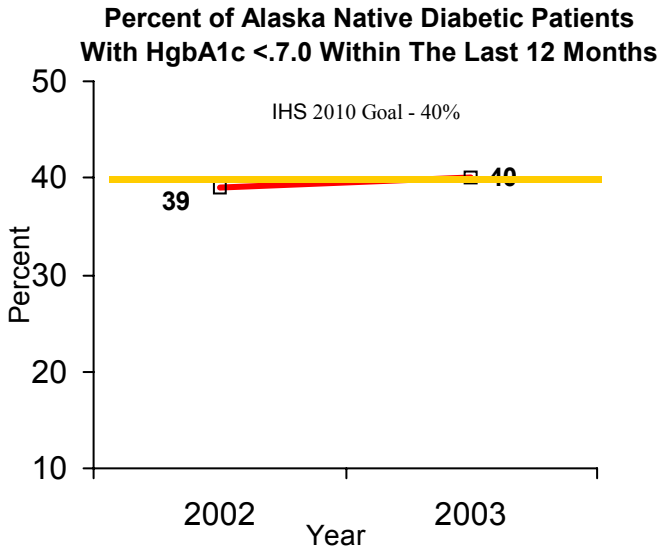
Indicator 2: During FY 2003, maintain the FY 2002 performance level for glycemic control in the proportion I/T/U patients with diagnosed diabetes.

The Alaska Area tribes are exceeding the national 2010 goal of 50% of diabetics with at least one HgbA1c.



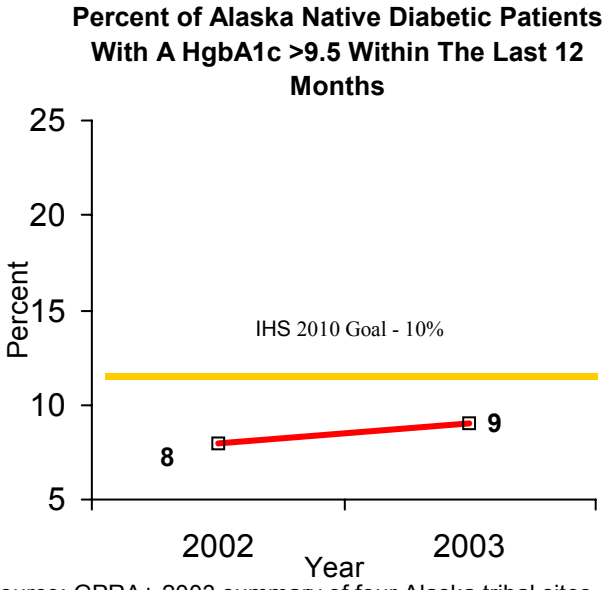
Source: GPRA+ 2003 summary of four Alaska tribal sites

Alaska tribes are maintaining the national target level of 40% for diabetic patients with HbgA1c <7.0.



Source: GPRA+ 2003 summary of four Alaska tribal sites

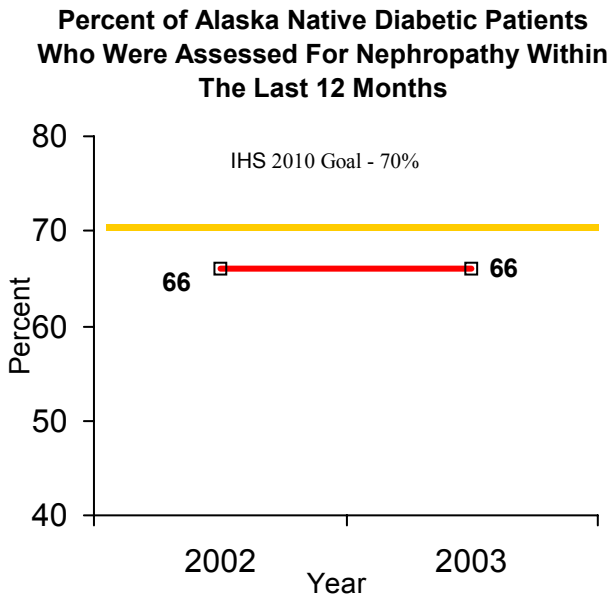
Alaska Area has exceeded the national goal of keeping the percentage of diabetic patients with HgbA1c >9.5 under 10%.



Source: GPRA+ 2003 summary of four Alaska tribal sites

Indicator 5: During FY 2003, maintain the proportion of I/T/U patients with diagnosed diabetes assessed for nephropathy.

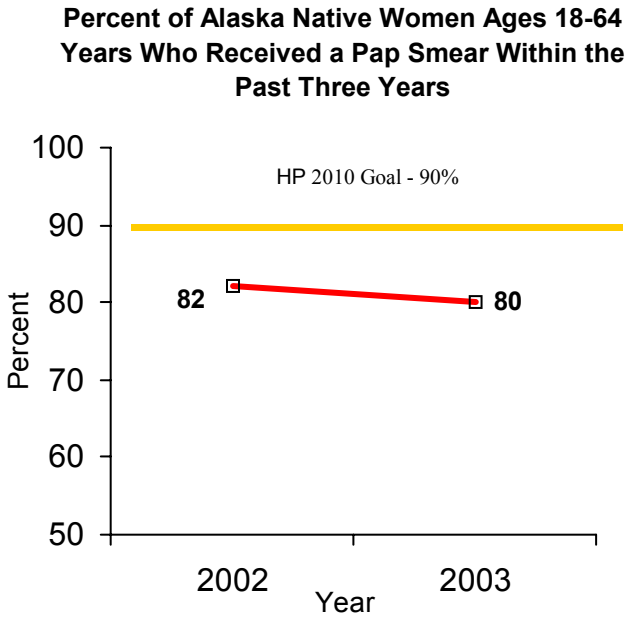
Alaska tribes are striving to increase the screening of diabetic patients for nephropathy



Source: GPRA+ 2003 summary of four Alaska tribal sites

Indicator 7: During FY 2003, maintain the proportion of eligible women patients who have had a Pap screen within the previous three years at the FY 2002 level.

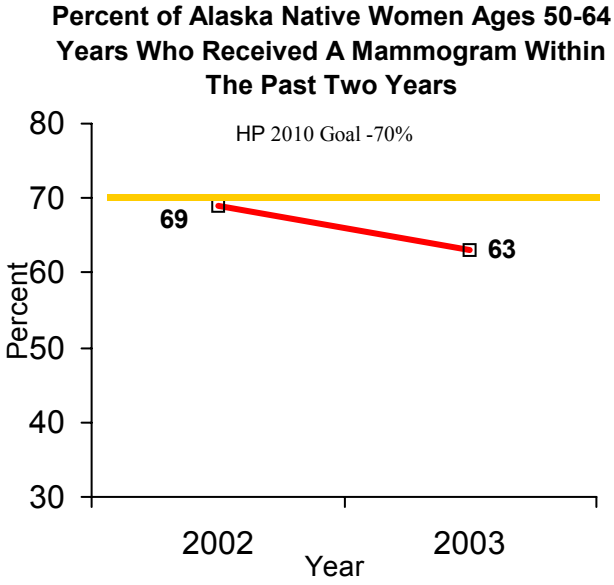
The 2003 data for Alaska Native tribes has shown a slight decline in pap screening for women ages 18-64 years.



Source: GPRA+ 2003 summary of four Alaska tribal sites

Indicator 8: During FY 2003, maintain mammography screening of eligible women patients at the FY 2002 rate.

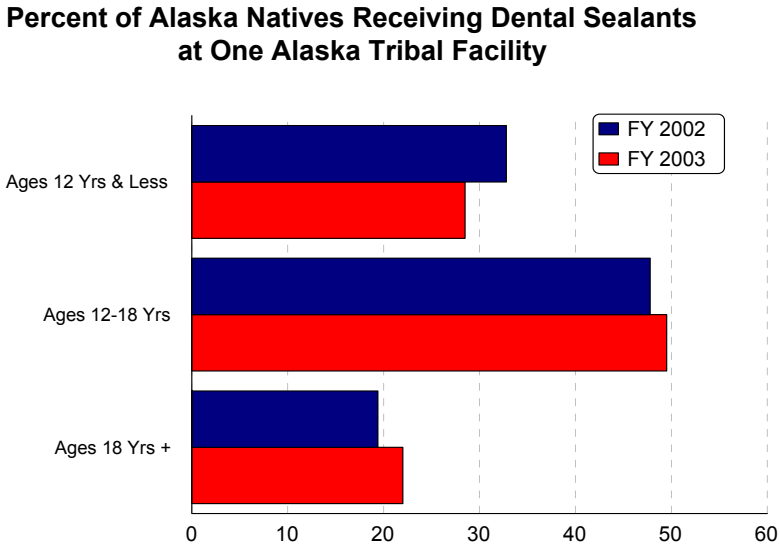
The GPRA+ data shows a decline in capturing Alaska Native women who receive a mammogram within the past two years.



Source: GPRA+ 2003 summary of four Alaska tribal sites

Indicator 14: During FY 2003, maintain the number of sealants placed per year in AI/AN children at the FY 2002 level.

The GPRA+ 2003 logic for dental sealants was determined to be invalid. These data are provided for your information. In 2003, there was an increase in dental sealants for ages 12-18 years at select Alaska tribal facility. An increase also occurred for ages 18 years and older.



Source: GPRA+ run on July 15, 2003 at one Alaska tribal facility

Indicator 16: During FY 2003 the IHS will address domestic violence, abuse and neglect by assuring that:

i. **at least 85% of I/T/U medical facilities (providing ER and urgent care) will have written policies and procedures for routinely identifying and following:**
•intimate partner abuse (IPV)
•child abuse and/or neglect
•elder abuse and/or neglect

A questionnaire was sent to 29 tribal facilities to survey their policy on treating domestic violence. Out of those 29 facilities, six (21%) responded. Of those responding, 100% had written policies and procedures for routinely identifying and following intimate partner abuse (IPV), child abuse and/or neglect, and elder abuse and/or neglect.

ii. **at least 60% of I/T/U medical facilities (providing direct patient care) will provide training to the direct clinical staff on the application of these policies and procedures.**

Of the facilities that responded to our questionnaire, 100% provide training to the direct clinical staff on the application of these policies and procedures.

iii. **(IHS Headquarters responsibility)**

Performance Objective D.2. **The Area Director will provide leadership and support to assist Area Indian health programs to meet the following GPRA indicators that measure preventive health interventions:**

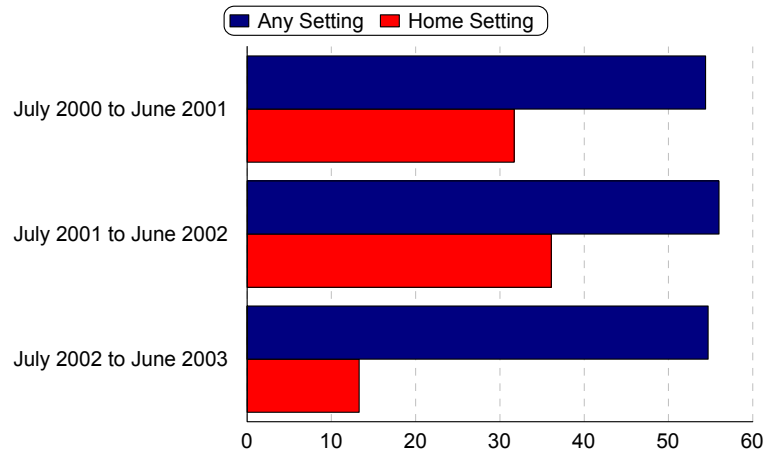
Indicator 12: During FY 2003, increase the proportion of AI/AN population receiving optimally fluoridated water by 1% over the FY 2002 levels for all IHS Areas.

During FY 2002, 51% of the Alaska Native population have fluoridated community water systems. The Alaska Native Health Consortium (ANTHC) will communicate the FY 2003 data to IHS headquarters when it becomes available.

Indicator 23: During FY 2003, maintain the total number of public health nursing services (primary and secondary treatment and preventive services) provided to individuals in all settings and the total number of home visits at the FY 2002 workload levels.

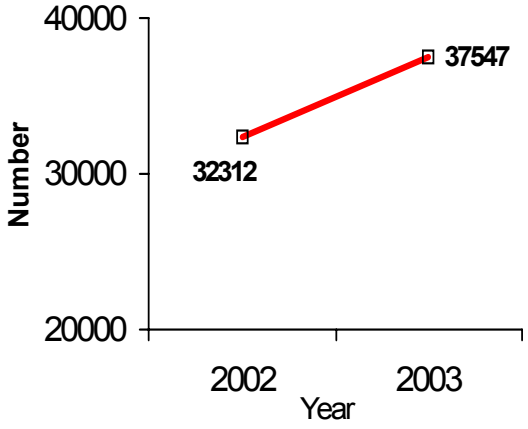
The following graph shows the workload for patients being seen by public health nurses in one select rural Alaska region. These data are assumed to be more accurate than the GPRA+ 2003 average, which includes urban areas where public health nurse visits are not counted in the local RPMS system.

Percent of Patients Served by Public Health Nurse Visits in a Rural Alaska Region



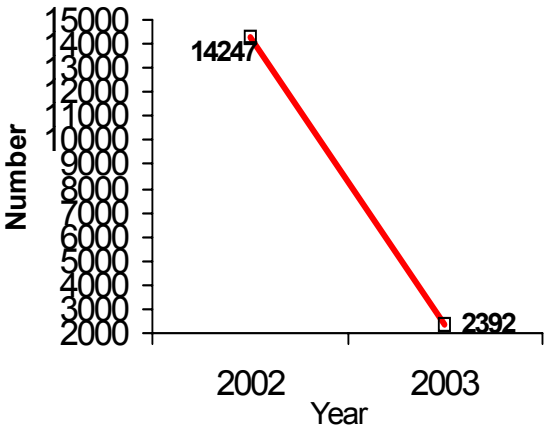
Source: GPRA+ run on September 12, 2003 in a Rural Alaska Region that has public health visits entered into their local data system.

Number of Public Health Nurse Visits to All Settings in Alaska



Source: GPRA+ 2003 summary of four Alaska tribal sites

Number of Public Health Nurse Visits to Homes in Alaska

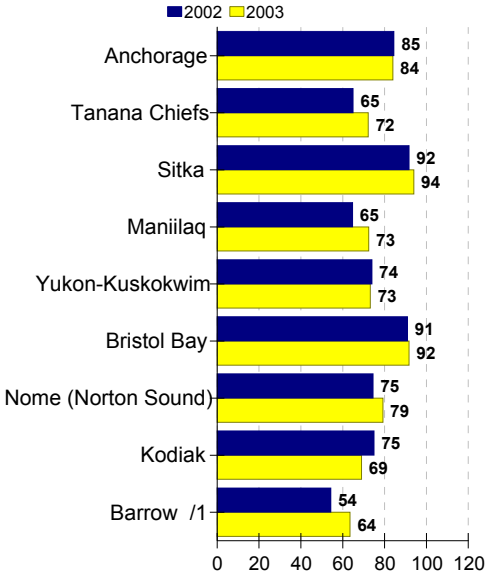


Source: GPRA+ 2003 summary of four Alaska tribal sites

Indicator 24: In FY 2003, maintain FY 2002 levels in the proportion of AI/AN children who have completed all recommended immunizations for ages 3-27 months, as recommended by the Advisory Committee on Immunization Practices.

It is our recommendation that the immunization data from the Alaska Native Tribal Health Consortium Immunization Coordinator be used instead of the GPRA+ 2003 or the suggested RPMS Qman report.

Alaska Native Immunization Rates for 3 - 27 month olds Comparing 2002 and 2003 Data

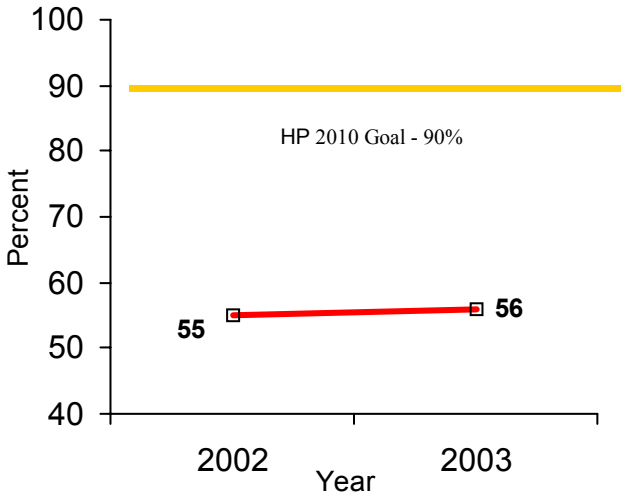


/1 Barrow did not start reporting until late 2001
Based on quarterly data 7/1/2001 - 6/30/2002; 7/1/2002 - 6/30/2003.
Source: Alaska Native Tribal Health Consortium Immunization Coordiantor

Indicator 25: In FY 2003, maintain FY 2002 influenza vaccination rates among non-institutionalized adult patients aged 65 years and older.

The Alaska Area tribes increased the vaccination rates among non-institutionalized adult patients aged 65 years and older.

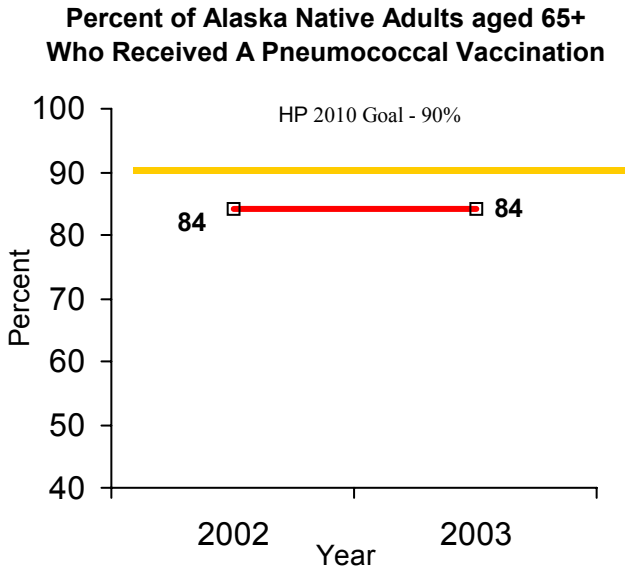
Percent of Alaska Native Adults aged 65 & Older Who Received An Influenza Vaccine In The Past 12 Months



Source: GPRA+ 2003 summary of four Alaska tribal sites

Indicator 26: In FY 2003, maintain the FY 2002 rate for pneumococcal vaccination levels among non-institutionalized adult patients age 65 years and older.

Alaska Area maintained the percentage of adults 65 years and older who received pneumococcal vaccinations.



Source: GPRA+ 2003 summary of four Alaska tribal sites

Indicator 27: During FY 2003, implement at least 36 community-based, proven injury prevention intervention projects across I/T/U settings.

Alaska Child Passenger Safety Initiative At the request of Alaska tribes, the Alaska Native Tribal Health Consortium (ANTHC) Injury Prevention Program implemented a safety seat distribution program called "Alaska Child Passenger Safety Initiative." ANTHC began purchasing infant, convertible and booster seats at dealer cost and storing them at the Alaska Utility Supply Center's (AUSC). All Alaska tribes can purchase the child safety seats from ANTHC at dealer cost. This eliminates the need for warehouse space on the part of the tribes, which has been difficult to find. During FY 2003, more than 1,000 child safety seats have been distributed, increasing the number of tribes with an active car seat distribution program from four to seven. The ANTHC Injury Prevention program sponsored the travel and course costs for three specialists to attend the AAA Child Passenger Safety Technician course in Bethel.

Smoke Alarm Project This is the third year of a five year smoke alarm project funded by the Centers for Disease Control and administered by the State of Alaska's Injury Surveillance and Prevention program. It is their goal to reduce house fire injuries to Alaska Natives by installing smoke alarms in every home, and to provide fire safety education. Every year participating tribes receive 750 photoelectric smoke alarms and funding for a village hire to assist in the installation of the smoke alarms. There are 5 tribes participating in the program. Smoke alarm use and misuse data are collected during and after smoke alarms are installed. This survey indicates that smoke alarm use in villages is increased from 20-30% to 90-100% after

implementation of this program. Earlier this year, one family in Fort Yukon and another in Buckland were saved by their smoke alarm alerting them of a fire in their home.

Safe Firearm Storage. In 2001, the Bristol Bay Area Health Corporation Injury Prevention program distributed trigger locks and gun safes to 40 homes in Manokotak. A study of this program indicated that almost 90% of the gun safes were used, but only about 30% of the trigger locks were used. Based on the community support for this project and the effectiveness it had on increasing safe firearm storage, the Alaska Native Tribal Health Consortium (ANTHC) Injury Prevention program is working with tribes to install gun safes in rural Alaska villages. During FY 2003, the State of Alaska and ANTHC purchased and distributed 150 gun safes that have been distributed to three tribes. Firearm safety education was also provided during an initial home visit. Each tribe is making unannounced visits back to each village to measure the use of the gun safes. One tribe is working with the Village Public Safety Officer (VPSO) to track the number of firearm-related calls that the VPSO receives in homes equipped with gun safes compared to the number of firearm-related calls in the control homes. The major obstacle in the gun safe storage program has been the lack of funding sources to implement more gun safe storage in villages.

Indicator 29: During FY 2003, increase by 5% over the FY 2002 level, the proportion of I/T/Us that have implemented systemic suicide surveillance and referral systems which include:

i. **Monitoring the incidence and prevalence rates of suicidal acts (attempts and completions)**

   There are several tribal programs to address suicide surveillance and prevention. We have received detailed information on one of them in the Northwest Arctic region. The Maniilaq Association Injury Prevention program maintains a suicide surveillance system that collects data on suicidal acts among the residents of the Kotzebue region. This surveillance system was improved and expanded when the Maniilaq Association was awarded a Substance Abuse and Mental Health Services (SAMSHA) grant to fund a suicide prevention project “Project Hope” in FY 2001. Data are collected in Kotzebue as well as the 11 villages served by the Maniilaq Association. Community health aides, police, doctors, nurses and counselors complete the data collection when a suicide attempt or completion occurs in the region. Project HOPE provides training to ensure that the information is recorded uniformly. The Maniilaq Association Injury Prevention program maintains a database and performs data analyses when requested by counseling services or Project HOPE staff. These data are used to track suicide trends over time and to evaluate the long-term impact of Project HOPE.

Other tribes with active injury prevention programs rely mostly on data from the Alaska Trauma Registry (suicide attempts) and the Alaska Bureau of Vital Statistics (suicide completions). Some other tribes also maintain village-based injury surveillance systems.

ii. Assuring appropriate population-based prevention and interventions are available and services are made accessible to individuals identified at risk.

The Maniilaq Association's Project HOPE works to ensure that appropriate interventions and services are available to at-risk individuals. Training provides participants with the skills to know how to identify, and what steps to take if, someone they know is thinking about suicide. Project HOPE also provides technical assistance to villages that want to implement community-based interventions to address suicide.

Injury prevention programs that promote gun-safe firearm storage have also prevented a number of firearm-related suicides. It was found that gun safes were more likely to be used by village residents than trigger locks. Before the gun safe program, 15% of firearms in village homes were locked. After distribution of gun safes, 78% of t he firearms in village homes were locked.

Indicator 30: During FY 2003, the IHS will continue collaboration with NIH to assist three AI/AN communities to implement culturally sensitive, community-directed pilot cardiovascular disease prevention programs and initiate expansion into at least one new AI/AN site. (Applies to Alaska, Oklahoma City, Albuquerque).

An IHS funded cardiovascular disease prevention program has been implemented by the Bristol Bay Area Health Corporation. The BBAHC selected the following five cardiovascular disease indicators: blood lipids, hypertension, body mass index (BMI), tobacco rates and patient education on exercise. Two other Alaska tribes have implemented cardiovascular disease prevention programs through the use of alternate funds.

- A cardiovascular disease primary prevention project the "Wise Woman Study" is being conducted by the Southeast Alaska Regional Health Consortium in the Mt. Edgecumbe Service Unit
- A cardiovascular disease primary prevention project "Traditions of the Heart" is being conducted by the Southcentral Foundation in the Anchorage Service Unit.

Indicator 37: During FY 2003, Areas will contribute to the national goal of providing sanitation facilities projects to 15,255 Indian homes (estimated 3,800 new or like-new homes and 11,455 existing homes) with water, sewage disposal, and/or solid waste facilities.

Alaska Area tribes served 4,093 homes with water facilities, and 3,004 homes with wastewater facilities in FY 2003.

Performance Objective D.3. **The Area Director will facilitate and support within the Area a comprehensive preventive health strategy to address increases in chronic diseases.**

Indicator 31: During the FY 2003, begin implementation or continue implementation of all components of the Indian health system obesity prevention and treatment plan developed in FY 2002 that include:

i. **a multidisciplinary stakeholder obesity prevention and treatment planning group**
ii. **a staff development and IT development plan to assure securing height and weight data for all system users to monitor AI/AN population obesity**
iii. **an infrastructure to collect, interpret and diffuse the approaches from obesity related demonstration projects and studies to IHS Areas and I/T/Us.**

The Alaska Native Tribal Health Consortium is represented on a multi-disciplinary prevention and treatment planning group. According to GPRA+2003 results, about 40% of active clinical users in Alaska tribal facilities have height and weight recorded in their RPMS patient records. Several tribes have used that information to begin designing obesity prevention and treatment interventions.

There is not currently an obesity prevention demonstration project in the Alaska Area.

Performance Objective D.4. **The Area Director will provide leadership and support to Area Indian health programs so that systems and programs are in place to enable the Area to track health outcomes by completing the following GPRA indicators.**

Indicator 17: During FY 2003, the IHS will continue the development of automated approaches for deriving performance information by:

i. **Completing collection of baseline data for any performance measures where electronic data collection was implemented in FY 2002 and continue collection into measurement years.**
ii. **Implementing additional electronically derived performance measures as their accuracy is proven to be sufficient.**
iii. **Distributing semi-automated LOINC mapping tool for IHS' clinical information systems to all (100%) I/T/U sites; achieve full local LOINC mapping at 5 sites in addition to the 5 pilot sites.)**

The Alaska Native Tribal Health Consortium information technology staff informed us that the Logical Observation Identifiers Names and Codes (LOINC) software has been installed on all local RPMS data systems in the Alaska Area. They are under the impression that the LOINC software is part of the most recent RPMS patch.

There are several Alaska tribes using the GPRA+2003 as an automated approach to monitor performance.

There are several Alaska tribes using ORYX software as an electronically derived performance measure for Joint Commission on Accreditation of Hospitals and Health Care Organizations (JCAHO) requirements.

Indicator 35: During FY 2003, the IHS will increase the number of active tribal user accounts for the automated Web-based environmental health surveillance system by 15% over the FY 2002 level for American Indian and Alaska Native tribes not currently receiving direct environmental health services.

The total Alaska Tribal users of the web-based environmental health surveillance system:

FY 2001 = 1
FY 2002 = 5
FY 2003 = 5

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Addendum

A. Alaska Native Tribal Health Consortium

Information Technology Services

A. Alaska Native Tribal Health Consortium

Contract with ANTHC for MIS services. The Alaska Area has an $85,470 contract with the ANTHC to provide computer support services to Area Office Employees. The ANTHC repairs and replaces computer equipment that we have purchased, maintains our connection to the ANMC campus network and updates our computer software. Responsibility and support for data quality, computer training, and system security are under the control and responsibility of ANTHC and the local tribes.

The ANTHC maintains RPMS related software, RISC systems, network services, telecommunications and telemedicine. The ANTHC and individual Alaska tribes have ownership of the RPMS local data systems.

IHS IT committees. The ANTHC has supported the Information Systems Advisory Council from its beginning and has provided members for many years including two successive co-chairs. ANTHC staff have participated in many ad hoc committees.

The Alaska Federal Health Care Partnership (AFHCP). The Alaska Area Office is an active participant in the AFHCP and has members on the Executive Committee, the Planning Committee and several other committees. This partnership of AANHS, ANTHC, ANMC, U.S. Coast Guard, Army, Air Force, and Veterans Administration provides all partners with shared educational opportunities including computer training shared clinical services, shared planning, and shared information technology projects such as teleradiology and the AFHCAN telehealth project.

Wide Area Network. The tribal Wide Area Network in Alaska (AFHCANet) is managed by ANTHC, the legs are purchased by tribes, usually with the assistance of FCC Universal Services Fund subsidies. The core is funded by AFHCAN. This network ties to IHS via tribal participation in the network, over half of t he 220 tribal clinics in Alaska now have connectivity to the system.

Support for RPMS and related software. Over fifty RPMS modules are operational on 12 computers serving almost one hundred clinical locations in Alaska. All new RPMS applications and upgrades are installed within 60 days of receipt and patches are installed within 30 days. The ANTHC has a long association with IHS ITSC in supporting alpha and beta tests for RPMS. The RPMS applications development group at the Alaska Native Medical Center has released several new packages and supports the development and implementation nationwide. In the past year ANMC has provided developmental support to ITSC on PIMS, TIU and PCC+; they have the most advanced PCC+ application in the IHS. The work ANMC is doing to interface SMS to RPMS will have benefits toward interfacing CPRS to RPMS as well. ANTHC is also supporting the development of the Community Health Center and Electronic Health Record modules.

Alaska moved its two largest RPMS databases to Cache before it was even released. All Cache conversions will be complete throughout the state by the end of CY 2003.

Creation of a statewide database sharing registration and visits, Multi-facility Integration (MFI), is more complete. The last active RPMS site is now on MFI. MFI now processes almost 1,000,000 patient encounters per year. Including Community Health Aides regionalized on hospital computers, MFI now shares data for 93 health care sites. Other villages are planning to do the same. ANTHC is actively adding small sites that have never had an electronic medical record to RPMS and MFI. Alaska is still the only Area in IHS with this capacity.

Laboratory Module patch 5 which includes LOINC codes support has been installed on the only site in Alaska running the IHS version of the Laboratory module, Barrow.

Support of telemedicine. The Alaska Area continues to make major advances in telemedicine. The Alaska Federal Health Care Partnership (Indian Health Service, Department of Defense, United States Coast Guard, Veterans Administration, ANTHC) is supporting three telemedicine projects in Alaska this year.

We are cooperating with the private sector in the Alaska Telehealth Advisory Committee (ATAC), which is formulating statewide policy, and setting up test projects. The AFHCP is joining with the ATAC to address the possibility of providing store and forward telemedicine capabilities to all (Government, nonprofit, and private) health care providers in Alaska.

The Alaska Teleradiology Project now has 13 sites statewide. Budget to do part of the third and final stage of the project has been designated for FY 2004. With matching funds from the tribes, this will complete all tribal regional installations. Funds for FY 2005 to complete more small sites are planned.

The largest project is the Alaska Federal Health Care Access Network (AFHCAN). In FY 2002 equipment was delivered for all 236 federal health care sites in Alaska. Actual utilization of the equipment has been delayed at one third of the sites mostly due to lack of telecommunications infrastructure. In FY 2003 and continuing in FY 2004, the emphasis is on increasing utilization (now over 10,000 cases), improving support with telemedicine coordinators and a help desk, and adding capabilities. Billing for telemedicine encounters has begun with Alaska Medicaid and a review of cases has shown a four to one savings by Medicaid due to travel not needed. The major uses in ENT and dermatology. In calendar year 2003 there are several studies addressing the sustainability of telemedicine after grant funding ends.

Support of telecommunications. Since the portion of the IHSNET in Alaska was cancelled, new dedicated access lines have been installed. The wide area network now includes all regional facilities and two thirds of the villages. The network includes other

participating agencies as well. All new lines are being installed utilizing the Universal Services Fund (USF) which can provide up to 90% savings; lines are T-1 or partial T-1. Internet service and Internet mail access is available to all tribal sites on the network plus others.

Polycom teleconferencing is available at 46 sites in Alaska including one in the Area Office Building which is connected to the campus IP network via wireless technology. This allows the cart with the Polycom unit to be moved to any conference room or office for use.

E-mail is available in all regional corporations although not in all village clinics.

Data/System Security. All tribal sites receive ITSC security notices. The ANTHC will continue to provide security reports for the Area Office as required. A wide range of Information Security material is available (including security training videos) for staff and remote sites. All personal computers on the Alaska Native health campus have password protection with additional password protection for RPMS and more secure web applications. Monitoring software tracks all access to the 1500 node network on the campus. Antivirus software has been loaded on all network servers and personal computers and is updated based on bulletins. Software has been loaded on the Internet Web server to prevent access to inappropriate materials. Backup tapes are made daily, rotated weekly and stored off-site. Through a state-wide HIPAA task force, all facilities have been meeting HIPAA deadlines.

Customer training. Multiple statewide training sessions on RPMS (e.g. PCC, UNIX, and Qman) are presented each year in Alaska, some supported by ITSC, some by ANTHC. Site Management training is offered annually or as needed. Classes on RPMS, Windows NT, Office Professional, computer hardware, etc., are offered weekly, throughout the year. New employees at the Area Office and ANMC are trained on PC use, RPMS, and data security at new employee orientation. Manuals for RPMS applications are distributed via ITSC CD to the remote sites and via the ANMC Intranet. ANMC computer help desk provides 7-day per week support. Cimarron Informatics has been used extensively to supplement local training for many sites.

Data quality. All admissions from tribal locations are tracked to ensure submission. HKT corrects errors in the installation of integration data via MFI.

GPRA. GPRA is becoming well supported by tribes in Alaska. A team from six regional corporations has worked extensively with ITSC to implement GPRA. They have implemented seven measures, five related to diabetes and two for Women's Health. The GPRA Pilot Project Team decided to concentrate their efforts on the diabetic GPRA indicators and the Women's Health indicators primarily because the GPRA results could be compared to data in the Diabetes Registry and the Women's Health Package.

After the initial baseline reports, the Pilot Project Team worked hard to clean their data by improving procedures and policies. Furthermore, they worked closely with IHS and Cimarron to evaluate definitions of numerators and denominators. With all the effort the Pilot Team has put into GPRA, they have become more confident about their data.

ANTHC's Health Statistician prepared a confidential report for the Pilot Project Team which included a discussion paper about the Area Aggregate report as well as graphs and tables from the Area Aggregate Report data. For those sites that submitted data to the Health Statistician, individual regional reports were prepared using format similar to that of the shared common report. Individual reports were distributed only to the regional recipient and not amongst the Pilot Project Team group members.

During the second week of September 2003 the Health Statistician received a last minute request from IHS's clinical GPRA lead for any Alaska data that could be contributed to the national GPRA results for Congress. Four of the six PIlot Project Team members gave written approval to transmit their data to California to be rolled up into the national report. This represents two thirds of Alaska's 2002 user population. In October graphs for the GPRA indicators will be distributed throughout IHS. The graphs will compare each Area's total submission outside the agency, not even to DHHS.

Addendum

B. Alaska Area Tribal Position Statement

B. Alaska Area Tribal Position Statement

Alaska Area Tribal Position Statement
regarding
Regional Support Model Proposed by the Restructuring Initiative Workgroup"

Presented and Approved
October 23, 2002

Alaska Tribal representatives present at the October 23, 2002, consultation regarding the recommendations of the Restructuring Initiative Workgroup reviewed and approved the following position regarding propose consolidation of certain administrative functions into regional support centers.

The Secretary through the IHS and tribes and tribal organizations in Alaska entered into the Alaska Native Health Compact (Compact) and individual Funding Agreements. Under the Compact and the Funding Agreements, all programs of the Alaska Area Native Health Service (Area Office), except certain residual functions, have been assumed by Tribes and Tribal Organizations. The programs, functions, services and activities of the Area Office were assumed by the Alaska Native Tribal Health Consortium (ANTHC) under the authority of section 325 of Pub.L. 105-83 and the Pub.L. 93-638, as amended.

Tribes and Tribal Organizations worked closely with the Area Office to define those functions that only a federal official may perform (residual). Tribes and Tribal Organizations also worked closely with the Area Office to develop transition plans for transfer remaining functions that would ensure that disruptions in service delivery, program support, and employment would be minimized.

These agreements were memorialized in the individual Funding Agreements between the Secretary and Tribes and Tribal Organizations and a "Memorandum of Agreement describing the Continuing Services of the IHS, AANHS." (Continuing Service Agreement) The Continuing Service Agreement is incorporated by reference into each Funding Agreement.

Under the Funding Agreement and the Continuing Service Agreement, the IHS, through its Area Office, has committed to continue to provide certain services to Tribes and Tribal Organizations. These include certain transitional services, which will diminish as the capacity of tribal providers to carry out the activity grows. The Funding Agreements and Continuing Service Agreement provide that as the activities of the Area Office diminish, the funds identified with the transitional services will be transferred to a tribal provider, principally the Alaska Native Tribal Health Consortium.

Since 1993, the Alaska Area Office has downsized from 392 employees to 47 employees, a reduction of 88 percent, by achieving greater efficiencies and by transferring functions to Tribes and Tribal organizations. The objectives of IHS Restructuring have already been achieved in the Alaska Area.

Proposed restructuring recommendations if adopted would dramatically change the ability of the IHS to meet its residual and transitional obligations under the Funding Agreements and Continuing Service Agreement with Alaska tribes and tribal organizations. Due to the geographic and time zone distance any of the support centers would have from Alaska, the quality and quantity of services available would diminish over that currently available. The Department of Health and Human Services must honor all financial and programmatic obligations made to tribes and tribal organizations in the Alaska Tribal Health Compact, Funding Agreements and Continuing Service Agreement, notwithstanding subsequent restructuring decisions.

Alaska Native Tribes and Tribal Organizations do not believe that the obligations made by the IHS can be satisfied under the regional support center restructuring model proposed. ***Alaska Native Tribes and Tribal Organizations strongly recommend that the Alaska Area be exempt from the regional restructuring proposed for the balance of the Indian Health Service.***

Addendum

C. Alaska Area Equal Employment Opportunity Activities

C. Alaska Area Native Health Service - Equal Employment Opportunity Activities

Affirmative Employment

The Area Director maintains a zero tolerance for sexual harassment. All allegations of sexual harassment are responded to within three days with fact-finding being conducted and completed as quickly as possible.

In compliance with Executive Order 11375, the Area Director has made a concerted effort to ensure that a staff member participates in the Federal Women's Program. The Area office conference room has been utilized for Federal Women's Program planning committee meetings. The Area Director has appointed a replacement for the FWP manager who transferred to another agency. The Area Director contributed funds towards ensuring FWP can provide training to federal employees in Alaska through its annual Career Challenges program.

The Alaska Area office has allowed flexible work place scheduling to accommodate residual staff members qualified debilitating conditions. Requests for reasonable accommodation are responded to in an expeditious manner.

The Alaska Area EEO staff have had the opportunity to participate in various Special Emphasis Programs through the interagency Civil Rights Committee (CRC). The ANMC campus provided a keynote speaker for the group during American Indian/Alaska Native Heritage month. The ANMC campus also provided speakers for Black Heritage month.

The Alaska Area supervisory staff attended a Diversity Day seminar conducted by the CRC.

The Alaska Area staff received training in Cultural Diversity and Barrier Removal on March 20, 2003 and March 28, 2003, respectively. The staff also were provided with the opportunity to attend the Federal Women's Program Career Challenges on April 25, 2003. A primary speaker at this program spoke on Multicultural Organizational Development.

The EEO Staff, in conjunction with DHHS OGC, developed, prepared and presented a Refresher EEO Basic training course which was available to all federal IPA employees.

Employment statistics for disabled individuals are 33 (3.3%) disabled with 5 targeted disabled individuals (.5%).

Complaint Processing

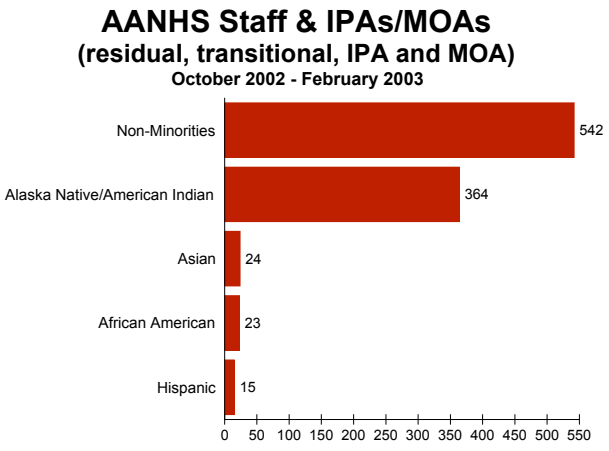
There have been two (2) informal complaints filed for FY 2003, by individuals on MOAs. One complainant did not go formal. The second is still in negotiation for informal resolution.

The Area Director attempts to ensure ANTHC and SCF recognize and attempt to resolve issues involving IPA/MOA employees when they arise.

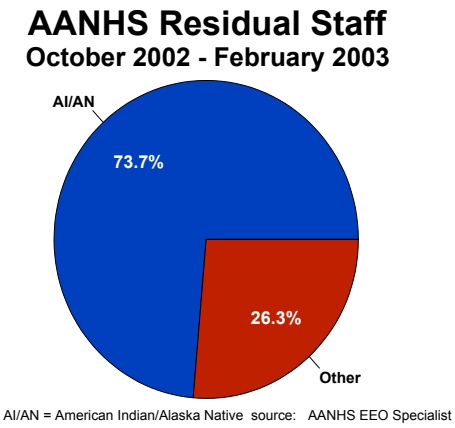
As a method of initiating a greater understanding of zero tolerance for federal employees, the Area Director has asked the EEO Specialist to provide information to all IPA/MOA employees in the Alaska Area. The Alaska Area Office has received and investigated allegations of sexual harassment involving IPA employees.

In response to an Administrative Judge's order, regarding a case file in 1998, the Area Director has received permission from the Alaska Native Tribal Health Consortium and Southcentral Foundation to provide EEO training to IPA employees working at the Alaska Native Medical Center. This training was completed during the week of January 13, 2203.

Prior to and during the informal complaint process, the Area Director supports the use of ADR.



IPA = Intergovernmental Personnel Agreement; MOA = Memorandum of Agreement
source: AANHS EEO Specialist



AI/AN = American Indian/Alaska Native source: AANHS EEO Specialist