2.3.1 Partnerships, Consultation, Core Functions, and Advocacy Category: Program Description, Context and Summary Performance

Program Description and Context

The Partnerships, Consultation, Core Functions, and Advocacy aggregation encompasses the IHS' administrative and management functions, relationships with stakeholders and consumers, and strategies for collaboration in pursuit of the IHS mission. Data for these indicators come from recognized sources including budget reports and audits, a HHS survey, and a survey of the universe of stakeholders using recognized social survey methods. The two components of this aggregation are:

Partnerships, Consultation, Core Functions, and Advocacy Category Aggregation

Direct Operations - supports management and administrative functions for Area and Headquarters staff including policy development, budget formulation, health program support, and accountability requirements (see page IHS-109 in FY 2002 budget document).

Facilities and Environmental Health Support - provides administrative and management support for the construction, maintenance, and operation of health care facilities, staff housing, and sanitation facilities (see page IHF-31 in FY 2002 budget document).

2.3.2 Partnerships, Consultation, Core Functions, and Advocacy Category: Performance Indicators

The choice of indicators for this aggregation category are based on the following criteria:

- supports and encourages tribal sovereignty, the government to government relationship between tribes and the Federal government, and tribal self-determination
- supports and encourages collaboration with stakeholders, agencies, and organizations directed toward improving the health of AI/AN people
- supports and encourages sound management practices

Achieving these performance indicators, as well as the overall coordination of the GPRA and other Federal accountability requirements represent a significant challenge for the IHS and its reduce management and public health infrastructure. The reorganization of Headquarters and many Area offices has resulted in flatter organizational structures, less specialization in function, and greater use of self-directed teams in order to increase efficiency. However, it has become increasingly clear that coupled with improved data management capacity, there are two functions that must be supported to assure overall program success and these are:

- assuring that continued and expanded opportunities for tribal consultation and participation in IHS endeavors is supported
- assuring effective recruitment of needed health discipline is achieved and that orientation, training, and support are available to enhance the retention these staff.

FY 1999 Performance Summary Table 4:
Consultation, Partnerships, Core Functions, and Advocacy Indicators

Performance Indicator	FY Targets	Actual Performance	Reference
Consultation Improvement Indicator			
Indicator 37: Improve the level of I/T/U satisfaction with the processes for consultation and participation provided by the IHS, as measured by a survey of I/T/Us.	**FY 02:** secure OMB clearance for instrument and baseline **FY 01:** implement policy and submit instrument* **FY 00:** revise policy and instrument **FY 99:** establish policy and collect baseline	**FY 02:** **FY 01:** **FY 00:** revised policy proposed and instrument developed **FY 99:** policy established but baseline delayed	**P:** p. 111 **B:** p. IHS-109 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Administrative Efficiency and Effectiveness Group			
Indicator 38: Improve the level of Contract Health Service (CHS) procurement of inpatient and outpatient hospital services for routinely used providers under contracts or rate quote agreements at the IHS-wide reporting level.	**FY 02:** 82% **FY 01:** 79%* **FY 00:** no indicator **FY 99:** no indicator	**FY 02:** **FY 01:** **FY 00:** **FY 99:** NA **FY 97:** 74% baseline	**P:** p. 112 **B:** p. IHS-109 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Indicator 39: Maintain administrative infrastructure (Area and Headquarters) no higher than FY 1999 target level while maintaining full compliance with major Federal requirements (i.e., GPRA, GMRA, ITMRA, etc.).	**FY 02:** no indicator **FY 01:** no indicator* **FY 00:** 1876 FTE or less **FY 99:** at least 10% under FY 97 level or 1876 FTE	**FY 01:** **FY 00:** 1,569 FTE **FY 99:** -22% (1,619 FTE) **FY 97:** 2085 FTE baseline	**P:** p. 113 **B:** p. IHS-109 p. IHF-31 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Indicator 40: Increase the number of interagency agreements and cooperative agreements with agencies and organizations that are directly linked to performance plan indicators.	**FY 02:** no indicator **FY 01:** no indicator* **FY 00:** 19 or more addressing indicators **FY 99:** increase by 10% over **FY 97** or 73 agreements	**FY 00:** 23 addressing indicators. **FY 99:** 86 total agreements and 18 address indicator **FY 97:** 66 agreements baseline	**P:** p. 115 **B:** p. IHS-109 p. IHF-31 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Indicator 41: Continue implementation of Managerial Cost Accounting systems across IHS settings.	**FY 02:** expand IT capability **FY 01:** secure IT capability **FY 00:** contin. implem. & develop pilot sites **FY 99:** begin implementation	**FY 02:** **FY 01:** **FY 00**: implem. contin. but pilots sites not developed **FY 99:** "cost centers" implemented in FY 1999	**P:** p. 116 **B:** p. IHS-109

Performance Indicator	FY Targets	Actual Performance	Reference
Quality of Work Life Indicator			
Indicator 42: The IHS will improve its overall Human Resource Management (HRM) Index score as measured by the DHHS annual HRM survey.	**FY 02:** at least 98 points **FY 01:** at least 97 points* **FY 00:** at least 94 points **FY 99:** no indicator	**FY 02:** **FY 01:** **FY 00:** 96 points **FY 99:** 93 points **FY 98:** 93 points baseline **FY 97:** 92 points	**P:** p. 117 **B:** p. IHS-109 p. IHF-31 * indicates revised FY 2001 measure, see Summary of Changes Table on pages 126-130.
Indicator 43: Support the Tribal Self-Determination through technical assistance and application of the IHS Contract Support Cost Policy.	**Technical Assitance** **FY 02:** 100% of new tribes **FY 01:** develop protocol **Contract Support Cost Review** **FY 02:** 100% of new tribes **FY 01:** develop protocol **FY 00:** no indicator **FY 99:** no indicator	**FY 02:** **FY 01:** **FY 02:** **FY 01:**	**P:** p. 118 **B:** p. IHS-109 p. IHF-31
Total Consultation, Partnerships, Core Functions, and Advocacy Funding:	**FY 02: $89,282,000** **FY 01:** $75,823,000 **FY 00:** $72,884,000 **FY 99:** $69,729,000 **FY 98:** $67,038,000		**P:** page # in perform. plan **B:** page # in budget justif.

FY 2002 Partnerships, Consultation, Core Functions, and Advocacy Indicators

Consultation Improvement Indicator:

Indicator 37: During FY 2002, the IHS will collect baseline data to assess I/T/U stakeholder satisfaction with the revised consultation process developed in FY 2001.

Rationale: The purpose of this indicator is to improve the consultation process with IHS stakeholders. It is fundamental to the realization of the IHS Mission and Goal that I/T/Us increasingly become participating partners in the important processes that will guide the Agency into the next century. Given the number and diversity of I/T/Us, formal policies are essential to assure broad input, a rational and equitable approach to making timely decisions, and the highest possible buy-in across I/T/Us. Equally important is securing the data to assess how well the processes are actually working, and then improving them. In addition, this indicator serves as a proxy measure of the effectiveness of the IHS Tribal Management program. Finally, during the initial reorganization of the IHS in 1995-96, the IHS was encouraged by its stakeholders to assure opportunities for local I/T/Us to evaluate the agency's progress in enhancing the consultation process and supporting recommended changes.

Approach: It is critical that the IHS form a strong and effective partnership with its I/T/U constituents in addressing the health disparities. This partnership is essential to ensure that resources are effectively and efficiently utilized to maximize the positive impact health programs have on the target I/T/U populations. Partnerships already exist with such tribal entities as the National Indian Health Board (NIHB), Regional Indian Health Boards, the Tribal Self-Governance Advisory Committee (TSGAC) and the National Congress of American Indians (NCAI).

The starting point for this activity was with the development and implementation of the IHS consultation policy and was to be followed by the development of a survey instrument to assess I/T/U satisfaction with the consultation process. This policy was actually developed ahead of schedule and was in effect at the start of FY 1999. In addition, a survey instrument was developed and tested in the spring of FY 1999. This survey instrument was to be used in FY 1999 to establish a baseline and was to be accomplished by several tribal and AI/AN organizations. However, concerns about the how the consultation process was being implemented refocused the attention of the I/T/U stakeholders on revising the policy to address specific consultation processes and new and anticipated legislative changes. As a result the collection of data was delayed pending the revision of the policy by a team that includes the I/T/U stakeholders.

The IHS elected to honor our stakeholders' preferences and support the revision of the consultation policy/process during FY 2000. However, the process of attempting to integrate the variety of strategies for revising the existing consultation policy proposed by stakeholder groups resulted in a delay in the overall process. It is now anticipated that for FY 2001, the IHS will implement a revised policy and prepare a revised instrument for clearance as required by the Paperwork Reduction Act. For FY 2002 it is anticipated that this clearance will be completed and a baseline score will be compiled.

Data Source: I/T/U survey instrument and protocol

Baseline: From baseline survey completed in FY 1999.

Type of Indicator: Process

Linkages: This indicator supports the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* and 4.3 *Increase Consumer's Understanding of their Health Care Options.* It also underpins the IHS' commitment supporting the Self-Determination process and AI/AN community empowerment.

Program Performance: The FY 2000 performance indicator stated that the IHS would work with I/T/U stakeholders to revise the consultation process and develop an appropriate survey instrument and protocol to assess I/T/U satisfaction with the IHS consultation process. The IHS met this indicator in the following manner. During fiscal year 2000, discussions with I/T/U stakeholders on the effectiveness of the consultation process occurred at several national meetings of tribal leaders as well as numerous inter-tribal regional meetings. Discussions culminated in a December 28, 2000 letter to all "Tribal Leaders" and others from the Director, IHS. The letter attached the current IHS policy and a revised policy for the IHS that had been proposed for implementation by the Tribal Self-Governance Advisory Committee. Comments on the policies are being solicited from Tribal Leaders, urban Indian health leaders, and others. It is likely that based on the comments received, and further consultation that must occur before policy changes are made, that the IHS will implement a revised consultation process and policy in FY 2001. A survey instrument has been developed that will measure the "satisfaction" with any new consultation process and policy that is implemented in FY 2001. Activities are underway at present to obtain any clearances necessary before the survey is implemented.

Administrative Efficiency and Effectiveness Group:

This group of indicators addresses the improvement of administrative functions that support the improvement of health care efficiency and effectiveness.

> **Indicator 38: During the FY 2002 reporting period, the IHS will have improved the level of Contract Health Service (CHS) procurement of inpatient and outpatient hospital services for routinely used providers under contracts or rate quote agreements to at least 82% at the IHS-wide reporting level.**

Rationale: It is important that IHS optimize its use of CHS resources. CHS regulations require the use of medical priorities to assure that persons with the most urgent need receive services and that alternate resources pay prior to IHS expending funds. Beyond these built-in requirements, IHS is making efforts to assure that we receive the best price available from our routine providers of care. To that end, we are seeking to ensure that contracts or rate quote agreements are in place that provide reduced rates to IHS and its patients with routinely used hospitals. While not every routinely used hospital will agree to some reduced rate schedule with IHS, many will, and it is to our advantage to continue to aggressively pursue cost-effective arrangements.

Approach: It is not feasible to pursue contracts or agreements with every hospital that provides services to IHS patients. Some hospitals are utilized on a one-time emergency basis when it is impossible for the patient to be moved to a contract facility, or when there is no contract facility in the vicinity. In other cases, the utilization of the facility is so infrequent that it is impractical

to contract with that facility for a small number of patient visits per year. Therefore, IHS is only interested in obtaining contracts or rate quote agreements with frequently used providers. As providers determine that agreements are feasible with the IHS, the percentage should increase.

Frequently used hospitals are defined as those facilities to which IHS paid more than $50,000 for inpatient services per year and/or more than $10,000 in outpatient services per year. Not all hospitals meet both criteria, and inpatient and outpatient service contracts and rate quotes will be tracked separately. Those facilities that IHS paid for catastrophic services will be adjusted to further develop valid data on payments for patient services. Changes to reflect calculation based on using amount paid; large amounts related to CHEF cases need to be adjusted from the calculation process for contracts and rate quote agreements. Adjustment of earlier percentage reported to be consistent with the changes due providers who have opted out of HCFA managed care plans.

To calculate the percentage rate we divide the amount paid to frequently used hospital providers with contracts or rate quote agreements, by the amount paid to all frequently used hospital providers, with an adjustment for catastrophic services. The IHS fiscal intermediary (FI), who makes IHS' CHS payments, will provide these amounts. The FI also maintains information on contract and rate quote agreements and applies the contract or agreement rate to the payment. The FI maintains records by individual provider and composite data can be provided.

Data Source: The IHS CHS database collected by Blue Cross and Blue Shield of New Mexico, the IHS Fiscal Intermediary.

Baseline: The IHS will use FY 1997 claims paid data as the baseline. For this year the calculated rate is 74 percent. The reason why the baseline of FY 1997 is chosen is that the data are 99 percent complete.

Type of Indicator: Process

Linkages: These indicators support the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* the accountability requirements of a DHHS OPDIV, and support H P 2010 objectives in Focus Area 1: Access to Quality Health Services.

Program Performance: No FY 1999 Indicator.

Indicator 39: ***No FY 2001 or FY 2002 Indicator***

Indicator 39: During FY 2000, the IHS Headquarters and Areas will maintain full compliance with major Federal requirements (i.e., GPRA, GMRA, Clinger-Cohen Act, etc.), without expanding the administrative staff above the FY 1999 FTE target level.

Rationale: A major recommendation in the IHS reorganization plan was to downsize and streamline the IHS Headquarters and Area Offices and move from controlling and directing to providing consultation and support to I/T/Us. This recommendation supports the continued transition to local control but represents a significant challenge because of the loss of economies of scale in the decentralization process. In the FY 1999 performance plan the IHS committed to

reducing the number of FTE s in IHS Headquarters and Areas by 10 percent over the FY 1997 level.

For FY 2000 the IHS is committing to maintaining the reduced Area and Headquarters administrative FTE level at the target FY 1999 level (i.e., 10% below the FY 1997 level) and to focus resources at providing access to services. Further reductions in administrative positions will be considered with caution given the increasing accountability requirements for which the Agency must be responsive and the importance of field support. Thus, this indicator has not been extended beyond FY 2001.

Approach: To accomplish this indicator the IHS continues the process of reorganizing Headquarters to a flatter and simpler structure and integrating the use of multi-disciplinary teams to address important functions, including the GPRA. Many Areas are also reorganizing to more efficient structures.

As described in Performance Indicator 40, we have been attempting to expand the development of partnerships with outside organizations to bolster our capacity to serve the needs of AI/AN people. Doing more of what is important without expanding administrative overhead will require considerable training and improved technologies, as well as ceasing to expend resources on low value work.

The evaluation of our success in this attempt at achieving more will come from the surveys of I/T/Us described in Performance Indicator 37. Feedback will come from the Department, OMB, and Congress relative to our level of compliance with the growing number of Federal requirements, particularly the GPRA, GMRA, Clinger-Cohen Act, and audits of the resources expended. In the long run, our success in these efforts will be reflected to a considerable degree in the level of realization of our component of the DHHS Strategic Plan and the IHS Mission and Goal.

Data Source: Audits of Area and Headquarters, I/T/U Survey, and feedback from HHS, OMB, and Congress.

Baseline: FY 1997 Area and Headquarters FTEs = 2085

Type of Indicator: Process

Linkages: These indicators support the DHHS Strategic Plan, Strategic Objectives 3.6 *Improve the Health Status of American Indians and Alaska Natives* and the accountability requirements of a DHHS OPDIV.

Program Performance: The FY 2000 indicator committed to IHS Headquarters and Areas maintaining full compliance with major Federal requirements (i.e., GPRA, CFO, etc.), without expanding the administrative staff above the FY 1999 FTE target level of 10% below the FY 1997 level (1,876). This indicator has been achieved with the FY 2000 total Area and Headquarters FTEs level of 1,569 while meeting Federal accountability standards. However, the large reduction in FTEs that has occurred with reorganization is greater than anticipated and has left "function holes" in the IHS infrastructure that are essential to replace to assure that the IHS can meet its accountability requirements. Thus, the IHS is discontinuing this indicator following this report for FY 2000.

Indicator 40: *No FY 2001 or FY 2002 Indicator*

Indicator 40: To increase collaborative support for improved health status of AI/AN people, the IHS will have increased the number of interagency agreements and cooperative agreements with agencies and organizations that are directly linked to performance plan indicators over the FY 2000 level.

Rationale: Given the demands in health care that the IHS continues to face, it has become increasingly important to the IHS's advocacy role to seek collaborative partnerships with other organizations that can assist in efforts to achieve the IHS Mission and Goal. While the number of agreements was initially identified as the most appropriate indicator, it has become clear that number is less significant than the area of focus and level of commitment spelled out in the agreement. Thus, this indicator was revised to address increasing the number of agreements specifically directed at performance indicators.

Approach: For many years the IHS has worked collaboratively with other organizations, particularly other HHS agencies (e.g., NIH, CDC, AHCPR), in efforts to improve the quantity and quality of services we provide. The IHS is currently in the process of proactively seeking additional and broader partnerships with organizations directed at setting in place long-term strategic approaches to addressing the interactive effects of health and social services, community empowerment, and economic development directed towards improved quality of life for AI/AN people.

Clearly opportunities exist for expanding agreements with existing organizations as well as developing new ones with other Federal, State and local agencies, as well as private sector organizations. In this light, our Director is currently spearheading a multi-departmental activity for AI/AN children and youth around two themes:

1. Ensuring a safe and healthy home and community
2. Ensuring personal development within the context of developing communities

Response thus far has been encouraging with active participation from HUD, DOI, DOA, DOT, and several HHS OPDIVs. The ultimate goal for the activity is to improve the status of AI/AN children and youth relative to indicators reflecting the two themes. The approach is to collaborate with agencies that serve AI/AN people to improve coordination of services and increase access to services for AI/AN communities (including urban areas). In addition, the initial workgroup for this activity embraced the importance of agencies documenting their commitment to the activity through identifying appropriate specific GPRA performance indicators.

Data Source: Audit of existing agreements.

Baseline: The FY 1999 total number of agreements was 86 as tracked by IHS Headquarters with those linked to performance measures was estimated to be 18. However, the number actually in effect is much greater when Area, and local I/T/U are considered and there is no practical way to secure the nature and number of these agreements.

Type of Indicator: Process

Linkages: This indicator broadly supports the DHHS Strategic Plan, Strategic Objective 3.6 *Improve the Health Status of American Indians and Alaska Natives***.**

Program Performance: For FY 2000 the IHS committed to increase the number of interagency agreements and cooperative agreements with agencies and organizations that are directly linked to performance plan indicators over the FY 1999 level. This was accomplished when a review of FY 2000 agreements monitored in Headquarters identified 23 agreements addressing performance measures compared to 18 for the FY 1999 agreements. However, this indicator has been discontinued for 2001 and beyond for three reasons. First, a larger number of small single focus agreements have recently been folded into larger multiple focus agreements thus making the number of agreements to have little validity in assessing the actual level of collaboration occurring. Another reason to discontinue this indicator is that while we can and have tracked the agreements negotiated by IHS Headquarters, there is no practical way to do so for the many agreements that are negotiated at Area and local I/T/U levels that are indeed assisting in meeting performance indicators. Lastly, this is a process measure in which the validation and verification is extremely subjective and not consistent with the goal of the IHS moving toward more objective and evidenced-based measures whenever possible.

Indicator 41: During FY 2002, the IHS will continue to expand Managerial Cost Accounting (MCA) capacity through an incremental investment in necessary information technology in accord with DHHS and OMB guidance.

Rationale: The Federal Financial Management Improvement Act of 1996 (The Brown Bill) requires IHS to achieve the linkage of resources to results through MCA. This legislation requires each agency to maintain financial management systems that comply with Federal financial management systems requirements, applicable Federal accounting standards, and the U. S. Standard General Ledger at the transaction level. As mentioned in the *Program Aggregation* section on page 31, caution must be exercised in applying manufacturing accounting approaches to a comprehensive public health program. Attempting to cost account for outcomes for complex chronic disease processes (i.e., diabetes) addressed by many health disciplines in diverse settings, with long time lags in effect, is plagued with threats to validity, and would probably represent an exercise in futility.

Approach: The IHS is analyzing technical alternatives for IHS cost accounting/cost reporting, including a detailed analysis of technical alternatives with cost benefit and trade off analyses. The results will be provided to a partnering group of agency and departmental staff to support strategic decision making regarding the development and implementation of cost accounting at IHS to link resources to results and to generate agency cost reports. The system is necessary to assist IHS leadership in maximizing the effective use of available resources and ensure that patient care can be provided to its customers. Perhaps the most significant benefit or goal for establishing MCA is to increase collections from private insurance, Medicare, and Medicaid.

Type of Indicator: Process

Linkages: This indicator supports the management and accountability requirements of GPRA, GMRA, Clinger-Cohen and a DHHS OPDIV.

Program Performance: The FY 2000 indicator committed to continuing the implementation of Managerial Cost Accounting (MCA) through the development of transitional pilot sites in accord

with DHHS and OMB guidance. This indicator was partially met by implementing 15 new "cost centers" to improve capturing cost by functions, and sponsored 1 of 2 national training on cost principles for staff at service units, areas and headquarters. The indicator also includes completing "cost reports" at 30 facilities and 12 Area Offices to be used for Medicare/Medicaid rate negotiation. Five additional sites were selected to complete first-year practice cost reports. The IHS reviewed the Veterans Administration Hospital financial cost accounting system in Albuquerque, NM, for evaluation and possible adoption by IHS.

Quality of Work Life Indicator:

Indicator 42: For FY 2002, the IHS will improve its overall Human Resource Management (HRM) Index score to at least 98 as measured by the DHHS annual HRM survey.

Rationale: The purpose of this indicator is to improve the quality of work life for IHS employees. The DHHS Quality of Work Life project is based on social-psychological principles that are associated with both organizational effectiveness and improved quality of life for members. As part of this effort, the Department has developed and refined a Human Resource Management (HRM) Index employee survey as a valid measure of management practices that are important to organizational performance. These practices include Morale, Climate for Innovation, Planning and Organization, Communication, and Operational Efficiency. Since the DHHS started conducting the HRM Index surveys in 1991, the IHS sample scores have consistently averaged below the overall average DHHS score which is normalized/adjusted each year to be 100 points. Thus, OPDIV scores below 100 are below the average and visa versa. Given that the elements assessed in this survey are fundamental to achieving the IHS Mission and Goal, the Agency is committed to improving this trend.

Approach: The IHS is now in the process of actively tailoring the implementation of the Department's Quality of Work Life project to its unique and diverse setting. Furthermore, efforts are under way to identify strategies to improve supporting functions such as training, organizational development, and improved communications networks. It is important to acknowledge that customer satisfaction is also a strong determinant of the quality of work life for health care providers. When consumer demand increasingly exceeds the capacity of the health care system to provide services, waiting times can become excessive, services are more restricted, and consumers are more likely to be disgruntled. The result of this pattern, which has been a reality in the IHS in recent years, is often more pressure and demands on providers that lowers their quality of work life and compounds the problem of retaining and recruiting health care staff. Thus, many other indicators in this plan that address access to services are critical to improving the quality of work life for IHS employees.

The Agency believes the proposed enhancements, coupled with the Quality of Work Life project, and restoring access to services will improve morale, communications, job satisfaction, and other factors sufficiently to be reflected in an improved HRM Index score for the IHS in FY 2002.

Data Source: FY 2002 DHHS HRM Survey

Baseline: FY 1999 DHHS HRM Survey Score was 93 for the IHS

Type of Indicator: Process/Impact

Linkages: This indicator directly supports the Department's Quality of Work Life project and generally supports the DHHS Strategic Plan, Strategic Objective 3.6 *Improve the Health Status of American Indians and Alaska Natives*.

Program Performance: In FY 2000 performance goal was to improve the IHS HRM Index score to at least 94 and this goal was met with a FY 2000 score of 96. As mentioned in the rationale above, this score is still below the DHHS average of 100 points and meeting and eventually surpassing this level will require a long-term effort that increasingly addresses the issues relating to access to care for consumers.

Self-Determination Support Indicator:

Note, this is a new FY 2002 and FY 2001 Indicator

Indicator 43: During FY 2002, 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 or letter of intent based on identified areas of need and with specific technical assistance in the area of calculating contract support costs.

b. reviewing all initial contract support cost requests submitted (100%) using a IHS Contract Support Cost Policy Review Protocol to assure the application of consistent standards in order to assure equitable and approvable requests.

Indicator 43: During FY 2001, 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. developing a technical assistance "needs assessment" protocol for systematically identifying the technical assistance needs of new compacting and contracting Tribes.

b. develop a Contract Support Cost Review Protocol for systematically and consistently applying the IHS Contract Support Cost Policy to all initial contract support cost requests.

Rationale: The amount of funding appropriated for contract supports costs has increased significantly in the last five years and has grown to approximately $250 million. The Congress and the Office of Management and Budget have requested that the Indian Health Service continue to review the soundness of its allocation policies concerning contract support costs and to take steps to assure that contract support costs provided to tribes are reasonable and do not duplicate other funding provided to tribes by the IHS under self-determination agreements. The provision of technical assistance to tribes and review of Contract Support Cost requests that is consistent with the IHS Contract Support Cost Policy and the Indian Self-Determination Act will address the concerns of the Congress and the OMB.

Approach: During FY 2001, IHS Headquarters and Area staff and tribal stakeholders will develop protocols for systematically identifying technical assistance needs and reviewing the contract support cost requests of new contracting and compacting tribes. In addition, Area IHS staff responsible for utilizing these protocols will be instructed in their application including training on the provisions of the IHS Contract Support Cost Policy.

During FY 2002, the IHS will utilize these protocols all newly contracting or compacting tribes. The verification that both protocols have been utilized will be documented in the Annual Funding Agreement that is signed by both the tribe and IHS. In the long run, success will be reflected in the greater number of requests that are technically accurate and consistent with the Indian Self-Determination Act and the IHS Contract Support Cost policy and may be included as target for this indicator in future years.

Data Source: Signed Annual Funding Agreements.

Baseline: Not Applicable

Type of Indicator: Process

Linkages: This indicators supports the DHHS Strategic Plan, Strategic Objective 3.6 Improve the Health Status of American Indians and Alaska Natives and the Indian Self-Determination and Educational Assistance Act.

Program Performance: No FY 2000 Indicator.