

Part I - AGENCY CONTEXT FOR PERFORMANCE MEASUREMENT

Tomorrow

We have wept the blood of countless ages as each of us raised high the lance of hate.

Now let us dry our tears and learn the dance and chant of the life cycle.

*Tomorrow dances behind the sun in sacred promise of things to come for children not yet born,
for ours is the potential of truly lasting beauty, born of hope and shaped by deed.*

Peter Blue Cloud

Overview of the Context of GPRA in the IHS

The Indian Health Service (IHS) has embraced the Government Performance and Results Act (GPRA) and its requirements as an extension of the public health approach that we have used for almost a half of a century. In this document the initial FY 2002 and revised final FY 2001 Performance Plans have been merged with the FY 2000 Performance Report consistent with the required format developed within the Department of Health and Human Services (HHS). This plan is submitted as our best effort at meeting the demanding challenge of the proposed *Healthy People 2010* goal of achieving equivalent and improved health status for all Americans over the next decade. It presents a strategic set of performance indicators to address the significant health problems the American Indian and Alaska Native (AI/AN) population experience.

Indeed the disparity in health status that the IHS must address is formidable, particularly in terms of death rates. Comparing the 1996-1998 Indian (IHS service area) age-adjusted death rates with the U.S. all races population in 1997 reveals greater death rates in the AI/AN population for:

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| 1) alcoholism - 638% greater, | 6) pneumonia and influenza - 67% greater, |
| 2) tuberculosis - 400% greater, | 7) homicide - 81 % greater, |
| 3) diabetes mellitus - 291% greater, | 8) gastrointestinal disease- 38% greater, |
| 4) unintentional injuries - 163% greater, | 9) infant mortality - 24% greater, and |
| 5) suicide - 91% greater, | 10) heart disease, 20% greater. |

It was not surprising that a recent Harvard School of Public Health/Centers for Disease Control and Prevention (CDC) study found that the lowest life expectancies in the country (including inner city ghettos) for both men and women exists in Indian communities. These rates are similar to ones seen in sub-Saharan Africa and are the lowest of any nation in this hemisphere except Haiti. It is also not surprising that these Indian people have also been identified as living in the poorest counties in the country. Even more alarming, the most recent data (provided in Section 1.2 of this plan) documents that the mortality disparities for AI/AN people are actually worsening.

Despite these formidable challenges, the IHS in partnership with its stakeholders, view the GPRA as part of the process for assuring the capacity to serve AI/AN people. We are optimistic about the future and encouraged and appreciative of the support of the Department, OMB, and Congress in the development of this and last year's budgets and of the improved level and quality of consultation that has occurred with tribes. In particular, the regional meetings/ listening sessions convened by the Department's leadership provided a valuable dialogue process that was

informative and empowering to the AI/AN people and should contribute to enhanced collaborative activities within and outside the Department.

The performance indicators in this plan are predominately directed at improving access to health services for AI/AN people. However, it is important to acknowledge that due to the nature of many of the diseases and conditions afflicting AI/AN people, they are not likely to respond immediately to increased access to services. Like an ocean liner or large freight train which continues to move forward for a considerable time even after the engines are reversed, so will some chronic and/or life-style related conditions continue to afflict the AI/AN population. For these conditions, improved health outcomes are likely to take several or many years before they are realized. Thus, initially it will be a significant challenge to stop the escalation of disease mortality and morbidity evident from the most recent data presented in Section 1.2 of this document.

This plan and its predecessors represents significant efforts over the past three years by the IHS and its diverse stakeholders in which a "bottom-up" approach to budget formulation and GPRA performance planning has been used. This approach was adopted to support the Indian self-determination process and honor the "government to government" relationship that exists with tribes. Beginning with the development of the FY 1999 budget and Performance Plan, regional meetings were held to outline the GPRA and budget formulation process for all IHS Area Formulation Teams.

These Area teams then provided representatives of their local programs the opportunity for input and review of the Area recommendations, which were then compiled. For the past three years Area Formulation Team representatives then came together along with tribal leaders and representatives from several Indian organizations to merge and reconcile the Area recommendations into a single IHS set of budget priorities.

Using these identified budget priorities, a multidisciplinary team of stakeholders that included health program, budget, and information technology experts, epidemiologists, and IHS and tribal managers developed this plan. In addition to the identified budget priorities this plan reflects the context of the Department of Health and Human Services (HHS) Strategic Plan and the *Healthy People 2010* goals and objectives.

This performance plan and the requested budget that underpins it, represent a cost-effective public health approach to best address the health disparities that prevail for AI/AN people. By most objective measures of efficiency and effectiveness in addressing health problems, we have been and are frugal and have a proud history of accomplishments that document the achievement of significant results long before it was required by law. Over the next decade, in partnership with our stakeholders, we can accomplish even more.

1.1 Agency Mission and Long-Term Goals

The Indian Health Service (IHS) has the responsibility for the delivery of health services to Federally-recognized American Indians and Alaska Natives (AI/AN) through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. In 1995 a group of stakeholders charged by the IHS Director to reorganize the IHS, revised the mission and goal and added a foundation as follows:

MISSION:

The mission of the Indian Health Service, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level.

GOAL:

To assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

FOUNDATION:

To uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

These three responsibilities have been integrated into the evolving IHS component of the Department of Health and Human Services (HHS) Strategic Plan for the GPRA to yield four broad IHS Strategic Objectives to guide the Agency into the next millennium. The first is essentially a restatement of the HHS Strategic Plan Objective 3.6 *Improve the health status of American Indian and Alaska Natives*, while the remaining three strategic objectives represent the means to achieve the first:

Strategic Objective 1: Improve Health Status

To reduce mortality and morbidity rates and enhance the quality of life for the eligible American Indian and Alaska Native population.

Strategic Objective 2: Provide Health Services

To assure access to high quality comprehensive public health services (i.e., clinical, preventive, community-based, educational, etc.) provided by qualified and culturally sensitive health professionals with adequate support infrastructure (i.e., facilities, support staff, equipment, supplies, training, etc.)

Strategic Objective 3: Assure Partnerships and Consultation with I/T/Us

To assure that I/T/Us, and IHS Area Offices and Headquarters achieve a mutually acceptable partnership in addressing health problems:

- *providing adequate opportunities for I/T/Us and American Indian and Alaska Native organizations to participate in critical functions such as policy development and budget formulation, and*
- *assuring that I/T/Us have adequate information to make informed decisions regarding options for receiving health services.*

Strategic Objective 4: Perform Core Functions and Advocacy

Consistent with the IHS Mission, Goal and Foundation, to effectively and efficiently:

- *execute the core public health and inherent Federal functions, and*
- *advocate for the health care needs of the American Indian and Alaska Native people.*

These Strategic Objectives are essential for the realization of our Mission, Goal, and Foundation over the next five to 10 years by setting the programmatic, policy, and management course for the IHS. They are also consistent with the most recognized approach to evaluating health care organizations in that they address the *structure, process, and outcomes* of health care delivery and provide the conceptual and philosophical framework for the performance indicators outlined in this annual performance plan.

During FY 2001, the IHS and its stakeholders will develop a process to identify specific long-term quantifiable health status and health care measures that will serve as benchmarks for focusing improvement efforts for the future. In essence, this effort will establish quantified targets for Strategic Objectives 1 and 2 and will require broad tribal consultation to secure acceptance and support. Preliminary work with stakeholders has identified several potential health measures to consider as long-term improvement targets for the AI/AN population that include:

- years of potential life lost
- accident/injury death rate
- diabetes prevalence and death rates
- infant death rate
- immunization rates for children and adults
- Quality of Life Index
- cancer survival rate
- obesity prevalence rate
- suicide rate
- rate of children free of dental decay and adults with 20 or more functional teeth
- prevalence of substance abuse (i.e., alcohol, drugs, and tobacco)
- percent of homes with adequate water and sewage facilities

Data for many of these measures are already available or soon will be. Developing strategies for securing data for selected measures not currently available will be a major part of this effort.

Clearly making measurable improvements in these health measures is mission critical because they represent many of the areas of greatest disparities between the AI/AN people and the U.S. general population. Eliminating only these disparities within even 20 years would represent a public health accomplishment of unparalleled magnitude in recent history.

1.2 Organization, Programs, Operations, Strategies and Resources

Humankind has not woven the web of life. We are but one thread within it. Whatever we do to the web, we do to ourselves. All things are bound together. All things connect

Chief Seattle

The IHS is the Operating Division (OPDIV) within HHS charged with administering the principal health program for the eligible AI/AN population. The IHS provides comprehensive health services through its I/T/U system of facilities and programs. Many of the people served by the IHS live in some of the most remote and poverty stricken areas of the country, and these health services represent their only source of health care. In terms of magnitude, the I/T/Us provide health services to over 1.3 million people through 151 service units composed of 550 health care delivery facilities, including 49 hospitals, 214 health centers, 7 school health centers, and 280 health stations, satellite clinics, and Alaska village clinics.

Within this system, Indian tribes deliver IHS-funded services to their own communities with about 44 percent of the IHS direct services budget in 12 hospitals, 155 health centers, 3 school health centers, and 239 health stations, satellite clinics, and Alaska village clinics. Tribes who have elected to retain the Federal administration of their health services at the present time receive services with about 56 percent of the IHS direct services budget in 37 hospitals, 59 health centers, 4 school health centers, and 44 health stations and satellite clinics. The range of services includes inpatient and ambulatory care, extensive preventive care, and a diversity of health promotion and disease prevention activities.

In addition, various health care and referral services are provided to Indian people away from the reservation settings through 34 urban Indian health programs. It is estimated that almost 60 percent of all AI/ANs now reside in or near urban centers and available evidence suggests they have considerable health care needs. The Contract Health Services program is an integral part of the IHS system for purchasing services from non-IHS providers to support, or in some cases in lieu of, direct care services. Contract Health Services represents about 18 percent of the IHS Budget and is distributed to IHS and Tribal programs at the same relative percentage as direct services funding (i.e., IHS = 59%, Tribal = 41%). In FY 1999, the IHS Fiscal Intermediary processed approximately 360,000 payment claims.

Since its inception in 1955, the IHS has demonstrated the ability to effectively utilize available resources to improve the health status of the AI/AN people. This contention is supported by dramatic improvements in mortality rates between 1972-74 and 1994-96, including:

- maternal mortality reduced 78% (27.7 to 6.1 per 100,000)
- tuberculosis mortality reduced 82% (10.5 to 1.9 per 100,000)
- gastrointestinal disease mortality reduced 76% (6.2 to 1.5 per 100,000)
- infant mortality reduced 66% (22.2 to 7.6 per 100,000)
- accident mortality reduced 57% (188.0 to 80.6 per 100,000)
- pneumonia and influenza mortality reduced 50% (40.8 to 20.2 per 100,000)

When compared with the U.S. general population, the IHS achieved these improved outcomes in the face several complicating factors including:

- lower per capita expenditures for health care
- limited availability of providers (e.g., half the physicians and nurses per capita)
- higher costs for providing health care in isolated rural settings (loss of economies of scale)
- lack of facilities in numerous locations and many outdated existing facilities (i.e., average age of IHS facilities is 32 years in comparison to 9 years for the private sector)
- lower utilization of health care services (e.g., 25% annual utilization of dental service for AI/ANs compared to about 60% for US population overall)
- significantly higher health care needs because of poor health status (significantly higher rates of diabetes, alcoholism, injuries, oral diseases, and overall death rate)
- high unemployment, poverty, substandard housing, and other recognized contributing factors to reduced health status

While overall outpatient visits have steadily increased with the AI/AN population growth of over two percent annually, decreases have occurred in access to non-urgent primary services that include:

- 37% decline in the number of well child services between FY 1992-97
- 35% decline in the number of physical exams between FY 1994-97
- 26% reduction in the proportion of people receiving dental services between FY 1992-99
- 68% reduction in water systems fluoridated between FY 1991-99
- 128% increase in denials of claims from health care contractors between FY 1994-99

In this context, the increasing demand for urgent care that has reduced the capacity of the IHS to provide the primary services that are critical to long-term health maintenance and improvement. Of greatest concern are the most recent mortality data (FY 1998) available from the National Center for Health Statistics adjusted for miscoding of AI/ANs. These data document an upward trend in deaths of AI/AN people for the period of 1996-98 compared to the period 1994-96 from cancer, diabetes, suicide, motor vehicle accidents, and heart disease. The net result of these categorical increases is an overall increase in death rate for AI/AN people from 699 per 100,000 population for the period 1994-96 to 715 per 100,000 population for the period 1996-98. With the U.S. general population mortality rate declining during these comparable time periods from 504 per 100,000 population to 479 per 100,000 population, it is clear the health disparity gap relative to AI/AN mortality is worsening. Chart I on the following page outlines these disturbing AI/AN mortality trends.

Chart I

MORTALITY RATE DISPARITIES CONTINUE

American Indians and Alaska Natives in the IHS Service Area 1994-96 to 1996-98 and U.S. All Races 1995 and 1997 (Age-adjusted mortality rates per 100,000 population)						
	AI/AN Rate 1996-98	U.S. All Races Rate 1997	Ratio: AI/AN to U.S. All Races	AI/AN Rate 1994-96	U.S. All Races Rates 1995	Ratio: AI/AN to U.S All Races
ALL CAUSES	715.2	479.1	1.5	699.3	503.9	1.4
Alcoholism	46.5	6.3	7.4	48.7	6.7	7.3
Tuberculosis	1.5	0.3	5.0	1.9	0.3	6.3
Diabetes	52.8	13.5	3.9	46.4	13.3	3.5
Motor Vehicle Crashes	54.8	15.9	3.4	54.0	16.3	3.3
Suicide	20.2	10.6	1.9	19.3	11.2	1.7
Homicide	14.5	8.0	1.8	15.3	9.4	1.6
Cervical Cancer	4.2	2.5	1.7	3.3	2.5	1.3
Infant Deaths ^{1/}	8.9	7.2	1.2	9.3	7.6	1.2
Diseases of the Heart	157.1	130.5	1.2	156.0	138.3	1.1
Cerebrovascular Diseases	29.5	25.9	1.1	30.5	26.7	1.1
Malignant Neoplasms (All)	124.0	125.6	1.0	116.6	129.9	0.9
HIV Infection	3.3	5.8	0.6	6.2	15.6	0.4
^{1/} Infant deaths per 1,000 live births.						
NOTE: American Indian and Alaska Native rates were adjusted to compensate for race misreporting on State death certificates.						

Given these trends and challenges, the IHS and its diverse stakeholders have been reorganizing the IHS and are continually developing alternative methods to assure more efficient health programs and administrative support to Indian communities. The redesign efforts emphasize patient care; strengthening government to government relations; streamlining administration and management; quality support services to field-based health care activities; diversification of operations; staffing new facilities; and fair treatment of employees. This performance plan supports and provides quantifiable measures for each of these priorities.

The budget supporting this performance plan proposes provides linkage to a multidisciplinary approach that crosscuts programs key to addressing complex health problems associated with chronic diseases and harmful behavioral health practices. This approach includes enhancing the integration of our diverse expertise from medical, behavioral health, and community health staff in order to address the top health problems identified by the I/T/Us. Emphasizing prevention strategies throughout the clinical service activities strengthens the community-based public health model. Furthermore, it is essential to maintain community health programs and supporting partnerships with community resources such as public safety programs, schools, and other community based organizations.

The first priority in the budget request is to maintain and in some cases increase access to basic health services for AI/AN people. In this context, the request addresses the multiple health issues affecting the AI/AN population and to assure the health of the AI/AN population does not continue its downward trend. The proposal targets the health problems identified as highest priorities by the I/T/Us and responsible for much of the disparity in health status for the AI/AN population. These include alcoholism and substance abuse, diabetes, cancer, mental health, elder health, heart disease, injuries, dental health, maternal and child health, domestic violence, infectious diseases, and sanitation.

The support for public health infrastructure is also fundamental to these activities. These investments will maintain surveillance, prevention and treatment services and are based on "best practices" defined in the public health literature. This approach is consistent with the trend of Federal entities adopting such industry standards. Many of the IHS performance indicators for "treatment" and "prevention" represent our commitment to this process.

An essential component of supporting access to services is to assure that there are adequate facilities and equipment for the provision of health services. The IHS must assure an efficient, safe, and pleasant environment for the provision of services by ongoing maintenance, repair, renovation, and replacement of health care facilities. The funding request for these functions is underpinned by performance measures in the section addressing Capital Programming/Infrastructure.

Also critical is the provision of contract support costs to the tribal health delivery system. These requested funds will provide for tribal communities to assure that there are utilities, training, clerical staff, administrative and financial services needed to operate health programs. This investment is consistent with the Administration's commitment to supporting tribal participation in the management of the programs and the principles of the Indian Self-Determination Act.

Another target of the FY 2002 funding request is water and sewer systems for new and existing homes at the community level to support further progress in preventing infectious diseases and improving the quality of life and is thus specifically addressed in this plan. This performance

plan backs this request with a specific performance measure as part of the Capital Programming/Infrastructure section of this document.

In summary this performance plan and budget request represents a commitment to utilized available resources to the maximum benefit in achieving our mission of improved health status for the AI/AN people.

1.3 Partnerships and Coordination

Given the magnitude of AI/AN health disparities and the resource demands they create, it is critical that the IHS identify and collaborate with all available outside organizations with the capacity, capability, and interest to assist in addressing these diverse health problems. Our resolve to develop this crosscutting network is evident by the number and diversity of collaborative activities that are currently in place and described in section.

The Indian Health Service has continued to develop and expand its crosscutting collaborations and partnership with other agencies and organizations to achieve common goals and objectives addressing health disparities of American Indians and Alaska Natives (AI/AN). These partnership and collaborations are building capacity across institutions, enhancing program outreach through shared resources, opening dialogue with new partners, developing or disseminating new health care and/or surveillance technologies, securing a variety of training and technical assistance support for I/T/U providers, networking to maximize knowledge and resources, disseminating information through activities of mutual concern, and developing tribally specific community-based, community driven research.

The following examples of recent and developing collaborative activities met one or more of the following criteria:

- clearly presents the true influence that the Federal agency and its programs wield
- shows program coordination as key elements of interest with GPRA implementation to achieve performance goals
- clarifies roles of the agency, related Federal agencies, and performance partners
- demonstrates agency strategy to coordinate efforts of crosscutting programs-activities
- documents uniqueness of the agency and its distinguishable contributions
- presents agency plans for eliminating duplication and overlap

PROGRAM COORDINATION BY PARTNER WITHIN DHHS:

Administration for Children and Families/Head Start Bureau

- The IHS and the Administration for Children and Families (ACF) have a longstanding collaboration (five years) with the Head Start Bureau. The technical assistance is for IHS to provide Health and Safety training and technical assistance to the 177 Head Start grantees, which are part of the American Indian Program Branch of the ACF, in the area of Health and Safety, Nutrition, Dental, Behavioral Health and General Medical Services. The collaboration also results in a full-time health and safety specialist position and a computerized data system for the IHS Head Start program.

- The IHS and the ACF are collaborating with the IHS Diabetes program, Nutrition program and the clinical providers to monitor and develop programs to address the 0-5 age group of AI/AN in prevention. This is an intervention program to address rising trends in obesity in this age group.

Agency for Healthcare Research and Quality

- The IHS and AHRQ co-sponsored a conference entitled "Crafting the Future of American Indian and Alaska Native Health into the Next Millennium." The purpose was to promote health care partnerships, including research partnerships, between academic medical centers and AI/AN organizations and tribes. IHS and AHRQ are maintaining collaborative efforts; strengthening health services research; increasing opportunities for the Native American population into research; and strengthening the research infrastructure of AI/AN organizations.
- The AHRQ Office of Research Review, Education and Policy (ORREP) is collaborating on potential research training for AI/AN people. The ORREP also participated in the Annual IHS Research Conference. Discussions regarding additional research possibilities have been held with other AHRQ staff.
- The AHRQ Center for Practice and Technology Assessment and the IHS have had discussions regarding possible collaboration and services through their evidence-based practice centers, including technology assessment and other related research activities.
- A collaboration with AHRQ is being pursued to support an Indian Primary-Care Based Research Network
- A collaboration with AHRQ is being discussed for development in 2002 to field an update of the Survey of American Indian and Alaska Natives (SAIAN) as part of the Medical Expenditures Planning Survey (MEPS).
- The collaboration continues on the development of the Healthcare Utilization Project to incorporate IHS data into a large nationwide inpatient database that AHRQ manages with the States.

Centers for Disease Control and Prevention Umbrella Agreement

The IHS and CDC have extensively collaborated in addressing a diversity of health issues over the past decade. As a result, the IHS and CDC now annually develop an umbrella agreement and work plan that currently addresses:

- **CDC/Agency for Toxic Substances and Disease Registry Tribal Liaison:** The purpose of this position is to strengthen inter-government response to tribal public health needs through consultation, networking, strategic planning, and improved coordination among federal and state governments, tribal communities, urban Indian health programs, and academic institutions. This helps to ensure that Indian health interests are represented in program decisions and policies.

- **Epidemiology/Preventive Medicine Training:** The IHS National Epidemiology Program hosts CDC Epidemic Intelligence Service (EIS) Officers for their two-year field epidemiology training experience, and Preventive Medicine Residents (PMRs) for a one-year field training. IHS can provide similar assignments for Prevention Specialists (Public Health Prevention Service). It provides the trainees practical experience while providing a service to the IHS. The IHS Epidemiology and the CDC/EPO are currently collaborating on a project to make basic epidemiology training available to tribal health departments; Navajo Nation is the pilot site.
- **CDC/National Center for Chronic Disease Prevention and Health Promotion-Chronic Disease Annual Workplan:** This intra-agency agreement/workplan was developed in 1990 consisting of two distinct segments, the R-90 (services provided by IHS to CDC) and the M-90 (services provided by CDC to IHS). Both segments consist of an array of components, the specifics of which are negotiated on an annual basis in the form of a workplan. In many cases IHS provides the FTE and CDC provides salaries for some of the staff supporting these activities. Highlights of this plan follows:
 - **Division of Cancer Prevention and Control (DCPC):** Provides for a field assignment for a CDC Public Health Advisor (PHA) to provide technical assistance/guidance for capacity building with state health departments, IHS tribes and tribal organizations. DCPC also provides funds for colposcopy training and other IHS cancer control activities. IHS provides an additional three FTE's to CDC, located in Atlanta, for direct technical assistance and consultation to tribes and tribal organizations through the National Breast and Cervical Cancer Early Detection Program, which currently funds 14 tribal screening programs.
 - **Division of Adult and Community Health (DACH):** IHS provides DACH with four FTE's located in Atlanta to support research, technical assistance, training, and planning. DACH will be the lead in overall planning, coordinating, and monitoring of chronic disease-related activities. The principal activities include but are not limited to:
 - **Memorandum of Understanding - IHS CDC/University of New Mexico:** The IHS provides an FTE for a field assignee with a Doctorate in epidemiology or related field to serve as a Senior Research Scientist for University of New Mexico Prevention Research Center for activities related to AI/AN communities.
 - **Health Promotion Activities for Older Adults:** This component provides technical assistance in the design, implementation and analysis of surveys for health promotion activities for older adults. Information from these surveys will be used to direct program development and evaluation of the health needs of AI/AN aged 55 and older.
 - **Behavioral Surveillance Branch (BSB):** Using the CDC Behavioral Risk Factor Surveillance Survey (BRFSS) this collaboration responds to requests from tribal epidemiology centers (Alaska Native EPI Center, Inter-Tribal Council of Arizona; Northwest Tribal Research Center, and Great Lakes Inter-Tribal Council) to assist in creating and/or analyzing BRFSS data files.

- **Cardiovascular Health:** The DACH provides technical assistance in the design, implementation, and evaluation of cardiovascular risk factor prevention and intervention programs. Provides dissemination of lessons learned from the Inter-Tribal Health Project (ITHP) to tribal communities in the Bemidji service area of IHS and throughout the United States.
- **Division of Oral Health:** This agreement includes a component to develop, implement and promote water fluoridation in AI/AN communities for dental disease prevention. A field assignee will be placed in Albuquerque with the IHS Environmental Management Branch.
- **Division of Diabetes Translation (DDT):** The IHS provides one FTE located in Atlanta, to support CDC/DDT in providing technical consultation and assistance on public health surveillance of diabetes to define the burden of diabetes and diabetes-related complications among the Native population. The DDT calculates age-specific and age-adjusted prevalence by area; hospitalizations and amputations. The CDC/DDT also provides a field assignee to IHS diabetes Program in Albuquerque to provide consultation and technical assistance in diabetes epidemiology to IHS.
- **Gallup Diabetes Research Center:** The IHS provides five FTEs and funding to NCCDPHP to support the National Diabetes prevention research Center in Gallup, New Mexico. The IHS and the NCCDPHP will jointly provide national leadership to plan, develop, implement and evaluate the National Diabetes Prevention research Center under the broad guidance of the Departments of Labor, health and Human Services, Education, and Related Agencies congressional Appropriations act, H.R. 2264, 1998 Conference Report, page S-12088.
- **Office on Smoking and Health (OSH):** The IHS provides CDC/OSH with one FTE for a field assignee located in Albuquerque, New Mexico, to develop, establish, and maintain a community based program for the prevention and control of tobacco use, and related health problems among AI/AN populations.
- **Division of Reproductive Health (DRH):** The IHS provides three FTEs to DRH to support a multifaceted approach to addressing reproductive-related health problems in AI/AN, including Sudden Infant Death Syndrome, and to assist tribes in community health surveys. One method is collection and analysis of reproductive health and Behavioral Risk Factor Surveillance (BRFS) information. After data collection, DRH assists tribes and organizations in the analysis, interpretation and dissemination of survey data. The Pregnancy Risk Assessment Monitoring System (PRAMS) conducts State-specific, population-based surveillance of women's behaviors before, during pregnancy and during the child's early infancy. Two FTE's are located in Atlanta and one FTE provides for a field assignee located in Albuquerque, New Mexico.
- **National Center for HIV, STD and TB Prevention (NCHSTP)**
 - **Division of Sexually Transmitted Disease Prevention:** The IHS provides an FTE for the field assignment of a Public Health Advisor (PHA) to assist in the planning,

development and implementation of sexually transmitted disease control programs among AI/AN. The PHA is located in Albuquerque, New Mexico.

- Communicable/Sexually transmitted Disease Prevention and Control: The IHS provides one-half time services of an Epidemiologist to share administratively the activities under this agreement. The agreement provides for the prevention and control of communicable and other sexually transmitted diseases among AI/AN. High rates of Chlamydia trachomatis may be found throughout AI/AN populations. Activities will include: developing and implementing surveillance systems for monitoring trends; initiating and managing national evaluation, screening and intervention programs and identifying high risk populations for other sexually transmitted disease including HIV.
- **Division of HIV/AIDS Prevention:**
 - Under another collaborative agreement that has been completed an epidemiologist will be designated to assist in the coordination of national surveillance, prevention, and control activities for HIV/AIDS and related opportunistic infections, STDs, and hepatitis B and C among AI/AN people.
 - Further collaboration with CDC/Division of Adolescent and School Health (DASH) is being conducted to provide HIV prevention program activities for the implementation and evaluation of HIV prevention education for AI/AN children and youth in schools on reservations, rural areas, and urban metropolitan areas. Training will be provided to teach in States that have a significant number of Indian students in the use of a curriculum, "Circle of Life HIV/AIDS Curriculum", developed by IHS. The curriculum is for grades K through 6th.
- **National Center for Infectious Diseases (NCID)**
 - Division of Viral and Rickettsial Diseases, Hepatitis Branch: The IHS provides an FTE for a field assignment to be located in Albuquerque, New Mexico, of an epidemiologist to assist in the planning development, and implementation of hepatitis prevention and control programs among AI/ANs. The purpose of this agreement is to provide for collaborative activities related to prevention and control of hepatitis A and C in AI/AN communities. The ultimate goal is to reduce the incidence of hepatitis as a health problem in AI/AN populations.
 - Special Pathogens Branch: The IHS and CDC have an ongoing intra-agency agreement that targets the hantavirus disease. The purpose of this agreement is to assist in the planning, development and implementation of hantavirus prevention and control programs among AI/ANs. Support provided includes assistance in determining trends in hantavirus morbidity and mortality; identifying and responding to outbreaks; and collaborating with tribal, state and local health departments and community-based organizations.
- **National Center for Injury Prevention and Control (NCIPC):** The NCIPC has had an intra-agency agreement with IHS since 1985 to help reduce unintentional and intentional injuries among AI/ANs. The CDC has assisted IHS with pilot injury surveillance projects, publishing MMWR reports and Surveillance Summaries, teaching in the IHS Injury

Prevention training program to build tribal capacity, evaluating community-based injury prevention and control programs, participate in the IHS's national advisory board on injuries, and collaborate as a national partner to raise awareness of injuries as a leading public health problem among AI/ANs. The CDC and the IHS also collaborated with the American Academy of Pediatrics and several tribal groups to present the first ever briefing on injury issues to select Senate staff. The IHS provides an FTE for an Atlanta-based Injury Prevention Specialist who collaborates with IHS on these and other projects.

- **National Immunization Program (NIP)**

- Vaccine-Preventable Disease Control: The IHS provides an FTE for the field assignment of a Public Health Advisor to assist in the planning, development and implementation of vaccine-preventable disease control programs among AI/ANs. The PHA, located in Albuquerque, New Mexico, will assist in implementation of the Vaccines for Children (VFC) program among AI/AN children.

OTHER IHS/CDC COOPERATIVE AGREEMENTS : The IHS and CDC collaborate on various specific projects in partnership with tribes, tribal coalitions, Alaska Native corporations, and academic institutions who are recipients of CDC and/or IHS cooperative agreement funds. Such activities may or may not occur in direct relationship to the aforementioned formal Intra-agency Agreements.

Food and Drug Administration

- The IHS and the FDA collaborated on recommendations to reduce patient and occupational exposures; to promote principles of radiation protection, and to allow the FDA to monitor radiation protection for conformance with existing agency and Federal policies.
- The IHS has a collaborative agreement with the FDA Center for Devices and Radiological Health for mutual support in the evaluation and use of medical radiologic equipment. During the past year the FDA provided equipment and training to allow IHS institutional environmental health staff to conduct performances and quality assurance evaluations of 300 medical and 1,000 dental diagnostic x-ray units.

Health Care Financing Administration

The collaboration with HCFA covers an array of issues that critically impact operational issues related to the Indian health care system and the provision of services by the IHS to its stakeholders. Many of the issues were directed at increasing the understanding of federal and state government agencies about the government-to-government relationship with the 550 federally recognized tribes and the need for consultation with tribal governments on actions that affected them. Following are current and ongoing collaboration issues.

- The IHS and HCFA Joint Indian Health Steering Committee continues to be an effective tool creating a better understanding of the unique needs of the IHS and, Tribes (I/T) for appropriate, representative policies.
 - Legislation Subcommittee: The IHS will continue to work with HCFA on legislative directives, e.g., reauthorization of the Indian Health Care Improvement Act, using

- Medicare rates for CHS payments, expanding payments to outpatient ambulatory clinics and for physician services.
- Operations Subcommittee: The IHS will continue to work with HCFA on program policy and operation issues such as reimbursement policies, outreach and education, and data sharing and other policy guidance.
 - Cost Reports Subcommittee: The IHS in collaboration with HCFA will address short and long range plans for development of hospital cost reports. This includes short and long range plans for a cost accounting system, and training of IHS finance and management staff
- The IHS and HCFA continue their collaboration with the National Medical Education program (NMEP) Task Force. The NMEP ensure that beneficiaries receive accurate, reliable information about their benefits, rights and health plan options; have the ability to access information needed to make informed choices; and perceive the NMEP (the Federal government and our private sector partners) as trusted and credible sources of information. The NMEP activities have included publishing Medicare & You Handbook, Internet activities, Toll-Free Medicare choices Helpline, National Alliance Network, Enhanced Beneficiary Counseling from State Health Insurance Assistance programs, the National Train-the-Trainer Program, and Regional Education About Choices in Health Campaigns.
 - The IHS and HCFA formed the Home Health Care workgroup to develop draft regulations to implement the Prospective Payment System. The workgroup will be reviewing amendments to the current regulations.
 - The IHS and HCFA work closely on the HHS Value-Based Purchasing Work Group that is part of the Quality Interagency Coordination Council. They have pursued the national goal to reduce the number of medical errors in health care environments and to build a safer health system nationally.
 - The establishment of an IHS Liaison to advise HCFA managers on policy information respective to health care programs administered by the I/T/U continues to be beneficial and effective.
 - The IHS and HCFA collaborated for the Prospective Payment System Minimum Data Sets that include current cost reports. These files are used to calculate hospitals' current Diagnostic Related Group prospective payment rates, etc. The intent of these data sets are to provide IHS with the necessary information to make payments in a timely manner.
 - The IHS and HCFA collaboration resulted in new Medicare and Medicaid reimbursement rates for the IHS and IHS-funded tribal facilities. This revenue source is used for medical staff, improved training, the purchase of additional medical equipment and improved facilities for IHS.
 - The IHS and HCFA collaborated on legislative issues that resulted in important HCFA policies and enhanced operational issues, i.e. Medicaid program waivers, the Children's Health Insurance Program (CHIP), new policy guidance and proposed regulations exempting AI/AN from any cost sharing provisions under CHIP for eligible children.

- The IHS and HCFA collaborated on Medicare enrollment data to provide more accurate information for assessing outreach to Medicare beneficiaries that are AI/AN to establish an accurate database for IHS. This information will be used also for analyzing AI/AN Medicare utilization patterns. Also, this database will be used by the IHS in claims processing to reduce the number of IHS Medicare claims rejected by HCFA fiscal intermediaries for errors.
- The IHS/HCFA collaborated together to discuss major issues affecting the policies and operations of each agency such as interfacing with state health care reform activities, federal waiver demonstrations, advising HCFA HQs and Regional Officers, State Medicaid Directors on how to consult with tribes in their States when drafting Medicaid waiver proposals.

Health Resources and Services Administration

- The IHS continues to collaborate with HRSA to provide support for PHS Primary Care Policy Fellowship program to bring 30 Federal and private sector primary care leaders to enhance their capabilities to advance the primary care agenda at the local, state, and national level. It also sponsors a mid-year Primary Care Networking Conference for collaborations.
- The IHS and HRSA have recently completed an agreement to provide HIV/AIDS education and training to health care providers that provide health care services to AI/AN people.
- The IHS and HRSA-Federal Occupational Health Program (FOHP) collaborated to share software enabling IHS to receive occupational health, environmental assessment and health information management support services from various resources and enables the IHS to meet its environmental management responsibilities.

National Institutes of Health

- The IHS and the National Institute of General Medical Sciences (NIGMS) are collaborating on bringing together in partnership academic research institutions, Indian tribes or Indian community based organizations. The purpose is to strengthen capacity for research on diseases of importance to American Indians and to develop a cadre of American Indian scientists and health professionals who will become active participants in competitive NIH funded research.
- The IHS and the NIH- National Institute for Dental and Craniofacial Research, in partnership with the State University of New York at Buffalo have a longstanding (five year) partnership to develop treatment regimens for individuals with diabetes who also suffer from periodontal disease. The first site for the study was Sacaton, Arizona, and the current site is Santa Fe, New Mexico. The results have been reported in the professional literature and the technology is being exported under a grant program.
- The IHS and NIH-National Institute of Diabetes and Digestive Kidney Diseases (NIDDK) collaborate on facilities and services to conduct clinical research studies primarily in the areas of diabetes and digestive diseases at the Phoenix Indian Medical Center (PIMC), Arizona. It also facilitates collaborative research interest in diabetic renal disease and epidemiologic surveys and studies.

HHS Office of Women's Health

- The National Indian Women's Health Steering Committee is conducting 11 surveys through Indian country to identify women's health issues and will be making recommendations to the Director of IHS.

Substance Abuse and Mental Health Services Administration

- The IHS along with other Federal Agencies are working with SAMHSA to support several Native American collaborations addressing mental health and the "Indian Self Determination: Summit on Tribal Strategies to Reduce alcohol, Substance Abuse and Violence."

COLLABORATION WITH OTHER FEDERAL AGENCIES

Department of Interior/Bureau of Indian Affairs

- The IHS along with other Federal Agencies are working with the DOI/BIA to support several Native American collaborations addressing mental health, domestic violence abuse and neglect, and the "Indian Self Determination: Summit on Tribal Strategies to Reduce alcohol, Substance Abuse and Violence."
- The IHS continues to work with the BIA to provide technical assistance and training for background checks of employees of tribal health programs.
- The IHS continues to be a partner in the support of the IHS/BIA Annual Youth Conference reaching Junior High and High School and college teens with an agenda that covers a wide variety of life issues.

Department of Justice

- The IHS and other federal agencies have partnered with the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention and Office of Community Oriented Policing Services to support coordinated activities in mental health and community safety for AI/AN children, youth, and families. The grant funds are for a 3-year period to provide tribes with easy-to access assistance in developing innovative strategies that focus on the mental health, behavioral, substance abuse, and community safety needs of AI/AN young people and their families
- The IHS and other federal agencies have partnered with the U.S. Department of Justice, Offices of: Tribal Justice, OJP Corrections Program and Office of Justice Program to co-sponsor the "Indian Self Determination: Summit on Tribal Strategies to Reduce alcohol, Substance Abuse and Violence." The conference will focus on developing a national agenda on alcohol, substance abuse and violence for Indian country; and an opportunity for Federal agencies to highlight promising practices and strategies on alcohol, substance abuse and violence. Tribes will be given materials, and they will be able to network with researchers.

Environmental Protection Agency

- The IHS and EPA have several interagency agreements to coordinate activities of both agencies pertaining to the environment and human health of AI/AN and their lands. Through their joint effort the EPA can provide resources to the Sanitation Facilities Construction

Program's national network of staff to promote their mutual interests, create cost-efficiencies and eliminate overlapping responsibilities, i.e. design and construct wastewater treatment projects.

- In their partnership with EPA, the IHS also enters into Memorandums of Understanding (MOU) with tribes to apply and manage Clean (CW) Indian Set-Aside grants to develop and manage their water and sanitation facilities program. The IHS and EPA provide technical guidance and support throughout the process.

Federal Emergency Management Agency

- The IHS, the Federal Emergency Management Agency (FEMA) and the U. S. Fire Administration (USFA) are collaborating to reduce the rate of fire and burn injuries in American Indian and Alaska native children, ages 0-5 years to half the national average by the year 2010. Fire is the leading cause of childhood injury death in the home and children under five years of age are at the highest risk.

U.S. ARMY MEDICAL COMMAND

- The IHS and the U.S. Army Medical Command collaboration permitted the IHS to access the Army's contract with Med-National. Med-National is a health manpower recruiting firm located in San Antonio, Texas. Through Med-National, the IHS has access to an alternate source of dental manpower and has been able to place 6 dentists in IHS and tribal dental clinics.

United States Department of Agriculture

- The IHS continues to work with the USDA for WIC services for Head Start Indian children to provide basic nutrition food items to ensure health physical development of children between ages 1-5 years old.

Uniformed Services University of the Health Sciences

- The IHS also has a collaborative agreement with the Uniformed Services University of the Health Sciences (USUHS) for technical assistance in ensuring environmental compliance of IHS health care facilities. During the past year, USUHS staff developed a comprehensive hazardous materials and waste management plan that will be applied in all IHS facilities.

Department of Veterans Affairs

- Nationally, the IHS is collaborating with the VA on targeted data systems and credentialing to increase the number of Native American veterans eligible for services and to identify under-served areas of Indian country where Native Americans reside.
- The IHS, HFCA and the Social Security Administration plan to include the VA in their collaboration to develop an agreement targeting education and outreach of veteran beneficiaries who are underutilizing their benefits and services.
- Many local IHS facilities have care agreements and pharmaceutical supply agreements with nearby VA facilities that maximize capabilities and extends the outreach of services for both agencies.

- The IHS participates in the VA Drug Prime Vendor Program. By collaborating with the VA and being included on the VA prime vendor drug contract, the IHS is able to take advantage of national drug contract prices negotiated by the VA. This allows the IHS to purchase selected pharmaceutical at substantially discounted prices, even lower than Federal Supply Service (FSS) prices in most cases. The IHS has been participating for several years and plans to continue this collaboration indefinitely. The program has resulted in very substantial savings for IHS over the years.

OTHER PROGRAM COORDINATION BY SUBJECT

Obstetrics and Gynecology Training and Technical Assistance from the American College of Obstetrics and Gynecology (ACOG)

- The American College of Obstetricis and Gynecologists (ACOG) Fellows In Service Program recruits and screens Board Certified or Active Candidates for Board Certification obstetrician-gynecologists (OBG's) for short term assignments in IHS facilities. These fellows augment local IHS staff when their OBG's are away for leave, educational training, maternity leave, or prolonged illness or disability. There are approximately 8-12 assignments each year, with 11 having been assigned this past year. A number of requests have already been made for this year's program.
- The ACOG Committee on American Indian Affairs meets with IHS Headquarters, Area, and Service Unit staff 2-3 times a year and conducts an Area-wide obstetric and gynecologic quality of care consultation site visit annually. All Areas with full-service obstetrics and gynecology programs are site visited on a rotating schedule. The Billings Area was surveyed last year. The Committee met with the IHS OBG clinicians in Albuquerque in July, 2000, and is scheduling its next site visit to the Phoenix Area in the spring of 2001.
- The ACOG-IHS Postgraduate Course on Obstetric, Neonatal, and Gynecologic Care is presented annually by specially recruited and selected ACOG and IHS faculty for approximately 100-110 IHS and tribal physicians, advanced practice nurses, and clinical nurses. This course is designed to provide a week-long update of obstetric, neonatal, and gynecologic care with the focus on practices appropriate in the primary care setting in often smaller or more remote facilities. Approximately 110 have registered for the next course to be presented in Aurora, CO, in September, 2000.

Injury Prevention

The mission of the IHS Injury Prevention Program is to decrease the incidence of severe injuries and death to the lowest possible level and increase the ability of tribes to address their injury problems. The IHS has initiated an aggressive public health attack to prevent traumatic injury among American Indians and Alaska Natives. Primary emphasis is directed to the injuries of the greatest cause, such as motor vehicle crashes, and to the most common risk factors, such as lack of occupant restraints, alcohol impaired driving, and poor road conditions in rural areas. Other emphasis areas are in childhood injury, the prevention of house fire-related injuries, and building the capacity of Tribes to address injuries in local communities through core programmatic funding and training in injury prevention.

To accomplish their mission, the IHS Injury Prevention Program has formed partnerships with many government and non-government agencies. The IHS has a collaborative agreement with the National Center for Injury Prevention and Control of the CDC for the purpose of injury prevention, with specific areas of interest in injury epidemiology and surveillance and in the evaluation of community-based injury prevention and control activities. During the past year the CDC and the IHS collaborated with the American Academy of Pediatrics and several tribal groups to present the first ever briefing on injury issues to staff from the Senate Select Subcommittee on Indian Affairs.

Other formal Interagency Agreements exist between IHS and the U.S. Fire Administration, and the National Highway Traffic Safety Administration. Program staff work with many other agencies and groups including the following; the National Safe Kids Campaign, the Consumer Product Safety Commission; Bureau of Indian Affairs' Law Enforcement Services and Division of Highway Safety; American Academy of Pediatrics, Committee on Native American Child Health and the Committee on Injury and Poison Prevention; Federal Highway Administration; HRSA's Maternal & Child Health Bureau; The Johns Hopkins University; Harborview Injury Prevention Research Center; and private foundations.

1.4 Summary FY 2000 Performance Report: Accountability Through Performance Measurement

A History of Commitment to Performance

The IHS has practiced performance management and performance measurement for almost a half of a century. We have demonstrated this commitment by being pioneers in quality assurance in health care, health services resource planning, the application of information technology to health care, and the use of alternative providers and the application of the Community Oriented Primary Care approaches to health care delivery. These efforts and many others were essential to achieving the mostly unspoken and unwritten commitment adopted by most I/T/U staff to accomplish the most good (i.e., improved health), for the largest number of people, at the lowest possible cost, and in a manner that is acceptable to the consumer and the provider. As presented in Section 1.2, between 1972 and 1994, these efforts resulted in dramatic improvements in mortality rates for AI/AN population.

During our early years the results of our efforts were published as reports and journal articles from across the healthcare disciplines, often in collaboration with outside researchers and evaluators. While this collaborative approach is still used today, since 1984 the results of these efforts in terms of the health services provided, health outcomes, and other relevant demographics of AI/AN people have been annually reported in the publication *Trends in Indian Health*. In 1990 a second annual report, *Regional Differences in Indian Health*, was added to provide similar information specific to each of the 12 IHS Areas.

More recently the IHS has prepared the *IHS Accountability Report* for each fiscal year since FY 1996, which overviews health program accomplishments and management accountability and includes the annual report on the financial statement audit. While performance management and performance measurement have come a long way with the implementation of GPRA, it represents a new challenge but a familiar concept for the IHS.

Performance Summary

With this submission the IHS has reported on 26 of the 27 performance indicators for FY 1999 and 29 of its 34 performance indicators for FY 2000. The single remaining unreported indicator for FY 1999 addresses injury mortality and comes from data provided by the National Center for Health Statistics and will not be available for approximately a year. Beginning in FY 2000, this measure was changed to address injury hospitalizations to allow timelier reporting. Relative to the four diabetes related indicators not reported previously for FY 1999, analyses of the FY 1999 Diabetes Audit were released in August 1999. These findings reveal that three of the four clinical diabetes indicator targets (Indicators 2, 4 and 5) have been met and one not met (Indicator 3), based on the most recent accepted criteria for these measures. These indicators represent improvements in diabetic care that have a strong evidence based association with reduce diabetic morbidity and mortality, and will stimulate enhanced efforts to meet all diabetes treatment targets in the future. In summary, of the 26 FY 1999 indicators now reported, 18 were completely met, six partially met, and two not met (childhood immunizations and blood pressure control for diabetics).

For FY 2000, we had expected the process of compiling performance data to be more efficient and timely than our initial effort last year, but that has not been the case. Early in the process of attempting to compile reports for several indicators based on our automated patient record data

system, several global and unforeseen data problems emerged. As part of our Y2K conversion efforts in 1999, the IHS retired the obsolete IBM mainframe computing platform that was used to aggregate Indian Health Service supported health care data nationally and prepare statistical reports, which are used to report on GPRA indicators. The conversion efforts successfully addressed the Y2K date change issue but proved to be challenging when migrating existing data and duplicating the complex set of algorithms used to aggregate data from decentralized collection points. As a result some data sets could not be generated or the verification processes were not fully functional.

Intensive efforts have since been focused on procedures to reestablish the essential report generating capabilities and ultimately improve data quality. These procedures involved measures to insure that data are input consistently at service points using standardized screening edits; focusing on accuracy of coding; refining the process for aggregation and transmission; standardization of program and data definitions; and other steps required to improve the quality and completeness of data. This has been and is a challenging process requiring a high level of coordination and cooperation between the local I/T/Us, Areas and to Headquarters.

The combination of improvements in the information technology architecture and the program improvements will ultimately improve the quality and availability of data. Current efforts are focused on securing data for indicator 26 not yet reported and on final data validation and verification for six other indicators (Indicators 1, 6-8,13 and 22). For a more detailed discussion of data validation and verification see section A.1 on page 122 in the appendix of this document. We are confident these technical set backs will be resolved in the near future and we remain committed to improving the processes for generating and making GPRA and other accountability data a major focus of our information technology development path.

From a more positive perspective, we have already realized benefits from these efforts to update and improve our data systems. Data for three indicators (i.e., Indicator 6, 7, and 27), that earlier in FY 2000 were believed to be dependent on manual assessment through chart audits, have recently been successfully extracted from our electronic patient records systems as a evaluation sample. While the completeness of the data from this process is still uncertain, we believe it represents an important further step in moving toward automated approaches of securing performance data. Based on this new capability, the chart audit originally planned as the primary approach for assessing these indicators will be used as a verification process for the electronic approach, and reported next year.

Another positive spin-off of these emerging IT capabilities is the addition of a newly proposed performance indicator for FY 2001 and FY 2002 (Indicator 17) that further expands the automated extraction of GPRA clinical performance measures by developing test sites to assess and improve data quality. Included in this innovative project are efforts to adopt recognized data standards for laboratory and other data that are now uniformly accepted by most of the healthcare industry and will be implemented within IHS in the near future. This project is also developing web-based training to support the efficient diffusion of newly developed technologies across the IHS.

Reflecting on FY 2000 overall, of the 34 performance indicators in the plan we are now reporting on 29, six of which are provisional findings pending further verification. Of these 29 indicators, 18 were achieved, nine partially achieved, and two not achieved. We will report on the remaining five indicators by this coming August. Perhaps the biggest disappointment was

not achieving the childhood immunization indicator for the second year and only achieving the dental sealant target in one age category. These are proven cost-effective public health services that we pride ourselves in the high level of coverage we maintain.

However, these findings were not all that surprising given continued difficulties in the recruitment and retention of health professionals, particularly dentists, pharmacists, and nurses. The IHS vacancy rate approached 20% for dentists during FY 2000 and continued during FY 2001 although progress has now been made in the dental category. Indeed, vacancies of this magnitude will continue to make the achievement of access-related performance measures very difficult. A detailed analysis of this problem is presented in the section that follows addressing external factors influencing success.

The other performance indicator that was not achieved for FY 2000 was Indicator 18 that addresses the diffusion of the Mental Health /Social Service automated reporting system to local programs. We believe that the major reason why no progress was made during FY 2000 was the overriding difficulties occurring in the conversion of the IHS automated data system as described previously in this section. However, for FY 2001 the IHS is implementing required automated data standards for reporting GPRA data from the Areas we and believe this requirement as well as additional marketing will expand the use of this software and also improve other data quality problems for 2001 and beyond.

Several of the process performance measures only partially achieved in FY 2000 were the result of IHS Area and Headquarters staff dealing with multiple priorities simultaneously and not being able to consistently making the GPRA requirements the highest priority. Given that many Areas and Headquarters have downsized over 50% the past few years in response to continued transition to tribal management of health programs, the level of ambient stress from conflicting demands and growing accountability requirements is a concern in adding more to people's responsibilities. However, IHS leadership has increased the visibility and priority of GPRA through a variety of venues creating an organizational awareness that GPRA is not going away but is likely to receive greater attention by OMB and Congress in the future. Furthermore, the IHS is assigning responsibilities for supporting GPRA across a broader distribution of staff with new individual performance standards. Also, by continuing to enhance the link between GPRA and the public health values we have long embraced, we will increasingly make GPRA a part of our corporate culture.

It is also worth noting that two successes in FY 2000 have resulted in our ability to set higher performance targets in FY 2001 than originally proposed. Our success in achieving a higher score in the HHS Quality of Work-life survey for FY 2000 allowed us to raise the FY 2001 target from 95 points to 97. From a public health perspective, we are pleased that our efforts in FY 2000 in improving water fluoridation compliance in pilot sites through an agreement with CDC has resulted in increased focus and earmarked funding for FY 2001. As a result all Areas will benefit from this effort and the performance target for improved access to fluoridated water in FY 2001 is expanded beyond the pilot sites to include all IHS Areas.

Probably the most important question that could be asked relative to our FY 2000 performance would be to describe what the level of accomplishment of GPRA indicators means in terms of actual improvements in health status of AI/AN people. Clearly this is a complex question that would be difficult to answer with much precision in the short run. Since many of our performance indicators deal with chronic diseases that cannot be addressed completely in the

short-term, most I/T/U public health professionals would likely be surprised if we accomplished more than holding the health status at a constant level for most conditions, with some worsening and perhaps a few improving. With the latest available mortality data (1996-1998) showing the continued increase in mortality for the AI/AN population, it is likely that the mortality disparities will not even be reversed for several years.

However, the improvements in access to critical primary services documented with the performance reports for FY 1999 and FY 2000 represent important steps in reducing the mortality and morbidity of chronic diseases. Likewise our indicators addressing prevention activities and pilot projects offer the potential to ultimately reduce the prevalence of these same chronic diseases. Making significant strides in reducing the health disparities in the AI/AN population will require continued improvements in access to treatment and preventive services to be sustained for many years as well as addressing the related problems of unemployment and poverty. These issues are discussed in the next section of this document.

Despite these challenges, the implementation of GPRA in the IHS has resulted in some continued benefits that are likely to contribute to future success. First, the GPRA/Budget Formulation process has increased collaboration and understanding of public health and budgeting across the diverse IHS stakeholders. The process of addressing these issues beginning at the local level and moving up has aligned and mobilized tribal leaders and consumers about funding issues that address significant public health problems. In this process health program staff have learned more about the IHS budget process and budget/finance staff have learned more about public health. But probably of most importance, tribal leaders and consumers have had the opportunity to have dialogue about the "big picture" of Indian health and learn more about both public health and budgeting.

This new knowledge appears to have resulted in improved cooperation across the diverse I/T/U network. As a result, I/T/U leaders are using this knowledge to speak with less parochial and more unified voices supported by data, to justify funding requests. Furthermore, a growing number of tribally managed programs that legally do not have to participate in GPRA are not only participating, but also encouraging other tribal programs to do likewise. A notable example of Tribal collaboration and participation in GPRA related activities is the partnership between the Nashville Area Office and its Tribes. The Area works closely with the United South and Eastern Tribes, Inc. (USET), which represents most of the Tribes in the Area. USET has identified 13 Tribal Health Objectives and chartered a Health Indicator Review Committee to review and refine this set of health indicators that each Tribe is recommended to monitor and report progress on. The Health Indicator Review Committee consists of Tribal health personnel and Area Office epidemiology, public health and environmental health staff. All USET Tribes have elected to participate in this project.

The Tribes have further demonstrated their commitment to this activity through their cooperation in providing key Area staff access to their data systems. The Nashville Area epidemiologist has established a mutually cooperative relationship with the Tribes that has improved the collation and validation process for assessing progress towards the national and Tribal indicators. This level of partnership is a noteworthy example of Tribal commitment and involvement in using health indicators to improve the health status of AI/AN people.

As a final reflection on FY 2000, the IHS is indebted to **Joe DeLaCruz** for his efforts in encouraging and assisting tribes in participating in the GPRA process. His untimely passing in

April 2000 was a loss to all AI/AN people and the organizations that support them. Our dedication of this submission in his memory is a tribute to his life-long commitment to the health and well being of the AI/AN people.

Key External Factors Influencing Success

A variety of external factors have functioned as powerful determinants in the level of attainment of the FY 2000 Performance Report and will continue to influence our success in future performance reports. It is important to acknowledge that for many of these factors the distinction between what is external versus internal is often blurred. However, making this distinction is a critical element in successfully addressing them.

Recruitment and Retention of Health Care Providers

As acknowledged in the previous section, vacancy rates for some health care providers are at the highest level in IHS' history and are directly related to difficulties in both the recruitment and retention of these providers. The reasons for these recruitment and retention difficulties are complex and include both external factors as well as factors within the I/T/U settings. The broader external factors are the growing debt levels for health professionals leaving school, coupled with increasing earning potential in the private sector as a result of a healthy economy and relative shortages of these health professionals. The factors within the IHS context include relatively poor salary parity between the Federal systems and the private sector, isolation and a lack of urban amenities in many reservation settings. Furthermore, limited spousal employment opportunities, ancillary support, and clinical space to address an ever-increasing patient load, have also contributed to recruitment and retention difficulties.

These local factors have been compounded by diminished professional support to IHS managed programs because of downsized Areas and Headquarters that has occurred in response the continued transition to tribal management of health programs. While this Area and Headquarters downsizing was a planned part of the self-determination process, it resulted in a loss of economies of scale greater than expected.

Collectively these trends and associated reductions in career development and training opportunities have appear to have resulted in a decrease in morale of IHS providers. Objective indicators for this trend include the relatively low score of the IHS in the 1998 and 1999 HHS surveys that define the Human Resource Management Index from the Department as a whole and for each OPDIV. This annual process is based on a survey of a sample of employees from each HHS agency and has been designed to assess several recognized components of the "quality of work life." While we are pleased to report that the IHS score for this survey did improve for FY 2000, the IHS score still remains below the Department average. Clearly a sustained effort will be needed to meet the performance targets for FY 2001 and FY 2002.

Lastly, there has been a significant increase in EEO filed complaints across over the past few years within the IHS. While this trend is undoubtedly the result of many factors, it is likely that staff morale and the stresses of downsizing have been contributing factors. Thus, the net effect of these trends is to compound the retention problem because the staff are affected by diminished support and overwhelmed by the patient load. For consumers, the waiting times for appointments increase and complaint rates increase. This can result in staff becoming discouraged and resigning as well as patients giving up trying to access the system for health

care needs except emergencies. In effect, patients may not proactively seek services such as well-baby, cancer screening, dental care, or diabetes control.

The IHS is committed to improving its performance in the recruitment and retention of well-qualified health care providers and the FY 2000 -2002 Budget Requests and Performance Plans strategically address this problem. Activities directed towards this end include:

- expanding web-based recruiting efforts
- expanding consideration of alternative Federal pay structures to address pay parity issues
- expanding the loan repayment program and making it more flexible for I/T/U use
- developing alternative mechanisms to support health disciplines in partnership with tribes and tribal organizations including the addition of two Tribal Epidemiology Centers and four Dental Clinical and Preventive Support Centers
- continuing efforts to enhance quality of work life (QWL) through greater adoption of HHS QWL policies and enhanced leadership training

The Role of Poverty

The relationship between poverty and higher levels of morbidity and mortality for both acute and chronic diseases and conditions has been documented worldwide. In fact, many of the racial and ethnic disparities in health status disappear when analyses control for education and socioeconomic status. Across Indian Country, mortality and morbidity rates generally follow the general economic indicators such a socioeconomic status, employment rate, and also educational level. As noted in the introduction of this document, the IHS serves several of the poorest communities in the country that also have the lowest life expectancy rates.

While increasing access to comprehensive health services over time will reduce both mortality and morbidity to some degree in these situations, health services alone are not likely to eliminate the huge health disparity gap that now exists, unless the other complex factors contributing to poverty are also addressed. However, it must be acknowledged that the current challenges associated with access to many essential services are contributing not only to poor health but also to poor economic conditions. Indeed, poor health status should be viewed as both a cause and an effect of poverty.

We offer an example of how powerful even relatively mundane and non life-threatening health problems can be when they reach extreme levels. Between 1988 and 1991 the IHS Dental Program participated in the World Health Organization sponsored International Collaborative Study of Oral Health Outcomes. Data were collected on the Lakota Sioux Indian people on the Pine Ridge and Rosebud Reservations in South Dakota and on Navajo people in the northeast corner of the Navajo reservation in Arizona and New Mexico. Other study sites include Baltimore and San Antonio in the United States and Latvia, France, New Zealand, and Japan. The study included calibrated and standardized oral examinations with assessments of disease rates and treatment needs and a detailed patient interview that included a history of dental experiences and problems.

The oral health examination corroborated findings from IHS surveys that the oral conditions of Navajo and Lakota Indian people were very poor with disease rates two to four times that of all other study sites. Findings from the studies patient interview that assessed the impact of oral health on a variety of quality of life measures revealed the following alarming findings:

- one third of school children report missing school because of dental pain.

- 25% of school children avoid laughing or smiling and 20% avoid meeting other people because of the way their teeth look.
- as a consequence of dental pain, almost a quarter of the adults are unable to chew hard foods, almost 20% report difficulty sleeping, and 15% limit their activities (i.e., work and leisure).
- three quarters of the elderly experience dental symptoms, and half perceive their dental health is poor, or very poor and are unable to chew hard food.
- almost half of the adults avoid laughing, smiling, and conversations with others because of the way their teeth look.

These "quality of life measures" were 200 to 400 % more severe for the Indian study respondents than those from any other sites including Baltimore and San Antonio. Clearly, conditions of this magnitude represent significant disparities in health status and are not just dental problems, but have significant social, psychological, and economic consequences on peoples' self-esteem and their ability to learn, secure employment, and reach their full potential. When such dental conditions are superimposed on top of other prevalent conditions normally considered far more severe such as diabetes, alcoholism, and family violence, a person's capability to achieve self-sufficiency is seriously compromised.

There is little doubt that in many AI/AN communities health status is contributing to the economic hardship they experience. It is also true that improved health care alone cannot make up for the lack of opportunities for economic development. Some tribes are making significant progress in this process and many of these are the ones who have exercised their option under the Indian Self-Determination legislation to manage their own health programs. While the IHS is not an economic development organization, we are committed to assuring that our available resources are used effectively to minimize the negative effects of poor health status on the general socioeconomic well being of AI/AN communities. Furthermore we are working to collaborate with the BIA, the Administration for Native Americans, and with other organizations with the capacity to assist in economic development. Our success in improving the health status of the AI/AN population in this century will continue to be strongly influenced by the overall success of efforts to address poverty in Indian Country.

A Lack of Cost-Effective Interventions for Chronic Diseases

A major challenge the IHS must address is how to provide health care in the face of increasing mortality and morbidity rates for diseases such as alcoholism, diabetes, and cancer that represent extremely costly conditions to treat. Of these problems, perhaps diabetes represents the greatest economic challenge to the IHS. Within the I/T/U system are communities with the highest diabetes prevalence in the world with many other communities showing accelerating increases annually. Although we are collaborating with CDC and the University of New Mexico to develop preventive approaches, at this point in time, there are no proven large-scale educational or medical interventions known to reduce the prevalence of this condition in populations.

Until a preventive technology is developed, we are faced with the costly medical management of diabetics that is currently estimated in the diabetes literature at \$5000 to \$9000 per patient per year. The IHS is funded at approximately \$1400 per person per year with Medicare/Medicaid, private insurance collections and out of pocket expenditures adding an estimated \$500-700 more. Thus, AI/AN people are funded at approximately \$2000 per person annually compared to almost \$4000 for the U.S. general population. In communities where the diabetes prevalence is approaching 40-50 percent, the entire available per capita funding could be completely

consumed in treating diabetes, leaving nothing for alcoholism, cancer, injuries, oral health, prenatal care, and well-baby/immunizations to name only a few.

Given these economic realities, the I/T/Us are faced with difficult choices in assuring access to essential health care. While there are always ways to improve efficiency and effectiveness and "do more with less," at least in this country, there are no private or public health systems that have set more cost-effective benchmarks for effectively addressing diseases problems of this magnitude than the IHS. It appears decidedly easier to show a profit in the health care industry than to improve the health of the poorer segments of the population. We contend that since our inception in 1955 to the early 1990s, the IHS has set the benchmarks for rural health care efficiency and effectiveness.

Clearly our long-term success in improving the health of the AI/AN population will be strongly influenced by the development of major cost-effective treatment and/or preventive technologies for addressing the many health conditions AI/AN people experience at high rates.

Third Party Collections

The IHS has established a priority to identify any available alternate resources and fully maximize third party collections for delivery of health care services. This priority was established in recognition that increasing collections is a critical element to maintaining and improving the delivery of health services to the IHS service population. Over the last few years the IHS has significantly increased its third party collections, as a result of higher negotiated Medicare and Medicaid rates, new authority to bill under CHIP and more efficient business management practices, involving patient eligibility determination, documentation of services and processing of claims. These increases have been critical to the I/T/U's ability to meet increasingly demanding accreditation and quality standards and maintain access to services in the face of growing health demands driven by population growth and increasing health disparities.

Specific to GPRA, third-party collections clearly contribute to many performance measures and are considered in a general way in setting performance targets. However, it is difficult to link collections to specific GPRA indicators in a quantified way for several reasons. First, unlike our budget authority that is specifically identified each year, we can only estimate our collections. We are able to do this with some accuracy because we do have previous year's collection amounts for all but a few freestanding tribally operated facilities. Our data on how these funds are actually used is considerably less specific. We do not have data on how collections are used by tribal programs because they are not required to provide it. Secondly, within the direct care settings our accounting system only identifies how collection are used at the object class level and this data is included IHS budget justifications each year (see page 72 of the FY2001 Congressional budget justifications). As a result, with our existing accounting capabilities there is no practical way to show for which funding categories or indicators these collections are being used in the many diverse IHS settings. Therefore capturing of such information with our current systems would be impractical and not cost-effective in the context of GPRA or sound public health practices.

The strongest link between these collections and a specific performance measure is Indicator 21 that addresses maintaining the accreditation of health care facilities. First priority for use of collections is directed to funding activities necessary to maintain JCAHO accreditation standards, including specific compliance with deficiencies documented during JCAHO/HCFE surveys. As a result, specific use of collections to meet accreditation standards varies widely

across our health care facilities. In some cases these funds are used to support health care staff positions and others to support building maintenance and compliance with life safety codes. In terms of the four broad budget aggregation categories our performance plan and indicators are based on (see page 39), a crude estimate for how these funds are directed would be 85 percent into the "Treatment" aggregation and 15 percent into the "Capital Programming/Infrastructure" aggregation. We have included estimated collections levels in the summary tables for these two aggregation categories (see pages 49 and 104).

We are encouraged that IHS and HCFA have been working in collaboration under a Joint IHS/HCFA Steering Committee to address major policy issues that improve the delivery of services to IHS populations who have Medicare and Medicaid eligibility. Many of the issues that have been addressed and that are being addressed by the Joint Steering Committee have some impact on IHS' ability to achieve the above objective of optimizing maximizing third party collections. For example, joint efforts to develop cost reports contribute to ensuring that IHS receives a fair reimbursement for its services.

Most recently, the IHS/HCFA Steering Committee have focused on developing a plan to implement the recently enacted legislation that authorizes the IHS under Part B to bill and collect for physician services provided to Medicare beneficiaries. Indeed, maximizing third-party collection will remain a critical activity in the achievement of the IHS Mission.

Transitions to Tribal Management

The rate of transition to tribal management of health programs has and will continue to represent a significant challenge to the IHS. This transition toward tribal management of health programs has required Area Offices and Headquarters to downsize significantly. While this was a planned part of the Self-Determination process, an unfortunate side effect of this downsizing has been the loss economies of scale and reductions in the IHS public health infrastructure. We are encouraged by this growing trend of growing tribal management of critical public health infrastructure including Tribal Epidemiology Centers and Dental Clinical and Preventive Support Centers.

There is also evidence that the transfer of resources and management control to tribes has freed them to innovate, develop alternative resources, find new mechanisms for building facilities, and enhance patient care, which ultimately will improve outcomes. What is still not completely clear at this time is at what level tribal programs will participate in GPRA performance measurement, given that it is voluntary based on current regulations. While a growing number of tribal programs have expressed a commitment to submit data for GPRA in response to our active marketing of its importance, some have expressed resistance based on a belief that it represents an optional administrative activity that diverts resources away from patient care.

Indeed the IHS is in a challenging position with the responsibility of including tribal programs in performance reporting, but lacking the authority to require tribes to submit their data. Despite these challenges the IHS remains committed to tribal self-determination and to performance management and views both as essential to the realization of our Mission and Goal.