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 final FY 2001 and revised final FY 2000 Performance Plans have been merged with the FY 1999 Performance Report consistent with the required format developed within the Department of Health and Human Services (HHS). This plan is submitted as an incremental step in complying with the Secretary's Initiative to eliminate racial and ethnic health disparities and the President's Initiative to Eliminate Disparities in Health Status Among Americans. Consistent with the proposed *Healthy People 2010* goal of achieving equivalent and improved health status for all Americans over the next decade, this plan outlines a strategic set of performance indicators to address the significant health problems of the American Indian and Alaska Native (AI/AN) population.

Indeed the disparity in health status that the IHS must address is formidable, particularly in terms of death rates. Comparing the 1994-1996 Indian (IHS service area) age-adjusted death rates with the U.S. all races population in 1995 reveals greater death rates in the AI/AN population for:

1) alcoholism - 627% greater,
2) tuberculosis - 533% greater,
3) diabetes mellitus - 249% greater,
4) unintentional injuries - 204% greater,
5) suicide - 72% greater,
6) pneumonia and influenza - 71% greater,
7) homicide - 63 % greater,
8) gastrointestinal disease- 42% greater,
9) infant mortality - 22% greater, and
10) heart disease, 13% 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 and requested funding increases supporting 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 FY 1999 and 2000 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 two 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 both the Department of Health and Human Services (HHS) Strategic Plan, the President's and Secretary's initiatives, and the *Healthy People 2000/2010* goals and objectives.

This performance plan and the requested budget that underpins it, represent a cost-effective public health approach to reduce 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. With reasonable support over the next decade, in partnership with our stakeholders, we will 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:

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

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 2000, the IHS and it stakeholders will identify specific long-term quantifiable health status and health care measures that will serve to provide benchmarks for focusing improvement efforts for the future. In essence, this effort will establish quantified targets for Strategic Objectives 1 and 2. While the IHS is waiting to review and consider the final recommendations from the Healthy People 2010 efforts, preliminary work with stakeholders has identified several likely health measures to set 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

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

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 554 health care delivery facilities, including 49 hospitals, 218 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 42 percent of the IHS direct services budget in 13 hospitals, 160 health centers, 3 school health centers, and 236 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 58 percent of the IHS direct services budget in 36 hospitals, 58 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 rather than reservations 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 1998, the IHS Fiscal Intermediary processed approximately 350,000 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:

- insufficient 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 which include:

- 20% decline in well child services between FY 1992 -96
- 14% decline in physical exams between FY 1994 -96
- 18% reduction in people receiving dental services between FY 1994 -96
- 28% reduction in water fluoridation compliance between FY 1994 -96
- 79% increase in denials of claims from health care contractors between FY 1993- 96

In this context, the increasing demand for urgent care 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 1996) 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 1994-96 compared to the period 1992-94 from cancer, diabetes, cerebrovascular disease, suicide, alcohol, and HIV/AIDS. The net result of these categorical increases is an overall increase in death rate for AI/AN people from 690 per 100,000 population for the period 1992-94 to 699 per 100,000 population for the period 1994-96. Given that the U.S. general population mortality rate declined during these comparable time periods from 513 per 100,000 population to 503 per 100,000 population, it is clear the health disparity gap relative to AI/AN mortality is worsening.

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; facilities staffing expansion; 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 a multidisciplinary approach that crosscuts programs key to improving health status and addressing complex health problems caused by chronic diseases and harmful behavioral health practices (see Executive Summary on page 14 to enhance the integration of clinical expertise from medical, behavioral health, and community health staff in order to address the top health problems identified by the I/T/Us. The community-based public health model is strengthened by emphasizing prevention strategies throughout the clinical service activities as well as expanding the 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 improve 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 is the beginning of a long-term plan to assure improvements in the health of the AI/AN population. 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 initiatives. These investments will support surveillance, prevention and treatment services and are based on "best practices" defined in health literature. This approach is consistent with the Presidential Executive Order directing Federal entities to employ 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 and improving health status in the long run is to assure that there are adequate facilities and equipment for the provision of health services. With average age of IHS facilities being 32 years, 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 adequate contract support services 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 expanding tribal participation in the management of the programs and the principles of the Indian Self-Determination Act.

Another target of the FY 2001 funding request is water and sewer systems for new and existing homes at the community level to support further progress to be made 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 an initial increment required to move forward to make improvements in the health status of AI/AN people and ultimately reduce the significant health disparities they face.

1.3 Partnerships and Coordination

Given the magnitude of AI/AN health disparities and recent trends in IHS funding, 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 cross-cutting network is evident by IHS Performance Indicator 35 that commits to expanding our collaborative network.

It is important to acknowledge that in most cases this assistance will not consist of providing health care personnel or resources to provide basic health services to AI/AN people. The exception to this pattern has been agreements made with military health units or medical and other health profession schools who make available health care providers for short periods of time. Thus, it is unlikely that the IHS will make significant gains in expanding access to services by expanding the collaborative network that result in adding significant numbers of providers to I/T/U system. However, the significant benefits that have been realized through these collaborations warrant further efforts to expand this network.

Most agreements and collaborative partnerships the IHS has negotiated relate to gaining assistance in developing or disseminating new health care and/or surveillance technologies or securing a variety of training and technical assistance support for I/T/U providers. In addition, IHS has been collaborating with HCFA to improve the annual rate setting process for Medicare and Medicaid. Over the last few years, HCFA has assisted IHS in the development of annual Medicare Cost Reports and this has served to improve the annual rate setting. Furthermore, improved rate setting has resulted in increased Medicare and Medicaid collections.

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, complementary and common
- documents uniqueness of the agency and its distinguishable contributions, complementary and common
- presents agency plans for eliminating duplication and overlap

PROGRAM COORDINATION BY PARTNER

WITHIN DHHS:

ACF/Head Start Bureau

- agreements for IHS to provide health related training and technical assistance to AI/AN Head Start programs
- collaboration in joint Head Start- IHS Obesity Prevention Initiative(see Indicator 25 on page 62)

AHRQ (FORMERLY AHCPR)

- collaborated to develop a Quality Measurement and Improvement fellowship position in AHRQ
- collaborating on incorporating IHS inpatient data in AHRQ's Healthcare Cost and Utilization Project database
- collaborated in supporting the December 1999 "Crafting the Future of American Indian Health" conference in San Diego to assist tribe in developing collaborations and partnerships with medical and university communities
- collaborating on working together to provide support as IHS restructures its research program
- collaborating on the development of a Medical Expenditure Panel Survey with the National Center for Health Statistics (NCHS)

ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (ASPE)

- supported the role of HHS with the White House Mental Health Conference to meet the mandate of the 1999 State of the Union address of President Clinton

CDC

The IHS and CDC have 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:

- cancer and cancer surveillance
- smoking and tobacco control
- diabetes and the Diabetes Prevention Center in Gallup, NM, which is a jointly sponsored initiative contracted to the University of New Mexico
- reproductive health/sexually transmitted diseases
- immunizations/vaccines
- injury prevention
- hantavirus surveillance and study

Other agreements with CDC address:

- chronic disease prevention and health promotion activities
- hepatitis prevention and control
- nutrient database for AI/AN foods as a component of the National Food and Nutrient Analysis program
- assignment of a public health advisor for vaccine-preventable disease control

In addition, the IHS and CDC are in the process of formalizing new agreements for FY 2000 addressing support for water fluoridation and exercise/fitness demonstration projects that are represented in the IHS FY 2000 and FY 2001 Performance Plans.

FDA

- assistance and cooperation in reducing radiation exposures; analysis of radiation use in diagnostic radiation operations; education and training on radiation health and safety and exchange of information on medical devices

HCFA

- establish a Liaison to advise HCFA managers on policy information respective to health care program's administered by the IHS and Tribal Governments
- established IHS representative on National Medicare Education Program Task Force
- established HFCA personnel assignments to Indian Health Care issues at all Regional Offices and at the Baltimore Office
- negotiated new Medicare/Medicaid rates for IHS
- collaborated on a number of legislative initiatives
- collaborated on IHS/HCFA eligibility listings of beneficiaries through Beneficiary Eligibility Workgroup
- collaborated on Home Health Care through workgroup
- collaborated through HCFA/IHS Steering Committee to discuss major issues affecting the agencies
- Collaborated with HSRA and IHS on "Dear State Health Official " letter announcing Department policy to exempt AI/AN children from cost sharing provisions under the SCHIP
- IHS representative on HCFA APC Workgroup
- collaborated on Business Office conferences and TECH Fair
- collaborated on reimbursement issues across state lines with our Regional Treatment facilities.

HRSA

- 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.

NIH

- NIH/NCI for research into etiology of cancer, incidence and prevalence among Northwest American Indians and Alaska Natives
- National Institute for Dental and Craniofacial Research - treatment of Native Americans with Non-Insulin Dependent Diabetes Mellitus and Periodontal Disease
- National Institute of Diabetes & Digestive Kidney Diseases - comprehensive evaluations of diabetic renal disease in the Pima Indian population and to provide for training in diabetes care
- provide engineering services to Rocky Mountain Laboratory Upgrade Project
- National Institute of General Medical Sciences -support various IHS grant projects

OMH

- support Tribal Colleges and Universities/HHS Annual Conference

OWH

- workshops for women's health issues

SAMHSA

- co-sponsor SAMHSA's Second National Conference on Woman, Life Pathways: Woman Healing, Thriving, and Celebrating

OTHER FEDERAL AGENCIES

DOI/BUREAU OF INDIAN AFFAIRS

- provide technical assistance and training for background checks of employees of tribal health programs
- addressed ongoing adolescent suicide problems among AI/AN youth
- co-sponsored June 1999 National Youth Conference with BIA and ANA.

DOJ

- develop capability to photographically document and electronically transmit photographs of injuries sustained by crime victims.

EPA

- coordinate activities of both agencies in a manner that promote the mutual interests, cost-efficiency, and overlapping responsibilities to design and construct wastewater treatment projects on American Indian reservations using cross-cutting services and resources.
- Tribes are provided the opportunity for consultation on projects and may choose to administer their project through grant applications with IHS and EPA providing the technical guidance and support.

U.S. ARMY MEDICAL COMMAND

- assist the IHS in obtaining professional services from dentists and dental hygienists

USDA

- agreement 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

VA

- Nationally, IHS is collaborating with VA on targeted data systems and credentialing.
- Native American veterans registered with VA will be targeted for VHA services as a result of identification of under-served areas of Indian country where Native Americans reside
- Many local IHS facilities have care agreements and pharmaceutical supply agreements with nearby VA facilities.

OTHER PROGRAM COORDINATION BY SUBJECT

IHS Director's Children and Youth Initiative

The IHS Director is currently spearheading a Domestic Policy Council multi-departmental initiative 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 encouraging with active participation from HUD, DOI, DOA, DOT, and several HHS OPDIVs. The ultimate goal for the initiative 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). Included in this

effort is the drafting of an Executive Order to redirect policy and support needed legislative changes. In addition, the initial workgroup of this initiative embraced the importance of agencies documenting their commitment to the initiative through identifying appropriate specific GPRA performance indicators.

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

- ACOG Fellows in Service Program recruits college ob/gyn doctors for short term assignments in IHS facilities to fill in while our IHS physicians are on leave, maternity leave, educational training, etc. There are approximately 12-15 assignments that occur during each year
- The ACOG Committee on American Indian Affairs conducts OB/GYN Quality Assurance site visits to 2-3 IHS facilities each year
- ACOG Post-Graduate Courses on Neonatal and Gynocologic Care course is built around and focuses the training to the environment/setting of IHS facilities and services. Approximately 100 doctors, nurses, physician assistants, and others attend annually to keep updated with OB/GYN standards.

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. Primary emphasis is directed to the greatest cause, motor vehicle crashes, and to the most common risk factors, lack of use of safety restraints, abuse of alcohol, and poor road conditions in rural areas. Other projects are focusing on preventing injuries to the elderly as a result of falling, the prevention of burn and fire injuries that occur in the home, the use of motorcycle and bicycle helmets to reduce traumatic brain injury, and drowning prevention.

To accomplish their mission, the IHS Injury Prevention Program has formed partnerships with many government and non-government agencies. Formal Interagency Agreements exist between IHS and the National Center for Injury Prevention and Control, the U.S. Fire Administration, and 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; National Safety Council's Air Bag Safety Campaign; Bureau of Indian Affairs' Law Enforcement Services and Division of Highway Safety; American Academy of Pediatrics, Committee on American Indian & Alaska Native Child Health; Federal Highway Administration; HRSA's Division of Maternal & Child Health; The Johns Hopkins University; Harborview Injury Prevention Research Center; and private foundations.

1.4 Summary FY 1999 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.

FY 1999 Performance Summary

The FY 1999 performance report is included with each indicator in Part II of this document. The data are summarized in tables that precede each set of performance indicators and are elaborated in greater detail under the description of each individual indicator. The Y2K efforts over the past year and recent conversion to new hardware and software at our data center diverted considerable attention away from normal health care data managing activities. As a result, when preliminary data runs were recently made, some of the new conversions routines were not completely functional and a significant volume of data were missing from many field sites. Despite these difficulties, with considerable effort the IHS is able to report on 20 of the 27 indicators. Of these 20 indicators, 16 were attained completely, four were partially attained, and one was not met.

While all of the IHS process indicators were met to at least some degree, the most challenging and most important measures in terms of our mission are the indicators that address access to critical health services. In this light, it is of great concern that the indicator addressing the immunization of children was not met for FY 1999. Similarly, while the dental indicators addressing access to care (Indicator 12, page 45) and dental sealant coverage in children (Indicator 13, page 46) were met, they do not represent increases in services for AI/AN people.

Furthermore, while data or analyses of data are not yet available for the indicators that address four indicators relating to services for diabetic patients (available by August 2000), it is uncertain whether these will be achieved.

This projection is largely based on growing difficulties in the recruitment and retention of health professionals, particularly dentists, pharmacists, and nurses, which have approached 20% vacancy during FY 1999 and are continuing in FY 2000; the highest rates in our history. 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.

Despite these challenges, the implementation of GPRA in the IHS has resulted in some unanticipated 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 within the political system to speak in 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 encouraging other tribal programs to do likewise. We are hopeful that the collaborative reflection on our successes and challenges from the FY 1999 GPRA process will serve to improve our performance in the future.

External Factors Influencing Success

A variety of external factors have functioned as powerful determinants in the level of attainment of the FY 1999 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 coupled with diminished professional support from downsized Areas and Headquarters, which includes reduced career development and training opportunities, have resulted in an a decrease in morale of I/T/U providers. Objective indicators for this trend include the relatively low score of the IHS in the 1998 and 1999 HHS surveys which 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." In addition to this measure, there has been a significant increase in EEO filed complaints over the past few years within the IHS.

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, patients giving up trying to access the system for health care needs except emergencies, and access to services such as well-baby, cancer screening, dental care, or diabetes control in effect become reduced.

The IHS is committed to improving its performance in the recruitment and retention of well qualified health care providers and the FY 2000 and 2001 Budget Requests and Performance Plans strategically address this problem. Activities directed towards this end include:

- expand web-based recruiting efforts
- expand use of alternative Federal pay structures to address pay parity issues
- expand the loan repayment program and make it more flexible for I/T/U use
- develop alternative mechanisms to support health disciplines in partnership with tribes and tribal organizations
- 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 limitations on 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 are extreme. 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 Agency for Native Americans, and with other organizations with the capacity to assist in economic development. Our success in improving health status in FY 1999 and many years to come will be strongly influenced by the overall success in addressing 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 threat 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 $1350 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 with 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 benchmarks for effectively addressing diseases problems of this magnitude with the resources the IHS has had available. 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 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, IHS has significantly increased its third party collections, which, have served to significantly boost the I/T/U's ability to improve the quantity and quality of its health care services being provided to its population. However, changes in legislation and

HCFA policy at the national or at the state level could affect current reimbursement collection levels and IHS' ability to maintain current service levels. For example, we have been working with HCFA to resolve several reimbursement issues regarding the States implementation of the Children's Health Insurance Program. One state has refused to reimburse IHS for inpatient physician services for CHIP eligible children.

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 superimposed on recent funding constraints has required Area Offices and Headquarters to downsize significantly. An unfortunate side- effect of this downsizing has been the loss economies of scale and reductions in the IHS public health infrastructure.
Furthermore, the Agency's ability to meet inherent federal functions including the GPRA has been reduced. However, 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. The level of success tribes are achieving is clearly linked to IHS funding and particularly contract supports funds. 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 unfunded and not required 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.