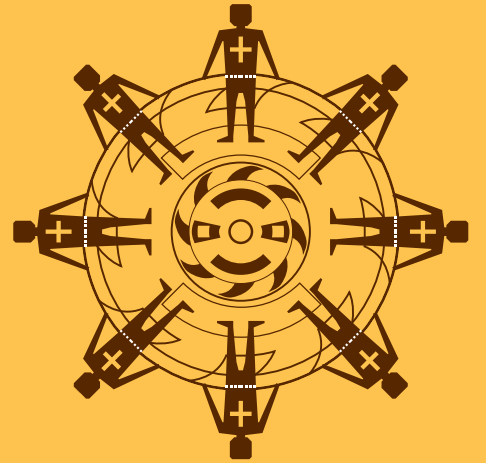# Indian Health Service

STRATEGIC PLAN 2006–2011

Indian Health Service

STRATEGIC PLAN 2006–2011

*Build and Sustain
Healthy Communities*

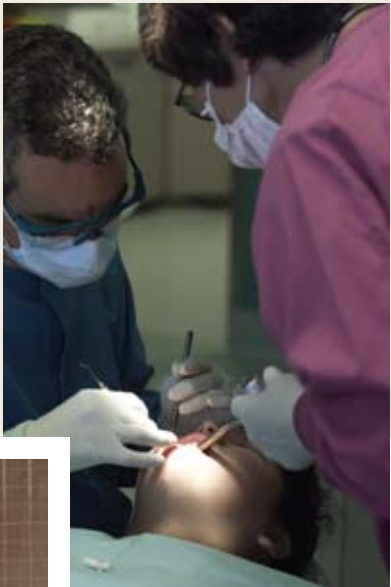*Provide Accessible,
Quality Health Care*

*Foster Collaboration
and Innovation across the
Indian Health Network*

FOREWORD

Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Director

As the Indian Health Service (IHS) begins its second 50 years, I am pleased to present the IHS Strategic Plan for 2006-2011, an insightful and carefully constructed update of the 2003 IHS Strategic Plan. I have elected to maintain the subtitle of "Improving the Health of American Indian and Alaska Native (AI/AN) People Through Collaboration and Innovation" because it still captures the focus essential for our success and reflects the approach used to create this update.

The IHS Strategic Planning Workgroup, a diverse group of Indian health stakeholders, developed the plan to leverage the Department of Health and Human Services' (HHS) Strategic Plan, the HHS Secretary's 500 Day Plan, and the President's Management Agenda, while expanding on the many important initiatives underway within the IHS to address the goals, needs, and health status trends affecting the Tribes and AI/AN communities.

A major goal of this updated plan is to build on the lessons learned in implementing the earlier plan while being responsive to the environment we face. Two themes in particular have become increasingly salient since the publication of 2003 plan. First, the role of accountability as demonstrated through documented performance has been elevated to the most potent element of effective advocacy for our Agency. While a focus on performance has been a critical element of the IHS public health approach since our inception just over 50 years ago, I am committed to making it a more systematic and universally accepted element of our organizational culture as we move forward. To this end, I have reactivated the IHS Performance Achievement Team (PAT) to guide the Agency toward a more consistent, efficient, and effective performance management approach. This plan will serve as a critical road map for the PAT in this effort.

Second, an emerging issue that we must address more aggressively is the alarming pattern of continued increases in health status disparities between AIs/ANs and the U.S. all-race population over the past several years. In response to this trend, I have developed three interrelated initiatives that address health promotion/disease prevention, chronic disease management, and the influential role behavioral health plays in life-style. Collectively, these areas of emphasis are now integrated into this plan with the long-term goal of closing the disparity gap.

I urge everyone committed to the health of AI/AN people to embrace this plan. I believe it is essential for the realization of a shared vision of enhanced collaboration and innovation leading to improved access and quality of health services, and ultimately to empowered, proactive, and healthier AI/AN communities.

Charles W. Grim, DDS

Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Director

The Indian Health Service (IHS) Strategic Plan 2006–2011
Executive Summary and Table of Contents

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The Indian Health Service (IHS) Strategic Plan 2006-2011 is an update of the 2003 IHS Strategic Plan based on a systematic assessment of the health care environ-ment in which the IHS now functions. This assessment process identified four critical planning challenges that underpin the development of this plan. They are:

1   Health care costs and the gap between disparities in health status and funding for AI/ANs will be difficult to address with historical approaches and anticipated appropriations.

2   The Indian health system must be able to assure an adequate workforce.

3   The Indian health system must expand and enhance its performance based culture.

4   The development and implementation of innovative models of health care delivery must be expanded.

While these challenges are daunting, they also present unique opportunities for the IHS to redefine its approaches and improve collaboration and synergy across the Indian Health network. The updated Strategic Plan is designed to offer cul-turally relevant, innovative, and proactive responses to these critical planning assumptions. The proposed Plan contains three strategic goals to meet them and implement the agency mission of raising the physical, mental, social, and spiritual health of AI/AN to the highest level. These goals are to:

   Build and Sustain Healthy Communities
   Provide Accessible, Quality Health Care
   Foster Collaboration and Innovation across the Indian Health Network

Each strategic goal contains several specific objectives that include the Purpose and Outcome and a list of Strategies for IHS and its partners to achieve each objective.

● **STRATEGIC GOAL 1**
Build and Sustain Healthy Communities

To achieve this goal, the Indian health system will mobilize and involve AI/AN communities to promote wellness and healing, develop public health infrastructure with Tribes to sustain and support AI/AN communities, assist AI/AN communities in identifying and resolving community problems by improving access to data and information, and strengthen emergency preparedness management in AI/AN communities.

● **STRATEGIC GOAL 2**
Provide Accessible, Quality Health Care

For this goal, strategies include providing safe, effective and high quality primary health care services, maintaining an adequate workforce, maximizing alternative resources, and providing accurate and timely clinical data on the health of American Indians and Alaska Natives, and quality health information for decision making to patients, providers, and communities through improved information systems.

● **STRATEGIC GOAL 3**
Foster Collaboration and Innovation across the Indian Health Network

This goal includes expanding coalitions and partnerships to build a dynamic Indian health network and developing new structures within the Indian health network to increase collaboration and innovation to improve and advocate for the health care of the AI/AN population.

The main themes of these goals and strategies include advocacy, community involvement, performance integration, investment in human capital and developing innovative models of health care. Achieving significant progress towards these goals will require a concerted effort by the Indian health system, the Indian health network, and its stakeholders, Tribes and communities. Progress will be evaluated through the achievement of established Agency performance measures. This plan will help guide the Indian Health Service as the Indian health network continues to embrace change, innovation, and advocacy in health care in the 21st century while honoring the history and traditions of AI/AN people.

Introduction

MISSION

The mission of the Indian Health Service is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

GOAL

To ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to all American Indian/ 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.

INTRODUCTION

"The Indian Health Service, in partnership with the people we proudly serve, strives to employ the technologies of modern medicine while remaining culturally grounded in the traditional values, wisdom, and heritage of the American Indian and Alaska Native people."
– A Culture of Caring

The Indian Health Service

Since 1955, the Indian Health Service (IHS) has been the agency within the Department of Health and Human Services (HHS) responsible for the delivery of health services to Federally-recognized American Indians and Alaska Natives (AI/AN). The IHS assumes this responsibility with a high level of commitment as the principal Federal health care provider and health advocate for AI/AN people. The IHS strives to provide high quality, comprehensive primary care and public health services through a system of IHS, Tribal, and Urban operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. This Indian health system currently serves approximately 1.8 million AI/AN people through 48 hospitals, 268 health centers, 135 health stations, 11 school health stations, 162 Alaska village clinics, 34 Urban Indian health programs, and 11 Tribal Epidemiology Centers.
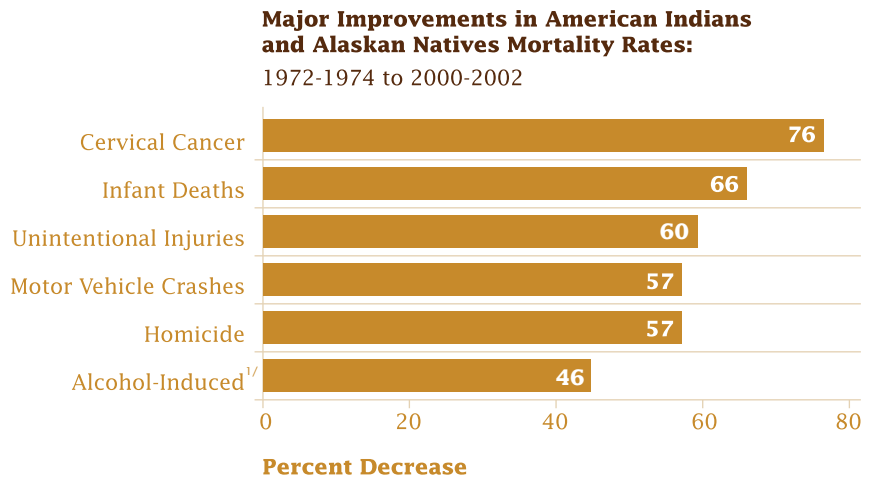
The AI/AN population is disproportionately affected by health conditions such as obesity, diabetes, oral diseases, cardiovascular disease, mental and behavioral health issues, and unintentional injuries. Despite dramatic improvements in mortality rates between the 1970's and early 1990's (Figure 1), current data show that health disparities, compared with the general U.S. population, have been increasing and, that some mortality rates for AI/ANs increased or decreased slightly during the mid and late 1990's. (Figure 2) The IHS is taking steps to address these health challenges and disparities by targeting increased access to services and innovations that address the greatest health threats.

To this end, the IHS has embraced the Director's three health initiatives to improve the health status of AI/AN people. These interrelated areas of focus include:
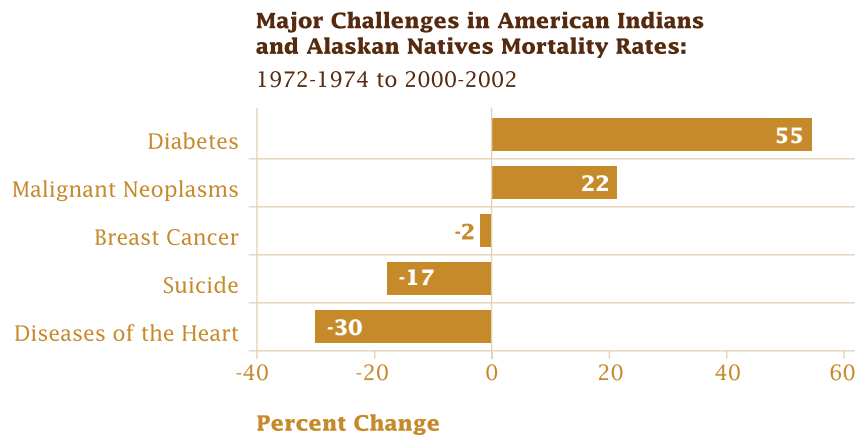
Behavioral Health   **Chronic Diseases**   **Health Promotion/ Disease Prevention**

Figure 1

Major Improvements in American Indians and Alaskan Natives Mortality Rates:

1972-1974 to 2000-2002

Cervical Cancer	76
Infant Deaths	66
Unintentional Injuries	60
Motor Vehicle Crashes	57
Homicide	57
Alcohol-Induced[1/]	46

0   20   40   60   80

Percent Decrease

[1/] Rate of alcohol-induced deaths is for the 1979-81 three-year period. Percent decrease represents changes from 1979-81 to 2000-02.
Source: IHS Division of Program Statistics

Figure 2

Major Challenges in American Indians and Alaskan Natives Mortality Rates:

1972-1974 to 2000-2002

Diabetes	55
Malignant Neoplasms	22
Breast Cancer	-2
Suicide	-17
Diseases of the Heart	-30

-40   -20   0   20   40   60

Percent Change

Source: IHS Division of Program Statistics

Indeed, behavioral health approaches to primary prevention of chronic diseases may offer the most promising and cost-effective interventions in addressing many of the most significant health problems AI/AN people currently experience.

The Director's Initiatives as well as local priority issues are being accomplished through systematic, evidenced-based and community-based approaches that are reinforced with partnerships at the community, local, State, and Federal levels. These efforts include working closely with Tribal Governments as they assume a greater role in improving health care in their own communities, consistent with the intent of the Indian Self-Determination Act and Tribal Self-Governance Amendments.

In addition to assuring primary health care for AI/AN people, the IHS works with Tribal communities to promote a solid public health infrastructure that has the capacity to respond to public health emergencies such as bioterrorism, natural disasters, and pandemic flu. The IHS will continue its health promotion and disease prevention and emergency preparedness efforts to improve the health status of AI/AN people, to reduce health disparities, and to protect the public health of AI/AN communities.

Development and Update of the Agency's Strategic Plan

The IHS Strategic Plan 2006-2011 is the product of a diverse group of IHS stake-holders, charged by IHS leadership to develop a comprehensive and systematic approach to the realization of the IHS Mission, Goal, and Foundation over the next five years. The Strategic Planning Workgroup brought together expertise in clinical care, public health, epidemiology, health care administration, health care financing, community development, Tribal sovereignty, education, environmental health, engineering, planning and facilities construction.

The focus of this plan comes from several sources. First, the goals and needs of the Tribes and AI/AN communities identified through the consultation process in a variety of venues were a major focus of this strategic plan. Three Department level primary performance-related directives were also considered: the President's Management Agenda, the Department of Health and Human Services' (HHS) Strategic Plan, and the HHS Secretary's 500 Day Plan. These three directives were integrated into a Departmental guidance called the HHS Top 20 that provides a set of program and management goals to all of the HHS operating divisions so that they align into One Department, One Direction, and One HHS. (Appendix D) Finally, two goals from the HHS Strategic Plan essentially reaffirm the IHS Mission and Goal and thus serve as macro themes for this document:

3.4   Eliminate racial and ethnic disparities.
3.6   Increase access to health services for AI/ANs.

The IHS Strategic Plan 2006-2011 is predicated upon a systematic assessment of the strengths, weaknesses, threats, opportunities, health trends, statutory and regulatory issues, performance requirements, and current and projected funding of the Indian health care system. During this process, the workgroup reaffirmed that the realization of the IHS Mission, Goal, and Foundation was largely dependent on effective collaboration and synergism between the IHS and its diverse stakeholders which are referenced throughout this Plan as the **Indian health system** and the **Indian health network.**

The Indian Health System and the Indian Health Network

The **Indian health system** consists of the IHS, Tribal, and Urban operated health facilities and programs with support and coordination provided by IHS Headquarters, 12 IHS Area Offices, and 11 Tribal Epidemiology Centers.

The Indian health system often represents the only source of health care for many AI/AN individuals, especially for those who live in the most remote and poverty stricken areas of the United States. The range of physical and behavioral services provided by the system includes emergency, inpatient, and ambulatory care; environmental and community services; and a diversity of health promotion, disease prevention, and public health activities. In addition, various health care and referral services are provided to Indian people away from the reservation settings through Urban Indian health programs and contract health services.

The **Indian health network** represents the IHS and the critical partners who share a responsibility or interest in the health of the AI/AN population. This network includes the Tribes; Tribal organizations; Urban Indian organizations; Federal Departments and agencies; State, city, and county governments; colleges and universities; inter-Tribal and private organizations; as well as others.

The IHS serves the leadership and coordinating role to expand and improve the increasingly diverse Indian health network to effectively pursue strategic opportunities.

How IHS Has Transformed: 50 Year Milestone

As the IHS has passed its 50 year milestone, the Agency and its Tribal partnerships have continued to evolve to meet the health needs of AI/AN people and their communities. These partnerships are based on Tribal sovereignty and a Government-to-Government relationship. In this context, sovereignty means that Tribes can govern their own territory and internal affairs and only Congress can override an Indian nation's authority. The Government-to-Government relationship is a Federal policy that requires the U.S. Government to consult with Tribes about how Federal actions may affect them.

From 1955-1974, the IHS provided health care to the AI/AN population through the use of Civil Service and Commissioned Corps Federal personnel systems. However, in 1975 this pattern began to change with the passage of the Indian Self-Determination and Education Assistance Act that gave Tribes the option of assuming the management of health programs in their communities and authorized funding for improvements in Tribal capacity to contract under this Act. From 1990-2000, the socio-economic status of AI/AN living in locations where tribes have assumed management control of major health and social services improved more than any other U.S. racial or ethnic group. This trend occurred independent of gaming enterprises and is attributed to the empowerment associated with tribal management. Hopefully, improvements in health status will soon follow.

The Self-Determination Act was amended in 1992 to authorize the Secretary of HHS to negotiate self-governance compacts with Tribes as part of the Self-Governance Demonstration Project to strengthen the Government-to-Government relationship between Federal and Tribal Governments and reduce Federal control over decision making. It enhanced fiscal control, resource allocation and management at the Tribal level. Thus, the amended Act provided Tribes three options to exercise their sovereign rights:

1. **Title I Contract**
2. **Title V Compact**
3. **Retain federally operated health programs**

Tribes that elect to contract or compact for the management of their health programs have the opportunity to reshape these programs at the local, Tribal level and implement innovative solutions.

Today the role of collaboration within the Indian health system is an accepted and valued part of our organizational culture. These collaborations have contributed to our effectiveness in budget formulation, performance planning, diffusion

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of best practices and overall Indian health advocacy. It is essential to continue and expand upon these changes. This strategic plan can serve as a road map for this critical process.
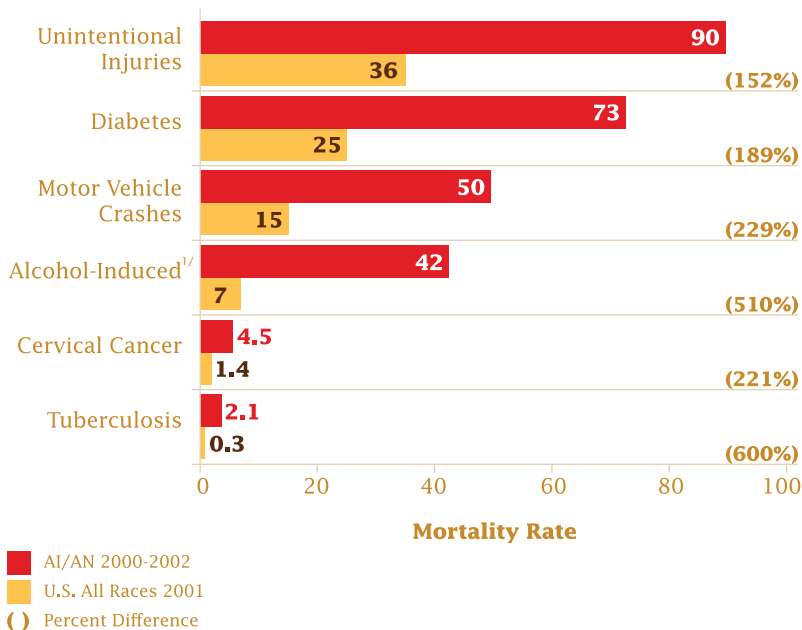
What IHS Faces

Even though the increased rate of AI/AN mortality observed in the 1990's has reached a plateau, health disparities with the general U.S. population are still on the rise (Figure 3). Clearly, declines in per capita funding for health care, inability to significantly expand access to services, diminished public health support-ive infrastructure, continued high rates of poverty, and the high prevalence of unhealthy lifestyle patterns have all contributed to these statistics. While improved access to new and innovative clinical care can help reverse this trend, new cultur-ally appropriate health promotion and disease prevention initiatives will also be essential. These initiatives must go beyond the walls of health clinics to empower and positively influence individual, family, and community health behavior. Real-izing these needed changes to occur on a large scale will require strong advocacy from two levels.

Figure 3

Mortality Disparities
Comparison of Rates for American Indians and Alaska Natives (2000-2002) and all U.S. Races (2001)

Unintentional Injuries: AI/AN **90**, U.S. **36** (152%)
Diabetes: AI/AN **73**, U.S. **25** (189%)
Motor Vehicle Crashes: AI/AN **50**, U.S. **15** (229%)
Alcohol-Induced[1]: AI/AN **42**, U.S. **7** (510%)
Cervical Cancer: AI/AN **4.5**, U.S. **1.4** (221%)
Tuberculosis: AI/AN **2.1**, U.S. **0.3** (600%)

Mortality Rate

■ AI/AN 2000-2002
■ U.S. All Races 2001
( ) Percent Difference

NOTE: These contribute to a difference in mortality of **1,040** for AI/AM compared to **855** to U.S. All Races.
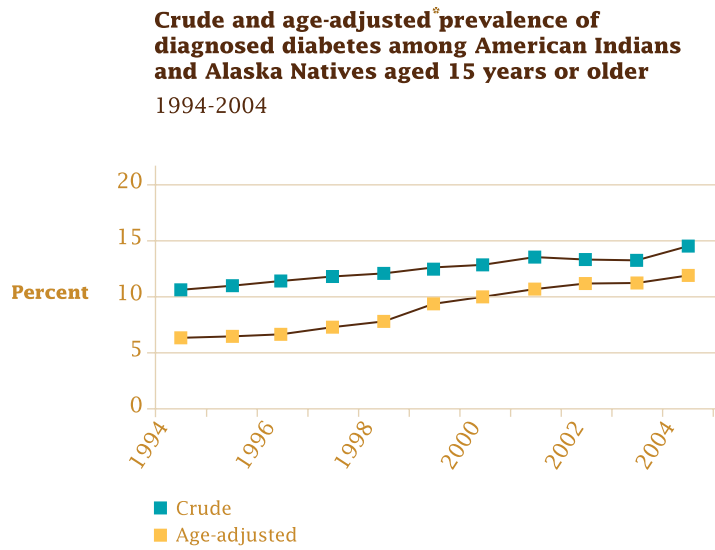
[1] Rate of alcohol-induced deaths is for the 1979-81 three-year period.
Source: IHS Division of Program Statistics

First, it will require high level advocacy from the Indian health network, HHS, Office of Management and Budget (OMB), and Congress that addresses three critical legislatively based commitments: the unique Government-to-Government relation-ship between the Federal government and Tribes, Treaty obligations for health care, and the Department's commitment to eliminate racial and ethnic disparities and to increase access to health services for AI/AN. Probably the most compelling visible outcome of such successful advocacy would be the reauthorization and funding of the Indian Health Care Improvement Act which has stalled in moving through Congress in recent years.

The second critical type of advocacy must address empowering AI/AN individuals, families, and communities in the acceptance of responsibility for adopting healthy life-style choices. Accomplishing this end will represent one of the greatest chal-lenges for the Indian health system. But this challenge must be faced because no reasonable amount of health care resources can adequately address many of the health problems plaguing the AI/AN population without such behavior change.

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Figure 4

Crude and age-adjusted*prevalence of diagnosed diabetes among American Indians and Alaska Natives aged 15 years or older

1994-2004

■ Crude
■ Age-adjusted

*Based on the 2000 U.S. standard population

Strategic Outlook of the Indian Health System

This strategic plan is based upon a systematic assessment of the health care environment in which the IHS functions as viewed from a five year time-frame. This evaluation led to the identification of four critical planning assumptions that are the basis for the development of this plan. These assumptions are:

1 *Health care costs and the gap between disparities in health status and funding for AI/ANs will be difficult to address with historical approaches and anticipated appropriations.*

Medical inflation and disease burden in AI/AN communities contribute to the rising cost of providing appropriate quality health care services. More specifically, this problem is aggravated with rising childhood obesity, diabetes, behavioral health issues including adolescent suicide and substance abuse, and continued high rates of unintentional injuries. At the same time, insufficient increases in appropriations have widened the gap between increased need and available resources.

To address increases in medical treatment costs, the IHS has embarked on cost effective health promotion/disease prevention activities such as tobacco cessation, obesity screening, and support of healthy lifestyle program centers. The growing toll of chronic diseases in the AI/AN population must to halted and reversed. (Figure 4) Recent efforts have also encouraged sound business practices, increased third party collections, and development of staff and human resource capacity to meet increasing needs.

In order to offset the potential disparities between appropriations and needs, while at the same time maintaining and improving the overall health of the AI/AN population, the Indian health system must focus on increasing efficiency, effectiveness, and the quality of health care delivery through data quality improvement, effective business planning, increased communication, and the acquisition of alternative resources. The IHS must continue a multi-pronged approach of advocacy, collaboration, and identification of new resources to meet increased demands in the face of uncertainty about appropriations from year to year.

2 *The Indian health system must be able to assure an adequate workforce.*

It remains critical that the Indian health system continually renew and expand its organizational capacity and expertise to meet its complex and growing human resource needs, consistent with the HHS Strategic Plan and the President's Management Agenda. Accomplishing this objective requires the ability to hire competent well trained staff and to support their development within the system through orientation, job experience, mentoring, and long and short term training experiences.

While recruiting and retaining qualified health care providers and placing experienced, qualified staff in administrative and leadership positions have long been difficult, these problems are now at the highest levels in IHS history. Furthermore, the continuing loss of expertise and organizational memory due to the retirement of experienced, well trained professionals, without an adequate number of highly skilled, mentored, experienced, and culturally competent staff of the next generation to replace them, continues to pose a challenge.
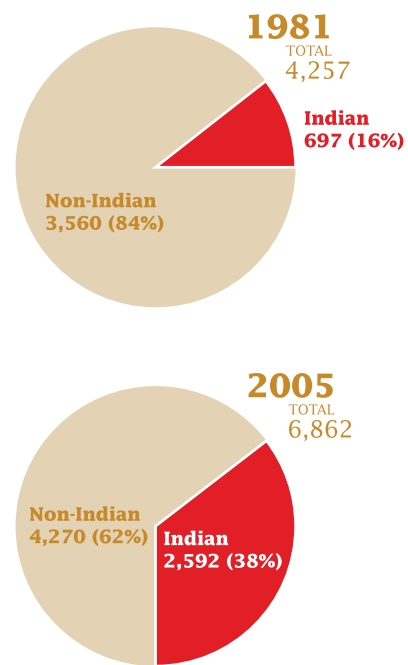
Clearly becoming more successful at human resource development at all levels of the Indian health care system will require multiple approaches and stakeholder collaborations. The IHS Scholarship program has served as a driving force in increasing the proportion of AI/AN people serving in health

professional staff positions, which now comprise 38 precent of the total health professional staff. From 1981 to 2005, the number of AI/AN health professionals almost quadrupled from 697 to 2,592 individuals by 2005. (Figure 5) To add to this supply of health care providers and leaders, educational partnerships with associations, universities and Tribal colleges must also be expanded.

Figure 5

Indian Health Service Health Professional Staff

September 9, 1981 vs. September 30, 2005*

1981
TOTAL
4,257

**Indian
697 (16%)**

**Non-Indian
3,560 (84%)**

2005
TOTAL
6,862

**Non-Indian
4,270 (62%)**

**Indian
2,592 (38%)**

* Total professional staff has grown by 61%.

Indian provider staff has grown by 272%.

Proportion of provider staff that is Indian has increased by 138%.

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3 *The Indian health system must expand and enhance its performance based culture.*

A fully developed performance based culture exists when the primary incentives support performance at the highest level of organizational capability in carrying out the Agency's mission and goals at all levels. The IHS Performance Achievement Team was established in 2005 to ensure the efficient and effective integration and coordination of performance across the Indian health system in partnership with the respective programs. Clearly achieving performance targets relative to increasing access to health care and improving health outcomes are the essence of the IHS Mission and Goal. An additional and increasingly important benefit of achieving a high level of performance is to meet the major Federal accountability requirements and ensure that the performance results are available to effectively advocate for the health care needs of the AI/AN people.

IHS performance accountability is structurally aligned to government-wide performance accountability strategies as well as the strategic direction of the Agency. The strategies are reflected through legislation, the President's Management Agenda, the Department's Strategic Plan, and the IHS Strategic Plan driven by organizational mission and goals that relate to improving access to services and improving health related outcomes. These elements form the structure of the IHS Director's annual performance contract.

The Director's Performance Contract is cascaded to the Agency's senior executive leadership contracts and their staff. Therefore, the cascade of objectives reaches every organizational level and individual staff by holding them accountable for performing the work linked to the objectives. The accountability leads back to the IHS Director who must account for the accomplishment of the Agency's work at the end of the fiscal year through an organizational performance self-assessment that is submitted to HHS for review and a rating assignment.

Equally significant, Tribally managed health programs have also demonstrated a strong commitment to performance management. Although not required by law, Tribally managed health programs now voluntarily submit performance data on health care for 85 percent of the population served. These programs have been highly successful in ensuring access to critical services that will contribute to improved health outcomes in the future. Similarly, all Urban Indian health programs have committed to providing comparable health care performance data beginning in fiscal year 2007. Indeed, the performance culture is expanding in the Indian health system.

4 *The development and implementation of innovative models of health care delivery must be expanded.*

The IHS has been a recognized leader in innovations of health care delivery since its inception. Many of these innovations have been driven by the realities of extreme unmet health needs, limited resources, and an enhanced understanding of the pathways that lead to undesirable health outcomes. Recognizing that adverse childhood experiences are highly correlated with adult chronic diseases, it is imperative that behavioral health services be more fully integrated into primary care settings. This integrated model of care is more likely to reach the most vulnerable children and families who suffer from a disproportionate burden of life stresses.

The IHS Director's Behavioral Health and Chronic Disease Initiatives support the further integration of behavioral health services in acute and chronic disease primary care settings. Improving access to these services will help address underlying post traumatic stress, substance abuse, anxiety, and depression that may prevent adequately addressing chronic conditions. Integrating culturally suitable behavioral health services in acute care may reduce suicidal and criminal behavior.

Recent advances in telemedicine have led to several examples of innovative care provided in remote sites which take advantage of partnerships within the Indian health system and with centers of excellence in the private sector and universities. The IHS will continue to support the development of health information technology and telemedicine projects to improve the quality and cost of medical imaging services, mental health care, diabetic vision screening, and consultation with specialists not available in many of our health care settings.

Advances in open access scheduling, disease management, and integration of support services are examples of innovation that lead to improved quality and productivity. Further innovations in the efficient and effective delivery of health care services will be sought and supported as strategic goals. Working with leading consultants, the IHS will monitor evolving technologies and health care models, internally and externally, and adapt and apply those that demonstrate a good prospect of improving the lives of AI/AN people.

Response: The 2006-2011 IHS Strategic Plan

The IHS Strategic Planning Workgroup believes that these four insights represent major challenges to the realization of the IHS Mission and Goal but also provide a unique opportunity to reformulate the approaches to be followed in moving forward. In this light, the 2006-2011 plan is designed to offer culturally relevant, innovative, and successful responses to these critical planning assumptions and is organized around three strategic goals:

1. **Build and Sustain Healthy Communities**

2. **Provide Accessible, Quality Health Care**

3. **Foster Collaboration and Innovation across the Indian Health Network**

Each strategic goal is composed of several specific objectives that include the **Purpose and Outcome** and a list of **Strategies** for achieving each objective. Achieving significant progress towards these goals will require a concerted effort by the Indian health system, the Indian health network, and effective resource advocacy. Introducing each goal is a vision statement presenting the outcome of implementing these strategies. Progress will be evaluated through the achievement of established Agency Performance Measures (Appendix C).

The Strategic Planning Workgroup intends that this plan will help guide the Indian Health Service in the realization of its Mission and Goal as the Indian health network continues to embrace change, innovation, and advocacy in health care in the 21st century while honoring the history and traditions of AI/AN people.
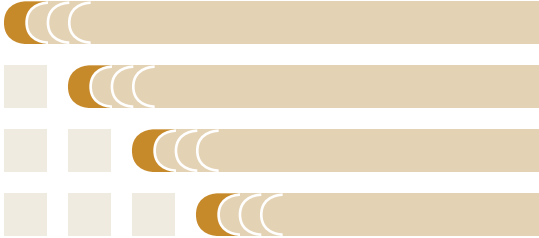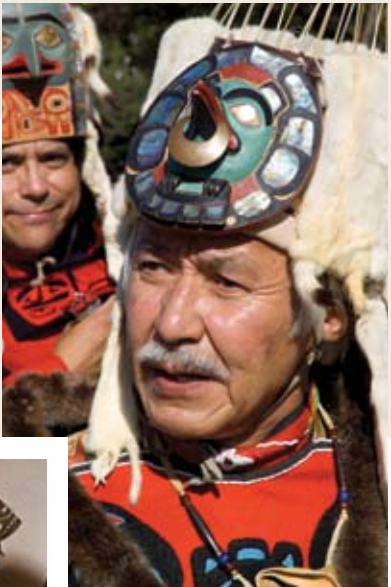

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Build and Sustain Healthy Communities

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OUTCOME VISION

By 2011, AI/AN Communities will experience improved health status and well-being through adopting healthy lifestyles as a result of:

- *a functional community-based public health infrastructure to monitor and address public health issues such as injury prevention, suicide surveillance, environmental surveillance, or other local priorities;*

- *accompanied by a sustained and active wellness program with improved access to appropriate community and behavioral health information; and*

- *an organized emergency preparedness management program.*

Objective 1.1
Mobilize and involve AI/AN communities to promote wellness and healing.

Objective 1.2
Develop public health infrastructure with Tribes to sustain and support AI/AN communities.

Objective 1.3
Assist Tribes and AI/AN communities in identifying and resolving community problems by improving access to appropriate information.

Objective 1.4
Strengthen emergency management in AI/AN communities.

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Objective 1.1

Mobilize and involve AI/AN communities to promote wellness and healing.

PURPOSE AND OUTCOME

Health is profoundly influenced by behaviors and environmental conditions occurring at the community level. Despite continued technological advances in medical science, the most powerful determinants of health and well-being remain how and what is consumed; care for bodies in terms of exercise, sleep, and personal hygiene; exposure to disease and injury; social determinants such as employment and income; exposure to hazards in the environment; and the nature of relationships with others. Thus access to state-of-the-art clinic-based health services alone is often inadequate in improving life expectancy, infant mortality, or the prevalence of chronic disease without the support of a public health system that targets other community-based venues to promote healthy behaviors, prevent disease and injury, and create a healthy environment for all.

For example, the steady decline of cardiovascular deaths that has occurred in the U.S. since 1970 has been attributed to the synergy of a number of changes, including: increased public awareness of the importance of diet, exercise, and healthy cholesterol levels; awareness of signs and symptoms of heart disease; improved emergency medical services; advances in hospital-based cardiac care; and decreases in tobacco use and air pollution.

For these reasons, the IHS has embraced the concept of community-oriented primary care (COPC model) as an essential part of improving community health. This approach is based on a proactive, collaborative approach between the local health care system and the community that includes four critical processes:

1.   Defining and characterizing the community.

2.   Identifying community health problems.

3.   Developing emphasis areas by planning/modifying the health program.

4.   Monitoring the effectiveness of the program modifications.

Experience in AI/AN communities has shown that the COPC model is an effective approach to treating and preventing the major health problems confronting those communities, including diabetes, heart disease, obesity, unintentional injuries, and behavioral health issues such as alcoholism, substance abuse and suicide. As an early innovator using the COPC model, the IHS staff can continue to play a central role by mobilizing individuals and empowering communities to promote wellness and healing as an essential part of this effort. Success in this endeavor requires broad community-based partnerships among Tribal Governments, schools, law enforcement, the Women Infants and Children Nutrition Program (WIC), Head Start programs, sanitation programs, the IHS, and others. It also requires a sufficient public health infrastructure, adequate data collection and distribution, and technical assistance that are addressed in Objectives 1.2 and 1.3 which follow.

The expected interim outcome is improved community involvement in health planning, health promotion, and health delivery. Long-term outcomes include increased rates of healthy behaviors, improved health status within communities, decreased rates of chronic disease, and improved life expectancy.

STRATEGIES

The IHS and the Tribal Epidemiology Centers will supply comprehensive technical expertise and leadership to AI/AN communities, Tribes and organizations through its experienced community based workforce.
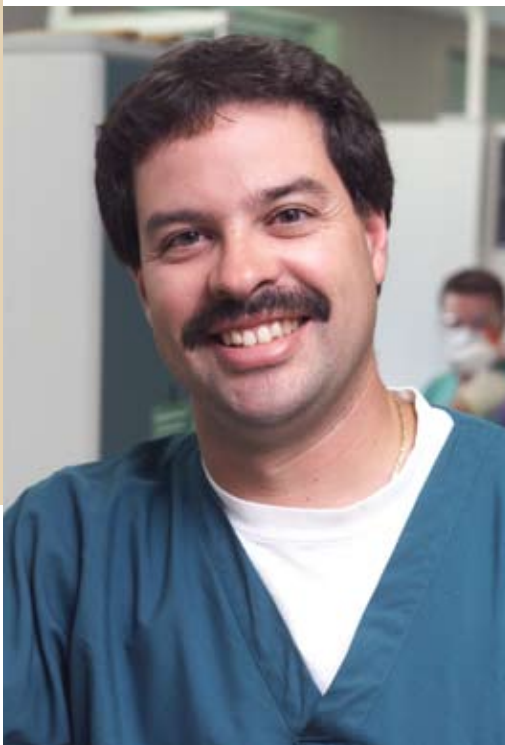
Community Health Initiatives

The IHS can supply technical expertise and support for community health initiatives that otherwise are not available in many AI/AN communities. The IHS will:

1. At the Headquarters, Area and Service Unit levels, assist in community-based assessment and health promotion initiatives; performance standards are written to include community involvement as an element of employees' performance appraisals.

2. Provide ongoing support for the Head Start initiative. This initiative ensures appropriate training for this program at local levels. Head Start programs offer some of the best opportunities for the early prevention of childhood obesity and substance abuse and the establishment of healthy lifestyles.

3. Continue to promote model programs, such as comprehensive injury prevention programs, and demonstration wellness projects.

4. Extend best practice guidelines for community health initiatives via the Web and other media.

5. Secure adequate evidence to support continuation of special initiative funding for prevention of diabetes, unintentional injuries, suicide, and other health conditions throughout the Indian health system.

6. Provide training and technical assistance through the Healthy Native Communities Fellowship in order to enhance capacity building at the local level for wellness.

Wellness and Healing in AI/AN Communities

There are many programs that target health promotion and disease prevention across various settings in the Indian health system. The success of these programs depends on respectful collaboration with AI/AN communities.

From its inception, the IHS has recognized the value of traditional beliefs, ceremonies, and practices to wellness and healing among AI/AN people. Traditional beliefs are honored as a healing and harmonizing force within individual lives and AI/AN communities. The IHS will:

1. Develop health and wellness initiatives by collaborating with community leaders and traditional healers.

2. Respect and integrate local traditional beliefs and customs with contemporary health care practices.

3. Provide ongoing support to grant initiatives related to diabetes, substance abuse, mental health, suicide prevention, unintentional injuries and other priorities.

4. Provide opportunities for local AI/AN community participation in performance planning at IHS operated facilities.

5. Disseminate the methodology of successful community-based interventions in a timely manner.

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Objective 1.2

Develop public health infrastructure with Tribes to sustain and support AI/AN communities.

PURPOSE AND OUTCOME

The health of a community is dependent on the public health infrastructure. The IHS has a long history of providing certain public health services such as public health nursing, the Community Health Representative (CHR) program, environmental health and sanitation services, injury prevention, infectious disease outbreaks survey and containment and others. In addition, IHS is closely engaged with many other State, Federal, and Tribal programs, from WIC to nursing home care. This complex network of programs and services comprises the "public health infrastructure" and supports the core public health functions of assessment, policy development, and assurance.

The IHS will continue to partner with Tribes to ensure that the public health infrastructure is adequate to accomplish the ten essential functions of public health.

The Ten Essential Services of Public Health

1. Monitor health status to identify community health problems.

2. Diagnose and investigate health problems and health hazards in the community.

3. Inform, educate, and empower people about health issues.

4. Mobilize community partnerships and coalitions to identify and solve health issues.

5. Develop policies and plans that support individual and community health efforts.

6. Enforce laws and regulations that protect health and ensure safety.

7. Link people to needed personal health services and assure the provision of health care.

8. Assure a competent public health and personal health care workforce.

9. Evaluate effectiveness, accessibility, and quality of personal and public health services.

10. Research for new insights and innovative solutions to health problems.

Depending on circumstances prevailing in each AI/AN community, IHS' public health role may be primary or secondary to Tribes and other partners.

The expected interim outcome is increased local participation in public health functions through implementation of the COPC or similar model. The expected long-term outcome is more comprehensive public health capabilities that are attuned to local circumstances and needs of individual communities.

STRATEGIES

The IHS, as a public health agency, is responsible for helping ensure that an adequate public health infrastructure exists for Tribes and in AI/AN communities. This implies the Agency must strike a balance between use of resources for individual health care and investment in public health functions to benefit the AI/AN community collectively.

Assess the Public Health Infrastructure

The IHS and Tribes will jointly assess capabilities and gaps in public health functions of AI/AN communities. Tools to measure baseline and progress are essential for this assessment of public health infrastructure. In collaboration with the Tribal Epidemiology Centers (TECs), the IHS will:

1. Assist the local health delivery sites in education, selection, and use of appropriate instruments to assess their public health infrastructure.

2. Provide technical assistance and training so that AI/AN communities successfully utilize these instruments to document and monitor their overall health status.

3. Integrate appropriate public health software with clinical data systems.

4. Assist Tribes in identifying critical environmental and injury risk factors and in using the information to plan for system improvements.

5. Expand partnerships with other Federal agencies such as Agency for Healthcare Research and Quality (AHRQ), Health Resources and Services Administration (HRSA) and National Center for Research Resources for maximum benefit to AI/AN communities.

Reduce gaps in public health functions in AI/AN communities

The IHS works closely with Tribes, Tribal groups and organizations to assure that public health functions, as well as access to direct care, are available and accessible in AI/AN communities. The availability of safe drinking water and adequate waste disposal facilities are fundamental to health promotion and disease prevention. Assuring such sanitation facility capacity in all family living units remains the single most important intervention in breaking the chain of waterborne communicable disease episodes as well as enhancing the health promotion and disease prevention efforts of other public health specialists such as public health nurses, nutritionists, and community health representatives. From a purely practical point of view, no other public health capacity plays a more significant day to day role in improving the quality of life for AI/AN people than securing these most basic sanitation services.

Thus, efforts to expand the capacity to assure these services through innovations and the development of new partnerships and resource bases must remain a priority. The IHS will:

1.   Strengthen and enhance the effectiveness of the Sanitation Facilities Construction Program by implementing the Program's strategic plan elements including

strengthening relationships with funding partners,

building Tribal capacity to sustain operation and maintenance of provided sanitation facilities,

developing a project management oriented culture, and

improving technical and administrative data systems.

2.   Expand public health training and education for health care providers and community leaders to build a strong public health infrastructure.

3.   Create an AI/AN public health Web page linked to the IHS website to widely share best public health practices. This strategy will include a means to readily obtain approval of new content, to promptly publish it on the website, and to maintain ongoing content of the website.

4.   Assure that appropriate patient health information is accessible via the Internet.

5.   Target public health resources to communities with identified gaps in public health functions and to those that have locally developed plans to realistically address those gaps.

Advocacy for appropriate public health

Ongoing advocacy for public health is essential to communities. Recent events have led to an increased recognition of the critical role that adequate public health infrastructure plays in the health care arena. The ability to assure that community-based public health needs can be adequately met requires ongoing advocacy for appropriate public health infrastructures. The IHS will:

1.   Distribute community health tools such as public health codes and standards to AI/AN communities.

2.   Use public health accomplishments as advocacy leverage to expand funding for TECs.

Objective 1.3

Assist Tribes and AI/AN communities in identifying and resolving community problems by improving access to appropriate information.

PURPOSE AND OUTCOME

The COPC approach empowers community members to participate in developing and implementing strategies to address community health problems. The IHS supports the use of the COPC model and other similar approaches in these efforts.

The expected interim outcome is improved access to information, tools, and technical assistance for Tribes and AI/AN communities. The long-term outcome is enhanced community participation in identifying and resolving community level problems and needs resulting in improved community health outcomes.

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STRATEGIES

Adequate data are essential to identify public health gaps and needs in AI/AN communities. Information technology and improved technical expertise in epidemiology and statistical analysis are essential components of building healthy communities.

Sharing Data

One of the stated goals of a public health oriented clinical information system is improved public health. Successful use of this system requires appropriate training in the acquisition, evaluation, sharing, and use of data. The IHS will:

1.   Uphold the standards of the Health Insurance Portability and Accountability Act (HIPAA) and Privacy Act.

2.   Create data marts within the data warehouse with information useful for public health purposes; assist Tribes and AI/AN communities in appropriately using the data warehouses.

3.   Expand community epidemiological information through supporting development of appropriate data sharing agreements.

4.   Negotiate data sharing agreements with States and other repositories of health information as appropriate.

Identify Community Health Problems

Community health problems can be identified through a number of techniques; however, most of these are dependent upon an adequate information system that aggregates health data at both the individual and community levels. These are essential for identifying gaps in community public health capabilities. The IHS will:

1.   Develop community level statistical summaries that can be evaluated by the community.

2.   Implement a master patient index at the national level.

3.   Implement statistical indicators that signal outliers and unusual trends that may signal community public health problems.

Monitoring and utilization of data to improve public and population health

Data and evidence-based criteria must be broadly shared and utilized in an appropriate manner to improve health status. The integration of a performance measurement, evaluation, and feedback loop is critical to improving health of individuals as well as populations. Furthermore, evidence-based criteria must continue to be used to identify appropriate clinical indicators. The IHS will:

1.   Develop a common framework for community health indicators that can be aggregated to form regional and national indicators.

2.   Foster national AI/AN public health leadership capabilities in interested AI/AN organizations (e.g., the TECs and the National Indian Council on Aging (NICOA) Data Project).

3.   Assist AI/AN communities in identifying and seeking non-IHS sources of public health funding.

4.   Monitor statistical trends in health and identify effective interventions and programs.

Community participation in data access and evaluation

Many AI/AN communities are involved in ongoing research and environmental health priority-setting projects. Participation by the community is essential to set environmental health and other priorities

and to design intervention programs pertinent to local conditions. The IHS will:

1.   Provide adequate training and resources for evaluation and use of data.

2.   Invite, recruit, and train community members for Institutional Review Boards (IRB).

3.   Provide technical assistance to AI/AN communities, including those conducting environmental health assessments.

Tribal Epidemiology Centers and Native American Research Centers for Health

IHS-funded Tribal Epidemiology Centers (TECs) and National Institutes of Health (NIH)-funded Native American Research Centers for Health (NARCH) serve a unique role within the communities of the Indian health system. These centers are able to provide appropriate coordination, evaluation and recommendations for community-based health care problems. In addition, they are strategically located throughout the AI/AN communities and serve as a conduit for technical and financial support from the IHS, Centers for Disease Control and Prevention (CDC), NIH, as well as non-governmental funding agencies. The IHS will:

1.   Coordinate public health assessments in AI/AN communities through the TECs.

2.   Expand collaborative public health efforts with NARCH, CDC, NIH, Agency for Healthcare Research and Quality (AHRQ), and other government agencies to provide public health services to Tribes and AI/AN communities.

Objective 1.4

Strengthen emergency management in AI/AN communities.

PURPOSE AND OUTCOME

The complexities and dynamics of emergency management are increasing in all settings, especially within AI/AN communities. As the proximity of Tribal lands to human and industrial development increases, the hazards associated with this influence amplify. Recent events have also emphasized the need for AI/AN communities to be prepared for natural, manmade, and public health disasters such as those caused by extreme weather, terrorism, and pandemic influenza. To address these issues, the IHS has taken a path to increase its capability to provide emergency management in a comprehensive program that respects preparedness, response, recovery, and mitigation as cornerstones. With this strengthened architecture, the IHS and AI/AN communities are forging new partnerships between Federal, State, local, and Tribal Governments to increase capabilities and awareness.

The IHS has adopted the structure of the National Incident Management System (NIMS) as directed by the President in the Homeland Security Presidential Directive (HSPD) -5. Beginning in 2005, the IHS initiated a new program area that addresses the issues of Emergency Management and Emergency Medical Services. This program will establish the necessary technical and operational assistance to elevate and enhance the capabilities of the AI/AN responder communities. The expected outcome of the efforts is that communities are ready and able to respond to emergency situations that affect the well being of the entire community.

STRATEGIES

To assist AI/AN communities in strengthening emergency management, the IHS will:

1. Provide technical assistance, guidance, and training to Agency and Tribal jurisdictions to enhance local health and medical preparedness objectives.

2. Facilitate electronic and classroom learning environments to assist Tribes in adopting the NIMS.

3. Encourage family emergency preparedness through school campaigns and preparedness kits.

4. Conduct Agency emergency management planning to make health and medical assistance available to Agency and Tribal jurisdictions during emergencies and disasters.

5. Enhance IHS' emergency management system to improve emergency preparedness and response to natural disasters and acts of terrorism.

6. Manage and operate the Agency's capabilities at existing facilities and in community settings for responding to public health and medical related emergencies and disasters.

7. Conduct a public information program to provide emergency management health and medical information to Agency and Tribal jurisdictions.

8. Utilize and strengthen the "Tribal Annex" in the National Response Plan.
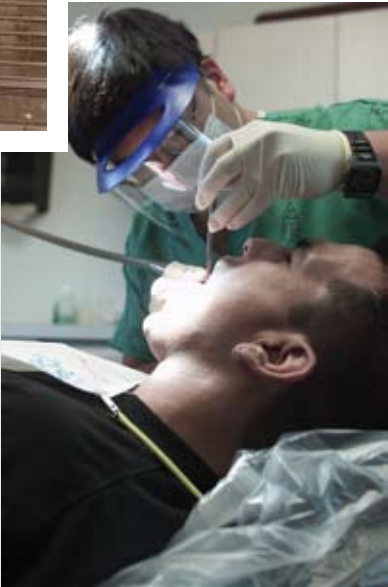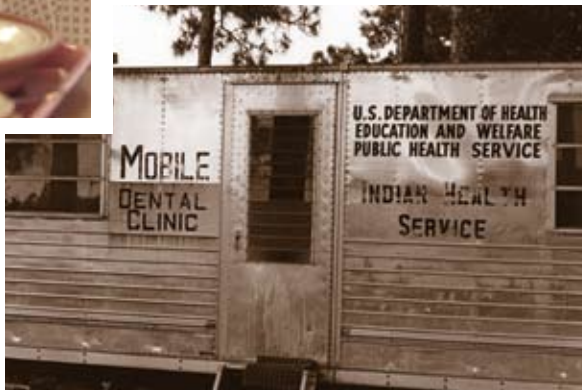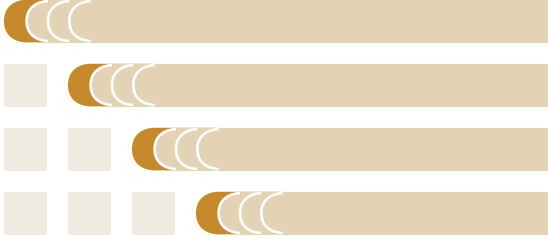
INDIAN HEALTH SERVICE
STRATEGIC GOAL 2

Provide Accessible, Quality Health Care

OUTCOME VISION

By 2011, the IHS service population will have experienced improved quality, acceptability, and access to health care through continuous consumer feedback and participation in health care planning and

improved efficiency in service delivery and maximizing of alternative resources

- *in facilities with sufficient physical capacity,*
- *staffed with an adequate supply of adequately trained and culturally competent providers to address the needs of the AI/AN people;*

improved clinical measures from quality clinical data obtained from the Electronic Health Record and other improved information systems;

resulting in reduced health disparities for American Indians and Alaska Natives.

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Objective 2.1
Provide accurate and timely clinical data on the health of American Indians and Alaska Natives.

Objective 2.2
Support the delivery of quality health care by maximizing alternative resources.

Objective 2.3
Expand and maintain an adequate workforce.

Objective 2.4
Provide comprehensive and effective primary health care services.

Objective 2.5
Improve the safety and quality of health care.

Objective 2.6
Provide quality health information for decision making to patients, providers, and communities through improved information systems.

Objective 2.1

Provide accurate and timely clinical data on the health of American Indians and Alaska Natives.

PURPOSE AND OUTCOME

Tribes, Alaska Native Corporations, and AI/AN organizations require accurate and timely clinical data to best serve the health needs of AI/AN people. Such information is also critical for Congress to make accurate assessments of the status of AI/AN health. The long term outcome will be better access to appropriate high quality services, improved health outcomes, and healthier communities.

STRATEGIES

The IHS should accurately assess health conditions, needs, and trends and provide these data to both the Tribes and Congress in the pursuit of common goals. All stakeholders need consistent and coordinated information based on the best available data that should be utilized in a culturally appropriate manner.

Performance Accountability Data and Health Needs

High quality, verifiable, and pertinent health data on the AI/AN population is necessary to formulate, implement, and evaluate programs and policies (also see Objective 2.6). The IHS will:

1. Develop local, regional and national data capacity and performance management infrastructure to effectively manage programs and meet accountability requirements.

2. Collect, assemble, and store aggregate data from participating members of the Indian health system.

3. Provide appropriate community-specific data for advocacy concerning specific local health needs in adherence to aggregate data access constraints.

Participation by Tribal Leaders

Tribal leaders play an active leadership role in advocating for improvements in Indian health care and in participating in the local planning, implementation, and management of Indian health programs. The IHS will:

1. Facilitate Tribal participation in performance planning and reporting.

2. Develop innovative coalitions and partnerships between Tribes and organizations (such as Friends of Indian Health) that focus on effective advocacy.

Establish Working Relations with State and Local Governments, and Private Organizations as well as Congress

Partnerships and coalitions are critical to effective advocacy. These are directly addressed under Strategic Goal 3.

Objective 2.2

Support the delivery of quality health care by maximizing alternative resources.

PURPOSE AND OUTCOME

The IHS supports the delivery of health care in the most efficient and effective ways available to these programs. This can be achieved through an emphasis on the following endeavors in close collaboration with Tribes:

- *improving operational efficiencies,*

- *improving third party collections,*

- *securing additional funding for the construction and staffing of new health care facilities,*

- *securing additional funding for expansion and modernization of existing facilities and improved staffing levels,*

- *demonstrating effectiveness and accountability in the use of all resources.*

The short term outcome will be maximized resource generation through improved business efficiencies and planning. The long-term outcome will be increased and adequate access to health care services resulting in improved health status.

STRATEGIES

Improve Revenues

Indian health system funding coupled with collections has traditionally been at the 60 percent level of need per capita compared to the general population. (Figure 6) In order to improve health status and access to medical care, other funding sources must be identified.

New initiatives must include building health care financing partnerships with outside organizations so the Indian health system can access additional resources. It is also imperative to understand the future direction of health care and health care financing to maximize opportunities and minimize threats to Indian health care. The IHS will:

1.   Continually update the IHS Business Plan to maximize revenues.

2.   Modernize the third party billing and accounts receivable package based on Medicare and Medicaid payment changes and claims processing requirements.

3.   Facilitate cooperative efforts with the States and local facilities to maximize third party benefits coordination.

4.   Improve third party business processes in the Indian health system.

Limit Costs

The IHS continues to recognize the need to improve efficiencies in the health care delivery arena. This is an inherent component of improving efficiency and maximizing the use of all available alternate resources. The IHS will:

1.   Expand negotiated rates for Contract Health Services (CHS) with all possible vendors.

2.   Explore opportunities to regionalize or consolidate common activities, such as financial, personnel, acquisition and property management services.

3.   Facilitate communication of successful business practices that result in cost savings. These may include drug and supply purchasing, standardization of equipment and systems, and partnering with private and governmental sector entities for cost savings.

4.   Facilitate cost accounting and improved cost reporting through the Unified Financial Management System (UFMS).

5.   Provide access to improved systems for strategic financial planning and feasibility analysis at all sites with Tribal input.

Figure 6: **2005 IHS Expenditures Per Capita Compared to Other Federal Health Expenditure Benchmarks**
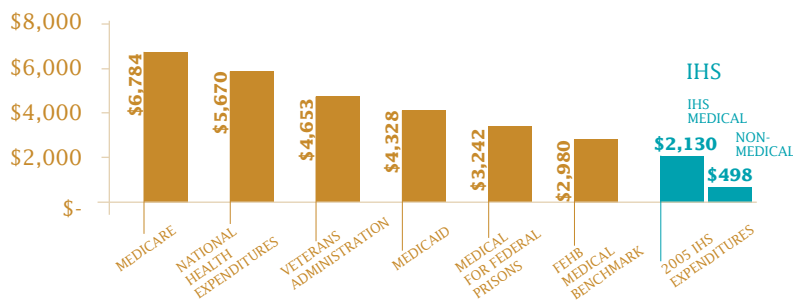
Funding From Other Organizations to Support AI/AN Health

In addition to its legislatively appropriated funds, the IHS relies on partnerships with its sister agencies in HHS to support health care programs and special initiatives that help improve the health status of AI/AN people. These agencies include:

1. Centers for Medicare and Medicaid Services (CMS)

2. National Institutes of Health (NIH)

3. Centers for Disease Control and Prevention (CDC)

4. Agency for Healthcare Research Quality (ARHQ)

5. Health Resources and Services Administration (HRSA)

6. Substance Abuse and Mental Health Services Administration (SAMHSA)

HHS also partners with other Federal Departments in support of AI/AN health programs and initiatives. They include the Departments of Veterans Affairs, Defense, Education, Agriculture, Transportation, Housing and Urban Development, Justice, and the Interior.

Additionally, State governments, private foundations, and corporations act as partners and are potential sources of needed funding. To encourage continued support from other organizations, the IHS will:

1. Assist the Tribal and Urban Indian health programs in applying for Federal grants.

2. Develop relationships with other non-Federal grant organizations.

3. Engage in partnerships with other Federal programs and outside organizations to provide staffing, training, current information, and evaluation resources to the Indian health system.

4. Eliminate existing barriers for accepting gifts and donations intended for Indian health care services, equipment, construction, and staffing.

5. Develop mechanisms to integrate services received through Tribal grants with the IHS.

6. Seek additional grant funding for the Director's Health Initiatives and special projects, e.g., elder health, women's health, child and adolescent health, HIV/AIDS prevention and treatment, and injury prevention. This will include expanding the capacity of Area Offices and IHS Service Units to pursue grants.

7. Explore development of an Indian Health Foundation.

Health Care Facilities

A critical component of the Indian health system is the health care facility itself. The ability to affect health status in any community involves increased access to quality health care. Increased access is dependent on having a modern health care facility that is properly sized for staff and equipment and located in close proximity to the communities where the AI/AN people reside. Alternative sources of funding are needed for facility planning, design, and construction. The IHS will:

1.   Continue implementation of the HHS Real Property Asset Management Program.

2.   Pursue authorities to allow acceptance of gifts and donations for construction.

3.   Seek increased Federal funding for the construction and renovation of health care facilities and replacement of outdated medical equipment.

4.   Collaborate with the Indian health network to seek alternative funding for new construction and equipment and staff requirements. Alternative methods may include increases in the Joint Venture Program, the Small Ambulatory Program, and other innovative cooperative endeavors such as mobile units and telehealth with funding from grant organizations.

5.   Pursue innovative planning and design techniques that improve health care delivery efficiencies through improved design and construction acquisition technologies.

6.   Apply lessons learned from Post Occupancy Evaluation Reports to improve facility planning, design and upgrades.

7.   Seek public and private grants, cooperative funding, and sharing of specialty health facilities and services through the Indian health network.

8.   Continue collaborative and sharing agreements with the Department of Veterans Affairs to enhance the health of AI/AN veterans.

Objective 2.3

Expand and maintain an adequate workforce.

PURPOSE AND OUTCOME

The Indian health system requires a quality, experienced workforce with the capacity to serve the health needs of AI/AN people.

The expected short and long-term outcome will be the hiring and retaining of qualified, culturally competent employees, developing the skills of current staff, and matching sources of technical expertise to need within the Indian health system.

STRATEGIES

The need for organizational capacity and expertise is evident at all levels of the Indian health system.

Staff Recruitment, Retention, and Development

Continuous education is necessary to apply new benefits of medical science, public health and information technology. It is also required to proactively seize opportunities to improve the health of AI/AN people.

Assuring an adequate workforce will be the result of hiring and retaining competent, well trained staff as well as developing staff within the Indian health system through orientation, job experience, mentoring, and short and long term training opportunities. The IHS will:

1.   Continue the marketing of career opportunities in the public health professions to AI/AN youth including internship programs such as Washington Internship for Native Students (WINS) and American Indian Science and Engineering Society (AISES).

2.   Assess the current and future workforce and technical expertise needs of the Indian health system and seek additional training resources from the broadest possible arena.

3.   Continue support for the development of executive healthcare leaders.

4.   Establish guidelines for continuing education of health professionals at the local level. Support for continuing education courses to maintain professional excellence and cultural competency by licensed independent practitioners is a high priority and must be consistently funded by local units.

5.   Place a high priority on retaining, developing, and nurturing health professionals to provide high quality service over extended time periods to provide continuity of care and trusting relationship necessary to implement the Director's Health Initiatives in chronic disease and behavioral health.

6.   Develop the professional skills of employees through use of programs such as the Environmental Health Support Center and Injury Prevention Specialist Fellowship.

7.   Expand on the job training assignments at Area Offices and Headquarters in critical competency areas such as contracting, personnel, and management.

8.   Ensure an ongoing process to identify and implement the best practices related to staff retention.

9.   Assess the current workplace for unsafe working and environmental conditions that place employees at risk for harm or injury.

10. Continue to explore options to provide adequate staffing for all facilities.

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Increasing Technical Capacity

Many sources of training and technical assistance are required to address the gap that exists between current and future capabilities and needs. Potential resources to meet these needs have been neither fully identified nor utilized thus far. The IHS will:

1. Identify and pursue training, technical assistance and collaboration from agencies with a focus on Healthy People 2010 and racial and ethnic health disparities. For example, CDC, HHS Office of Minority Health, SAMHSA, and NIH are implementing actions to address health disparities through demonstration projects. The IHS appointee to the HHS Office of Intergovernmental Affairs is a resource who can also assist in identifying and building such relationships.

2. Expand contracts with Tribal colleges and university affiliated health professional schools for continuing education partnerships. Schools of medicine, dentistry, nursing, public health, pharmacy, and sanitation and construction engineering will be considered. Affiliations with medical and dental residencies in specialties needed by the system will be continued and expanded where appropriate to meet recruitment needs.

3. Facilitate the development of educational programs that can be shared via the Internet and/or satellite to remote service delivery sites. This strategy will be done in conjunction with other Federal agencies (e.g., CDC, VA).

4. Provide technical assistance and training in advocacy to Tribes and Tribal groups, in conjunction with the Friends of Indian Health and other organizations advocating on behalf of AI/AN populations and healthcare programs.

5. Develop an Internet-based resource list of people and organizations that have proven capacity in consulting, training, and technical assistance for specific Indian health needs.

6. Establish mentoring programs using current, retired, former, Federal, Tribal, or Urban program staff.
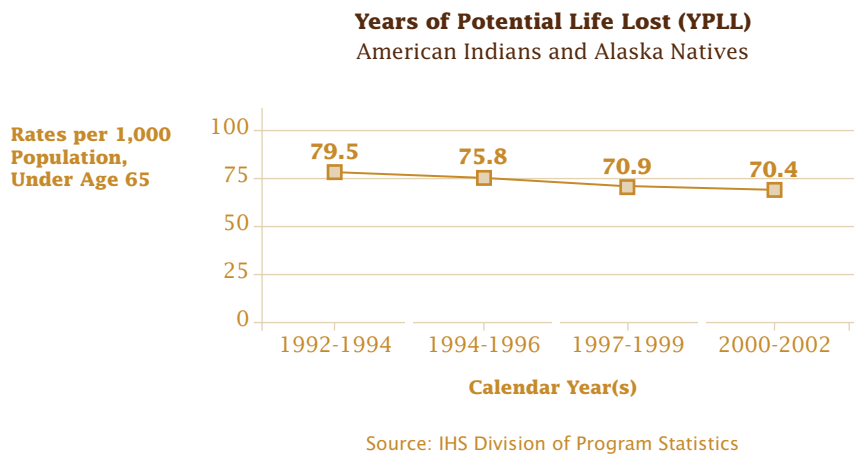
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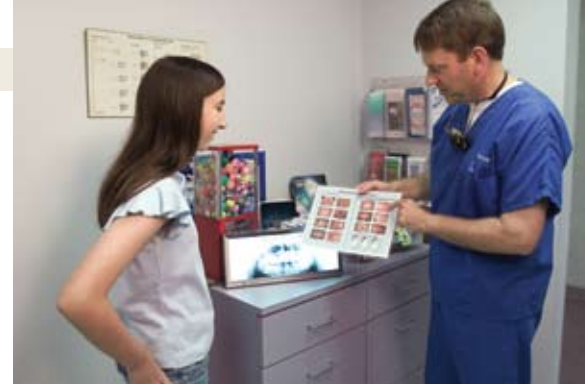
Objective 2.4

Provide comprehensive and effective primary health care services.

PURPOSE AND OUTCOME

The provision of comprehensive and effective primary health care services, including individual and community health services, is critical to the realization of the IHS Goal.

The expected long-term outcomes of this objective, in addition to improved consumer satisfaction, are improved life expectancy, decreased chronic disease morbidity, and a reduction in disparity in health status of AI/AN people as compared to the general U.S. population over the next ten years. (Figure 7)

Years of Potential Life Lost (YPLL)
American Indians and Alaska Natives

Rates per 1,000 Population, Under Age 65

Calendar Year(s)	YPLL
1992-1994	79.5
1994-1996	75.8
1997-1999	70.9
2000-2002	70.4

Source: IHS Division of Program Statistics

Figure 7

STRATEGIES

The Indian health system targets health conditions that disproportionately affect AI/AN communities. The co-location of services such as dental, pharmacy, and public health nursing improves cross-discipline coordination and is more convenient and effective for patients. The Indian health system will further integrate mental health, substance abuse, disease prevention, health promotion, and social services with primary care. Integrated services in primary care are more cost effective and successful in addressing the conditions and diseases that disproportionately affect AI/AN population such as alcohol abuse, obesity, diabetes, heart disease, substance dependencies, and depression. Since chronic disease is commonly based on unhealthy behaviors and adverse childhood experiences, the IHS will be able to address issues earlier and more broadly using this integrated model. The Indian health system has been a leader in providing integrated services and strives to continuously improve this model of success.

To address the disparity in access to quality health care, the Indian health system will continue efforts to provide consistent medical care in familiar clinical and community settings for AI/AN and their families. Evidence from the primary care literature supports that a regular source of high quality, community based, and culturally appropriate care can reduce disparities in access and health outcomes.

Expand access to comprehensive, effective primary health care services

Expanding access to comprehensive, effective primary health services in AI/AN communities is essential to achieving health parity with the general U.S. population. Sufficient resources, facilities, and equipment together with a culturally competent, highly skilled workforce are fundamental to achieving parity. Targeted innovative telemedicine projects in remote and rural areas, such as the IHS-Joslin Vision Network and the Mobile Women's Health Clinic in the Aberdeen Area, are particularly effective. The expansion of telemedicine is a practical solution to increasing access to quality health care in isolated settings. The strategies listed below complement the funding and staffing strategies addressed earlier in Strategic Goal 2. The IHS will:

1.   Assist Indian health system facilities in their ongoing development and integration of evidence-based clinical services, including telemedicine approaches, into the health care delivery system.

2.   Evaluate cost-effectiveness, accessibility, acceptability, and quality of rendered personal and public health care and report findings and performance improvement plans to consumers.

3.   Redesign primary care clinics so that quality services are delivered to patients in a convenient, timely, and efficient manner.

4.   Support the hiring and retention of appropriate nursing staff to improve access and quality care.

5.   Support the integration of pharmacy and behavioral health services into the primary care setting.

6.   Seek national resources to assist IHS Service Units and Tribes to expand primary care services.

Community Directed Research into AI/AN Health Issues

The NIH is making significant investments in research into the causes, prevention, diagnosis, and treatment of a variety of diseases that are prevalent in AI/AN communities. Tribal participation in the NIH Strong Heart Study, Pathways, NARCH, and Diabetes Prevention programs has provided valuable information on the effectiveness of these interventions in AI/AN communities.

NIH research grants available through universities and non-profit organizations must be tapped to identify cost-effective interventions for the diseases devastating AI/AN communities. These grants support the development of the infrastructure for disease interventions in these communities. The IHS will:

1.   Petition Federal research grant-making agencies for Tribal participation in research grants.

2.   Educate these agencies on the need to develop grants that respond to the health needs of AI/AN communities, promote intervention infrastructure that is sustainable within the communities at the end of the research project, and provide AI/AN students and professionals with research training opportunities.

3.   Provide technical assistance to Tribes in applying for research grants through the Tribal Epidemiology Centers (TECs) and/or Area Offices, and potentially serve a coordinating role in the research project.

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Objective 2.5

Improve the safety and quality of health care.

PURPOSE AND OUTCOME

This strategic objective requires enhanced development and deployment of clinical and technical interventions that have been proven to improve quality of health care and the safety of patients.

The expected outcome will be increased patient safety, patient knowledge, and quality of health care as measured by consumer satisfaction indicators as well as other evidence-based criteria such as adverse event rates, facility accreditation, and health outcomes.

STRATEGIES

Quality of care is a broad goal that encompasses improving health status for individuals, communities, and populations while decreasing disease burden. The identification and reduction of adverse events in the healthcare system and the integration of evidence-based practice into clinical, public health and administrative practices are also important factors as is the appropriate and timely adoption of new medical technologies. In addition, cost effectiveness analysis and technological assessment should be integrated into medical decision making at the individual, community, and population level.

Integration of Best Practices into the Provision of Care

Tools for accumulating and disseminating best practices are critical to the improvement of healthcare decision-making and patient outcomes. The Indian health system must work to develop access to appropriate clinical, public health and cultural tools that can be used within AI/AN communities. Integrating appropriate clinical and public health best practices within the Indian health system will result in improved quality and safety for patients as well as communities. The IHS will:

1.   Support initiatives that will ensure integration and access to culturally appropriate clinical and public health practice management.

2.   Ensure ongoing and current access to best practices through Internet-based interfaces, media, and other venues accessible to staff.

3.   Coordinate the development, dissemination, and integration of best practice guidelines into the health care delivery system through the Indian health network.

4.   Integrate population and public health guidelines into individual patient care delivery systems.

5.   Ensure customer satisfaction with available services through the use of surveys, focus groups, and other appropriate assessment tools.

6.   Seek the expertise and collaborate with organizations that are pre-eminent in the arena of healthcare quality and safety.

Assure culturally competent care

While many patient care providers are from local communities, there are many providers who have little, if any, exposure to cross-cultural issues before working in the Indian health system. The provision of compassionate care requires an awareness of cultural issues. The IHS will:

1.   Facilitate the evaluation and compilation of current approaches to educating providers about cultural competency.

2.   Collaborate with HRSA and other Federal organizations to ensure access to other appropriate resources that can be used to achieve cultural competency.

3.   Assure that an emphasis on cultural competence is incorporated into all employee leadership training sessions.

4.   Integrate basic cultural competency training during orientation of new health care providers and provide continuous refresher training for current staff.

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Implementation of quality systems in health care

Once best practices are developed, recognized, and disseminated, there must be a continued emphasis on integration and evaluation of their impact. This cycle will use a quality improvement approach to facilitate ongoing implementation and improvement. The IHS will:

1. Enhance and deploy the IHS Electronic Health Record (EHR).

2. Develop and support an appropriate adverse event-tracking system in conjunction with other programs within the HHS. This system will provide ongoing confidential collection, evaluation, analysis, and recommendations for decreasing adverse events. Eventually, this system will be integrated into the Resource and Patient Management System (RPMS).

3. Ensure the deployment of computerized provider order entry (CPOE) systems at point of care.

4. Develop and support an automated medication administration process utilizing barcodes in order to enhance patient safety and patient care.

Quality clinical indicators

In order to improve health status, the Indian health system must make comparisons both within the system and the larger healthcare community. The adoption of comparable health outcome indicators that are used by others will help in this endeavor. For instance, comparison with some Health Plan Employer Data and Information Set (HEDIS) indicators may enable IHS to highlight excellence and identify problem areas. In addition, there are many facilities within the Indian health system that are models for excellence in delivery of care. These models should be recognized and shared when appropriate.

The IHS must ensure the development of an overarching framework for performance indicator selection and the implementation of a feedback mechanism to improve health outcomes. The IHS will:

1. Develop appropriate clinical performance indicators that include public health priorities identified locally, regionally and nationally.

2. Ensure ongoing interagency collaborations with other groups, including the AHRQ and the Ambulatory Care Quality Alliance (ACQA) that are working on clinical indicators. This work will result in the integration of the IHS indicator set to reflect national clinical priorities.

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Ensure Consumer Access to Health Information

Many consumers receive care in remote sites under difficult conditions with few information technology (IT) resources. These conditions aggravate the ability of the Indian health system to assure access to consumer information. Increased consumer access to health information is essential to the goal of improved health status. The IHS will:

1.   Establish appropriate Internet-based patient health information.

2.   Make patient education documentation easier and more integrated into the delivery of care system using clinical IT solutions.

3.   Increase access to IT solutions in collaboration with the Indian health network.

Ensure Provider Access to Healthcare Knowledge and Expertise

The continued growth of health information makes it increasingly difficult to maintain current clinical knowledge. It is critical that the IHS foster access to healthcare knowledge and expertise, including traditional health practices, throughout the Indian health system. Health care can be improved by better access to culturally relevant health information at the point of care. The IHS will:

1.   Ensure wide area network (WAN) access to appropriate Internet-based healthcare knowledge resources for use by healthcare providers who are on the WAN.

2.   Ensure that healthcare IT solutions include access to appropriate healthcare knowledge resources at the point of care.

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Objective 2.6

Provide quality health information for decision making to patients, providers, and communities through improved information systems.

PURPOSE AND OUTCOME

The availability and ongoing development of a comprehensive information technology (IT) system is necessary to meet the needs of providers and consumers. This system is designed to facilitate and improve the provision of care at all levels.

The expected outcome will be that the Indian health network will have improved access to integrated health, administrative, and financial data to support individual patient care and public health decision-making, and advocacy.

STRATEGIES

The IHS can benefit from nearly 40 years of work in aggregating clinical information via computers. The RPMS, the current IHS clinical information system launched in 1968, has been continually enhanced through the integration of financial, administrative, and clinical data. This ongoing IT work is consistent with this strategic objective.

Further improvements in the IT system are dependent upon technology that requires an underlying infrastructure based upon a solid IT architecture. This improved infrastructure is a core part of improved quality health information.

However, as previously stated in objective 1.3, the need for data within the Indian health system will only continue to increase. Data quality (i.e., accuracy, reliability, and validity) and quality patient care will continue to play a highly visible role both within and outside the IHS. Data quality is only partially dependent upon technology. Improved data quality also reflects other sustained improvement initiatives, including accuracy of data entry, legibility of handwriting, appropriate and timely data exports, and accuracy of coding.

Ongoing support for IT solutions will lead to the development of a more integrated system that will address the current and projected data needs, including clinical as well as administrative and fiscal.

The IT solutions must be able to support the following:

Medical decision making;

Improved AI/AN health outcomes and quality of patient care;

Population and public health initiatives;

Epidemiology activities to identify short- and long-term threats to the health of AI/AN communities;

Analyses to improve the cost effectiveness of services provided;

Data to support performance budget formulation;

Data collection, aggregation and evaluation for the quality and outcome indicators needed for facility accreditation, advocacy efforts, and accountability requirements;

Data to support programs seeking grants from other funding sources;

Data for AI/AN community-directed research.

Enhance the capacity of the telecommunications network

The IHS telecommunications infrastructure connects the Indian health system facilities to each other and the national data repository. Ongoing systematic enhancements are essential to modernize these telecommunication networks so that end users understand and maximally utilize the data. The IHS will:

1.   Participate fully in the HHS Department-wide modernization efforts.

2.   Participate in the HHS United Financial Management System (UFMS) initiative (see UFMS strategies below).

3.   Leverage external partnerships to develop and implement solutions that meet the growing IT requirement.

Ensure the security of information and information systems

The IHS must provide adequate risk-based protection for information and information systems, particularly to ensure the security of patient health information. The IHS will:

1.   Ensure that IT systems used by the Indian health system are certified and accredited and fully compliant with Federal Information Security Management Act (FISMA) and HIPAA requirements.

2.   Employ a defense-in-depth approach to select and implement reinforcing protection measures.

3.   Continuously review and test protection measures to ensure proper operation individually and collectively.

4.   Ensure the protection of sensitive and critical information and information systems by all involved parties.

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Ensure patient privacy

Policy and procedures need to be developed to ensure that the privacy of individuals is protected, while allowing transfer of information that is critical for individual as well as public health. The IHS will:

1. Ensure that our IT solutions are HIPAA and Privacy Act compliant.

2. Ensure information security and privacy efforts are mutually supportive and integrated.

Utilize data to improve health care delivery

One of the stated goals of a clinical information system is improved patient care and outcomes. This objective requires appropriate training in the acquisition, evaluation, and use of data within the clinical setting. The IHS will:

1. Ensure access to adequate resources for data evaluation, appropriate use, and privacy.

Facilitate the sharing of information

Changes are needed to support the integration of clinical, administrative, fiscal, and infrastructure information from the Indian health system. This information is used to help improve the health of AI/AN people.

Indeed, one of the most significant improvements any information technology architecture can make is to achieve interoperability between disparate systems. The IHS is positioned to take advantage of technology developments in both government and commercial sectors to achieve a standard for sharing data. The IHS will:

1. Provide leadership, coordination, and training in the development and support of RPMS for Indian health system use.

2. Provide input into the Federal and clinical IT standards community.

3. Continue to develop and support ongoing data sharing relationships with Tribal Epidemiology Centers and State, Federal, and private organizations (e.g., State vital record departments and cancer registries, the National Center for Health Statistics, CDC immunization registries, and CMS).

4. Continue development of Internet-based patient-centric applications (ORYX) quality measurement initiative and the Clinical Reporting System (CRS). The agency also will continue development of Internet-based aggregated individual and population health and service data. This assures analysis of business and health data, including national information reporting.

5. Establish standard hardware and softward desk top configuration (e.g., spreadsheets, word processing, and email applications).

Implementation and Support for the Unified Financial Management System

The Unified Financial Management System (UFMS) is being implemented within HHS to integrate the Department's financial management structure. The UFMS is scheduled to be implemented in October 2007 throughout the IHS. It is anticipated that the UFMS will expand access to timely, reliable, and consistent financial information, enabling IHS managers to make more timely and informed decisions regarding their operations. While the UFMS will not have the capability for absolute cost accounting, it will generate improved financial data for decision making and improve the capability for producing cost reports.

Currently the Agency prepares a total of 59 cost reports for Federal and Tribal facilities using the Method E cost reports for Medicare cost reports. The current methodology allows for Medicare and Medicaid all-inclusive rate negotiations for both Federal and Tribal facilities. The IHS will continue to refine the Method E cost reports using UFMS and the IHS clinical reporting system, RPMS. The IHS will:

1. Develop and integrate cost accounting solutions into our clinical IT package that will interface with finance, accounts receivable, billing, data entry, coding, health record, and patient registration, and will be compatible with PCC Plus, Envoy, Transworld, and Medicare/Medicaid electronic posting platforms.
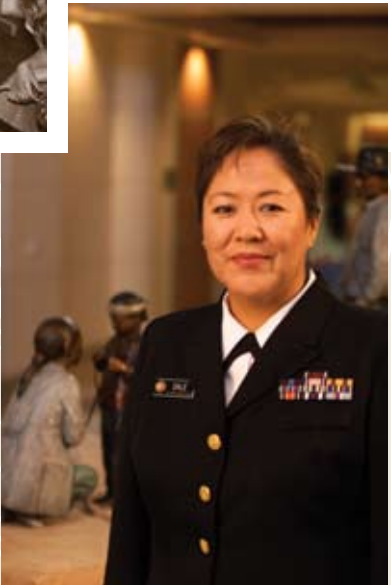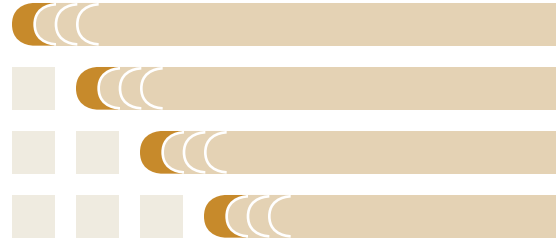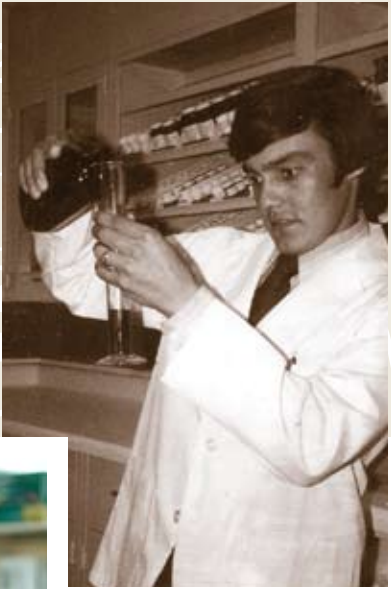
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Foster Collaboration and Innovation across the Indian Health Network
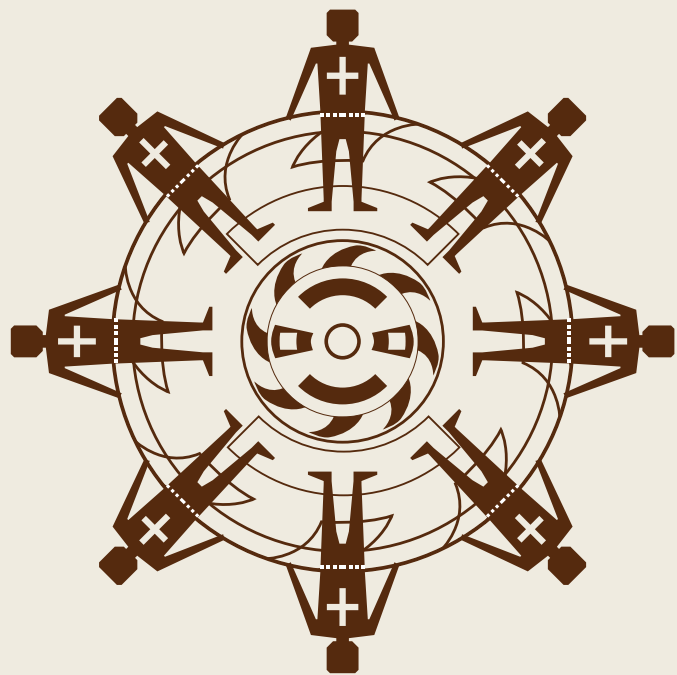
OUTCOME VISION

By 2011, the Indian health network will have emerged as a well coordinated and increasingly synergistic coalition that is significantly contributing to the realization of the IHS Mission and Goal through:

- *the coordinated sharing of information, pooling of resources, and development of new organizational structures;*

- *the development, evaluation, and diffusion of effective health care innovations; and*

- *successful Indian health advocacy culminating with the reauthorization and funding of the Indian Health Care Improvement Act.*

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Objective 3.1
Expand coalitions and partnerships to build a dynamic Indian health network.

Objective 3.2
Develop new structures within the Indian health network to increase collaboration and innovation to improve and advocate for the health care of the AI/AN population.

Objective 3.1

Expand coalitions and partnerships to build a dynamic Indian health network.

PURPOSE AND OUTCOME

Internal as well as external collaborative efforts are required to establish an environment where opportunities for partnering and collaboration are continually sought and supported.

The short term outcome is to expand the network of organizations working together to improve the health of AI/AN people. The long-term outcome is a comprehensive umbrella of organizations working collaboratively to effectively contribute to and advocate for the health of AI/AN people, and the realization of the IHS Mission, Goal, and Foundation.

STRATEGIES

The IHS recognizes that current and potential partners, as well as adequate resources, are critical to carrying out this Strategic Plan. This is evidenced by well-established, successful partnerships such as the collaboration between the IHS and the Department of Veterans Affairs, NIH, CDC, SAMSHA, and other Federal agencies.

Support for Coalitions and Partnerships

To foster the continued development of collaboration and partnerships in improving the health of AI/AN people, the IHS will:

1. Assure the development of partnership-coalition development plans at multiple levels, including national, State, private sector, Area, and local levels.

2. Describe and demonstrate the importance of partnerships and coalitions to encourage appropriate consideration of such relationships in program planning and development.

3. Include objectives in annual management performance reviews that will demonstrate the creation or enhancement of partnerships and coalitions.

4. Establish ways to assure that partnerships and coalitions are properly acknowledged and supported among IHS staff, e.g., the creation of an annual award for partnerships and coalitions.

5. Actively promote constructive partnerships between Tribes and Urban Indian organizations.

6. Encourage and recognize partnership and coalition building.

7. Establish a formal feedback infrastructure to assure that input and feedback to key stakeholders and partners are accomplished in a consistent, accessible, and timely manner, e.g., through a list serve and representation on the Indian Health Leadership Council.

8. Through the Indian health system, form workgroups to actively pursue potentially useful partnerships and coalitions and communicate those linkages to the rest of the network.

9. In addition to the formal Tribal Consultation Policy, implement a communications plan and strategy to assist Tribes in better understanding IHS programs, to encourage full participation and to engage Tribes in partnership and coalition building. The IHS will continue to work with existing Tribal organizations (e.g., the National Indian Health Board, National Indian Education Association, and the National Congress of American Indians) to share information with Tribes via their existing communication channels, such as newsletters, websites, e-mails, and meetings.

10. Strengthen partnership with the Office of Minority Health (OMH) and collaborate in the implementation of their Strategic Plan for Communication and Coordination with American Indians and Alaska Natives to Eliminate Health Disparities towards achieving the following goals:

· *Increase communication and outreach with Tribal communities that will increase access to HHS resources through OMH and increase Tribal knowledge about the function and activities of OMH. In turn, OMH will increase the Department's awareness of AI/AN issues through interagency collaboration.*

· *Increase and foster partnerships between the OMH and other entities to eliminate health disparities in Tribal communities, while developing opportunities that will increase access for Tribes to the OMH.*

· *Develop opportunities, initiatives and programs that will increase access for Tribes to OMH's services.*

Objective 3.2

Develop new structures within the Indian health network to increase collaboration and innovation to improve and advocate for the health care of the AI/AN population.

PURPOSE AND OUTCOME

Structures and strategies are needed that support innovation and collaboration across the Indian health network. These efforts target the realization of both innovations and improvements in the health care delivery system and effective advocacy for the health care needs of the AI/AN population. Fundamental to accomplishing both of these outcomes is improving the communication matrix that is critical to sustaining the Indian health network. More specifically, improvements in communication should help overcome inhibitions in both collaboration and innovation across the Indian health network.

The long-term outcome of Strategic Goal 3 is directed at the most recognized legislative advocacy benchmark, the reauthorization of the Indian Health Care Improvement Act. This law, originally passed in 1976 and since twice amended, represented health care reform legislation aimed at improving the health and well-being of AI/AN people. It represented the pinnacle of decades of Indian health advocacy efforts and the reauthorization of this expired statute could represent a milestone of similar proportion.

STRATEGIES

The IHS must define and implement an organizational culture where new and better methods to achieve the IHS Mission and Goal are continually sought, discovered, and disseminated. Creative innovations with significant impact must be encouraged, supported, and rewarded within the Indian health care system.

Clearly the diversity of programs within the Indian health system alone makes communication and coordination a challenge; however, expanding and improving these processes to include the larger Indian health network will be increasingly important. An essential first step in this process is completing an inventory of current innovations and partnerships and developing an ongoing process for keeping this inventory updated. The increasing use of new information technologies in AI/AN health care shows great promise.

From the perspective of advocacy communications, the Friends of Indian Health can serve an expanded role for linking with their component health related organizations concerned about Indian health issues. These organizations can serve as powerful allies in partnership with Tribes in advocating for Congressional support for the reauthorization of the Indian Health Care Improvement Act and Indian health funding related legislation.

Indeed, the diversity of the Indian health network provides a tremendous opportunity for pooling resources and developing innovative and creative solutions to Indian health problems. For example, due to the nature of their limited federal funding, the Urban Indian programs have relied upon building collaborations and partnerships with many local and State agencies to support their efforts in filling gaps in health care delivery. Therefore, these programs can serve as models of innovative and creative solutions through collaborative partnerships.

Supporting creativity and innovations across the network must be balanced with the performance management and accountability requirements, as well as ongoing internal and external evaluations to support program improvement. The IHS will develop approaches that balance these needs and take advantage of expanded evaluation efforts.

Innovation may best be supported across the network by the emergence of new organizational structures and partnerships. Promising examples of these include practice based networks with other health care entities, expanded collaborative applied research projects through mechanisms such as NARCH, TECs, other Federal agencies, and component/association members of the Friends of Indian Health. Furthermore, as noted earlier in this plan, innovative efforts to integrate primary health care services more seamlessly with behavioral health must be aggressively pursued and encouraged.

The IHS and Indian health leadership have recognized the need for long-term strategizing of AI/AN health care in the midst of growing challenges. Indian Centers of Excellence could provide the structure and process for ongoing discussion and analyses of challenges and issues anticipated in Indian health care. These centers could also serve as a bridge between proven culturally based research and analytical activities and their practical application to the delivery of health care. It is also likely that such an organizational structure could serve as a valuable catalyst for the expansion of the Indian health network. The IHS will:

1.   Expand the existing awards process to recognize innovative programs and processes, including creative employee solutions, and effective partnerships and project teams throughout the Indian health system.

2.   Develop a plan to consistently and systematically evaluate programs, systems, and processes that meet both external accountability requirements and internal management needs in an efficient manner. Such an evaluation process should be broader in focus than the Government Performance and Results Act (GPRA) and Program Assessment Rating tool (PART) processes and positively support the concept of a culture of accountability in the Indian health system.

3.   Build on its current successes (i.e., Tribal Consultation Policy, Self-Governance and Direct Federal meetings, report dashboards, etc.) to develop communication models to targeted groups by:

Expanding Internet-based information systems.

Developing standardized communication evaluation protocols for the various components of the Indian health network (e.g., the IHS Tribal Consultation Policy).

Augmenting the use of technology and other communication channels with consistent interaction of key personnel at the Headquarters, Area, and local Tribal and Urban health care delivery program levels.

Supporting the development of Area level communication policies that ensure adequate provider communication between Indian health system sites.

4.   Expand the coordinating role of the Friends of Indian Health in working with Tribes, health professional organizations, and other stakeholders in responding to Congressional committees and other critical advocacy efforts.

5.   In conjunction with a Center of Excellence, develop a database of ongoing Indian health related partnerships and coalitions and successful innovative applications that will be evaluated and disseminated within the Indian health network by a coordinating committee.

Appendices

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APPENDIX A: Strategic Plan 2006-11 Update Team

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Director's Health Promotion/Disease Prevention Initiative

Issue/Background

The main health challenges currently faced by American Indian and Alaska Native people are the increasing health conditions and chronic diseases that are related to lifestyles issues such as obesity, physical inactivity, poor diet, substance abuse, and injuries. To help meet these challenges, the Indian Health Service (IHS) has launched a Health Promotion and Disease Prevention (HP/DP) Initiative to develop a coordinated and systematic approach to enhance preventive health approaches at the local, regional, and national levels. This Initiative is aligned with the President's HealthierUS, HHS Steps to a HealthierUS, and Healthy People 2010.

Strategies/Goal

The goal of the HP/DP Initiative is to create healthier American Indian and Alaska Native communities by developing, coordinating, implementing, and disseminating effective health promotion and chronic disease prevention programs through collaboration with key stakeholders and by building on individual, family, and community strengths and assets. To this end, the IHS has:

1.   Established a HP/DP Policy Advisory Committee to provide oversight and policy guidance to the agency; and

2.   Established a Prevention Task Force to develop a strategic plan to enhance and improve disease prevention and health promotion efforts by identifying diseases with the greatest disparities and developing a framework to address these diseases.

In addition, the IHS is continuing its ongoing efforts to:

1.   Establish HP/DP coordinators in the 12 IHS Areas to support IHS, Tribal, and Urban programs in developing, implementing, and evaluating health promotion and chronic disease prevention efforts;

2.   Create and expand Federal, corporate, foundation, and academic partners to support healthier behaviors;

3.   Promote and expand community and clinical health promotion and chronic disease prevention best practices;

4.   Build the capacity for effective health promotion practices at the local level by increasing the knowledge, skills, and capacities of Tribal, IHS, and Urban program health workers and leaders;

5.   Promote and adopt environmental, school, and worksite polices that support healthier behaviors;

6.   Develop a clearinghouse of best practices, resources, training, and community assessment tools to enhance community access;

7.   Develop communication materials to raise awareness to specific health concerns; and

8.   Conduct continuous process, impact, and outcome evaluations that are aligned with GPRA and Healthy People 2010 objectives.

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Director's Chronic Disease Management Initiative

Issue/Background

Chronic conditions such as diabetes, cardiovascular disease, asthma, renal disease, depression, and cancer have become increasingly prevalent in American Indian and Alaska Native communities and are placing growing demands on health care systems. Given the limited available resources, there is an urgent need for a strategic plan to address the treatment and prevention of chronic conditions in the Indian Health Service (IHS) health care system.

Strategies/Goal

The goal of this initiative is to develop a process for the IHS to effectively and efficiently address chronic conditions. A strategic plan will be developed using a model for chronic illness care created from the experience of the IHS Division of Diabetes Treatment and Prevention, the Chronic Care Model, the WHO Innovative Care for Chronic Conditions Framework, and the Institute of Healthcare Improvement. These models and experience suggest that our approach to chronic conditions can be improved by creating a health care system that is practical, supportive, population-based, and evidence-based. The system should promote an interactive relationship between informed, motivated patients and a health care team that is prepared and proactive. The Chronic Care Model has been successfully applied to a variety of chronic illnesses, health care settings, and target populations.

To accomplish this goal, the agency will focus on these strategic areas:

1. Create a positive policy environment by establishing funding sources, a project management team, and a multi-disciplinary team from within and outside of IHS to develop expertise in specific areas of chronic disease prevention and care.

2. Create an executive committee and designate an executive leader responsible for moving the process forward.

3. Create multi-disciplinary workgroups to focus on aspects of implementing this chronic disease initiative such as communication, information technology, measurement, training, and pilot programs.

4. Describe current activities and enhance future activities around chronic illness care using the six elements from the Chronic Care Model. These elements are:

The community
The health system
Self-management support
Delivery system design
Decision support
Clinical information systems

5. Leverage resources and raise awareness about chronic conditions by establishing community partnerships and working with advocacy groups, non-profit organizations, and other federal agencies.

6. Focus on patient and family by developing and testing culturally appropriate and known effective education materials for people at risk of chronic conditions and those with existing chronic conditions.

7. Conduct continuous evaluation by tracking and reporting agreed upon measures.

Director's Behavioral Health Initiative

Issue/Background

For many American Indian and Alaska Native (AI/AN) communities, there is a lack of understanding of the role of behavioral health in health promotion and disease prevention. Many chronic health conditions are linked to life-long behavior patterns, and therefore can be prevented by a change in lifestyle. By focusing on effective behavioral health techniques and integrating Tribal traditions and customs, we can bring proven behavioral health strategies and specific health promotion and disease prevention programs to AI/AN communities. The Indian Health Service (IHS) Behavioral Health teams, i.e., the national program, Area programs, and Tribal/Urban programs, should provide the leadership in such change for the agency and the Department of Health and Human Services. The IHS Behavioral Health programs include community-oriented clinical and preventive services whose activities are part of a broader, multidisciplinary health team, including IHS and Tribal clinics and hospitals. Over the last 15 years, most of those programs have transitioned from IHS to local community control via Tribal contracting and compacting, so Tribes are managing their own behavioral health programs. Regardless of management, however; substance abuse, trauma, forced cultural change, poverty, lack of economic opportunity, and isolation significantly complicate the health process for American Indians and Alaska Natives, and overall health disparities are significant.

Strategies/Goal

Currently, local behavioral health programs are primarily crisis-oriented treatment centers. Promoting the behavioral health of individuals, families, and communities on an ongoing basis, as opposed to only working from crisis to crisis, will require a system-wide effort to change approaches, seek new and sustainable resources, and maximize current program effectiveness. Use of multiple funding sources, collaborations, technology, data-driven program models, and clinically sound behavioral approaches must be integrated with the traditions and healing practices of the community to maximize health and wellbeing. It is an undertaking that will take years, but one that holds the promise of significant benefits for communities across the country.

To address this situation, the agency will focus on four strategic areas:

1.   Mobilize Tribes and Tribal programs to promote behavioral health in systematic, evidence-based approaches that embrace traditions and culture as critical foundations for that health;

2.   Support and promote programmatic collaborations within communities, as well as with state and federal programs and agencies;

3.   Promote leadership development from the community to national level, with training and mentorship; and

4.   Provide advocacy for behavioral health programs in Indian communities among federal, state, Tribal, local, and private organizations.

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IHS Performance Measure 2006	IHS Program Performance Measure, 2006	IHS Strategic Plan 2006-2011
1. Diabetes: Poor Glycemic Control: Proportion of patients with diagnosed diabetes with poor glycemic control (A1c > 9.5). [outcome]		Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
2. Diabetes: Ideal Glycemic Control: Proportion of patients with diagnosed diabetes with ideal glycemic control (A1c < 7.0). [outcome]	HCFC-1, Annual Outcome: Percent increase in the proportion of diagnosed diabetics demonstrating ideal blood sugar control at each new facility TOHP-3, Long Term, Outcome: Percentage of AI/AN patients with diagnosed diabetes served by tribal health programs that achieve ideal blood sugar control. HCFC-10, Long Term Outcome: Percent increase in the proportion of diagnosed diabetics demonstrating ideal blood sugar control within 7 years of opening new facility. *PAR:* *2. Diabetes: Ideal Glycemic Control: Proportion of patients with diagnosed diabetes with ideal glycemic control (A1c < 7.0). [outcome]*	Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
3. Diabetes: Blood Pressure Control: Proportion of patients with diagnosed diabetes that have achieved blood pressure control (<130/80). [outcome]		Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
4. Diabetes: Dyslipidemia Assessment: Proportion of patients with diagnosed diabetes assessed for dyslipidemia (LDL cholesterol). [outcome]		Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
5. Diabetes: Nephropathy Assessment: Proportion of patients with diagnosed diabetes assessed for nephropathy. [outcome]		Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services

HHS Strategic Plan 2004-2009	HHS 20 Department-Wide Objectives, 2006	HHS Secretary's 500 Day Plan 2005
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices Goal 5: Improve the quality of health care services	1. Transform the health care system, e) Reduce disparities in ethnic and racial health outcomes.	Transform the health care system
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices Goal 5: Improve the quality of health care services	1. Transform the health care system, e) Reduce disparities in ethnic and racial health outcomes.	Transform the health care system
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IHS Performance Measure 2006	IHS Program Performance Measure, 2006	IHS Strategic Plan 2006-2011
6. Diabetic Retinopathy: Proportion of patients with diagnosed diabetes who receive an annual retinal examination. [outcome]		Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
7. Cancer Screening: Pap Smear Rates: Proportion of eligible women who have had a Pap screen within the previous three years. [outcome]	HCFC-2, Annual, Outcome: Percent increase in Pap screening, facility-level denominator	Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
8. Cancer Screening: Mammogram Rates: Proportion of eligible women who have had mammography screening within the previous two years. [outcome]	HCFC-3, Annual, Outcome: Percent increase in mammography screening; facility-level denominator	Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
9. Cancer Screening: Colorectal Rates: Proportion of eligible patients who have had appropriate colorectal cancer screening. [outcome]		Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
10. YRTC Improvement/Accreditation: Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more). [output effective 05]		Goal 2: Provide Accessible Quality Health Care; Objective 2.5) Improve the safety and quality of health care
11. Alcohol Screening (FAS Prevention): Alcohol use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients. [outcome]	HCFC-4, Annual, Outcome: Percent increase in alcohol screening for female patients of childbearing age; facility-level denominator	Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services

HHS Strategic Plan 2004-2009	HHS 20 Department-Wide Objectives, 2006	HHS Secretary's 500 Day Plan 2005
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices Goal 5: Improve the quality of health care services	1. Transform the health care system, e) Reduce disparities in ethnic and racial health outcomes.	Transform the health care system
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices Goal 5: Improve the quality of health care services	1. Transform the health care system, e) Reduce disparities in ethnic and racial health outcomes.	Transform the health care system
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices Goal 5: Improve the quality of health care services	1. Transform the health care system, e) Reduce disparities in ethnic and racial health outcomes.	Transform the health care system
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices Goal 5: Improve the quality of health care services	1. Transform the health care system, e) Reduce disparities in ethnic and racial health outcomes.	Transform the health care system
Goal 5: Improve the quality of health care services Goal 1: Reduce the major threats to the health and well-being of Americans; 1.4 Reduce substance abuse	1. Transform the health care system, e) Reduce disparities in ethnic and racial health outcomes. 19. Emphasize healthy Living and Prevention of Disease, Illness, and Disability, c) Reduce the incidence and consequences of injuries, violence, substance abuse, mental health problems, unintended pregnancies and sexually transmitted diseases.	Transform the health care system
Goal 1: Reduce the major threats to the health and well-being of Americans Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices Goal 5: Improve the quality of health care services	1. Transform the health care system, e) Reduce disparities in ethnic and racial health outcomes. 19. Emphasize healthy Living and Prevention of Disease, Illness, and Disability, c) Reduce the incidence and consequences of injuries, violence, substance abuse, mental health problems, unintended pregnancies and sexually transmitted diseases.	Transform the health care system

IHS Performance Measure 2006	IHS Program Performance Measure, 2006	IHS Strategic Plan 2006-2011
12. Topical Fluorides: Proportion of patients receiving one or more fluoride treatments. [outcome]		Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
13. Dental Access: Percent of patients who receive dental services. [outcome]		Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
14. Dental Sealants: Number of sealants placed per year in AI/AN patients. [outcome]		Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
15. Diabetes: Dental Access: Proportion of patients diagnosed with diabetes who obtain access to dental services. (No longer a measure in 2006) [outcome]		
16. Domestic (Intimate Partner) Violence Screening: Proportion of women who are screened for domestic violence at health care facilities. [outcome]		Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
17. Data Quality Improvement: Number of GPRA clinical performance measures that can be reported by CRS software.		Goal 2: Provide Accessible Quality Health Care; Objective 2.1) Provide accurate and timely clinical data on the health of AI/ANs, 2.5) Improve the safety and quality of health care, 2.6) Provide quality health information for decision making to patients, providers, and communities through improved information systems

HHS Strategic Plan 2004-2009	HHS 20 Department-Wide Objectives, 2006	HHS Secretary's 500 Day Plan 2005
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices Goal 5: Improve the quality of health care services	1. Transform the health care system, e) Reduce disparities in ethnic and racial health outcomes.	Transform the health care system
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices Goal 5: Improve the quality of health care services	Transform the health care system, e) Reduce disparities in ethnic and racial health outcomes.	Transform the health care system
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices Goal 5: Improve the quality of health care services	1. Transform the health care system, e) Reduce disparities in ethnic and racial health outcomes.	Transform the health care system
Goal 1: Reduce the major threats to the health and well-being of Americans; 1.6 – Reduce the incidence and consequences of injuries and violence	9. Protect life, family and human dignity. 19. Emphasize healthy Living and Prevention of Disease, Illness, and Disability, c) Reduce the incidence and consequences of injuries, violence, substance abuse, mental health problems, unintended pregnancies and sexually transmitted diseases.	Protect life, family and human dignity
Goal 5: Improve the quality of health care services; 5.5-Accelerate the development and use of an electronic health information infrastructure	1. Transform the health care system, b) Accelerate the adoption and use of an electronic health information infrastructure in the U.S.	Transform the health care system

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IHS Performance Measure 2006	IHS Program Performance Measure, 2006	IHS Strategic Plan 2006-2011
18. Behavioral Health: Number of sites using the RPMS Behavioral Health (BH) software application. In 2006 changes to: Proportion of adults ages 18 and over who are screened for depression. [Changes to outcome in FY 2006]		Goal 1: Build and Sustain Healthy Communities; Objective 1.3) Assist AI/AN communities in identifying and resolving community problems by improving access to appropriate information Goal 2: Provide Accessible, Quality Health Care; Objective 2.1) Provide accurate and timely clinical data on the health of AI/ANs, 2.4) Provide comprehensive and effective primary health care services
19. Urban IS Improvement: Expand Urban Indian Health Program capacity for securing mutually compatible automated information system that captures health status and patient care data for the Indian health system. In 2006 changes to: Number of urban programs using automated patient record system and data warehouse.		Goal 1: Build and Sustain Healthy Communities; Objective 1.3) Assist AI/AN communities in identifying and resolving community problems by improving access to appropriate information Goal 2: Provide Accessible Quality Health Care; Objective 2.1) Provide accurate and timely clinical data on the health of AI/ANs, 2.5) Improve the safety and quality of health care, 2.6) Provide quality health information for decision making to patients, providers, and communities through improved information systems
20. Accreditation: Percent of hospitals and outpatient clinics accredited (excluding tribal and urban facilities).		Goal 2: Provide Accessible Quality Health Care; Objective 2.5) Improve the safety and quality of health care
21. Medication Error Improvement: Number of Areas with a medication error reporting system. [outcome] In 2006, changes to Medical Error Improvement: Number of areas with a medical error reporting system.		Goal 1: Build and Sustain Healthy Communities; Objective 1.3) Assist AI/AN communities in identifying and resolving community problems by improving access to appropriate information Goal 2: Provide Accessible Quality Health Care; Objective 2.1) Provide accurate and timely clinical data on the health of AI/ANs, 2.5) Improve the safety and quality of health care, 2.6) Provide quality health information for decision making to patients, providers, and communities through improved information systems

HHS Strategic Plan 2004-2009	HHS 20 Department-Wide Objectives, 2006	HHS Secretary's 500 Day Plan 2005
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices Goal 5: Improve the quality of health care services	19. Emphasize healthy Living and Prevention of Disease, Illness, and Disability, c) Reduce the incidence and consequences of injuries, violence, substance abuse, mental health problems, unintended pregnancies and sexually transmitted diseases.	
Goal 5: Improve the quality of health care services; 5.5-Accelerate the development and use of an electronic health information infrastructure	1. Transform the health care system, b) Accelerate the adoption and use of an electronic health information infrastructure in the U.S.	Transform the health care system
Goal 5: Improve the quality of health care services	1. Transform the health care system	Transform the health care system
Goal 1: Reduce the major threats to the health and well-being of Americans Goal 5: Improve quality of health care services; 5.3 – Reduce medical errors	1. Transform the Health Care System, a) Increase access to high quality effective health care that is predictably safe.	Transform the health care system

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IHS Performance Measure 2006	IHS Program Performance Measure, 2006	IHS Strategic Plan 2006-2011
23. Public Health Nursing: Number of public health nursing services (primary and secondary treatment and preventive services) provided by public health nursing.		Goal 2: Provide Accessible Quality Health Care; 2.4) Provide comprehensive and effective primary health care services, Objective 2.6) Provide quality health information for decision making to patients, providers, and communities through improved information systems
24. Childhood Immunizations: Immunization rates for AI/AN patients aged 19-35 months. [outcome]	HCFC-5, Annual, Outcome: Percent increase in coverage of childhood immunizations; facility-level denominator	Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
25. Adult Immunizations: Influenza: Influenza vaccination rates among adult patients age 65 years and older. [outcome]	HCFC-6, Annual, Outcome: Percent increase in coverage of flu vaccinations for adults; facility-level denominator	Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
26. Adult Immunizations: Pneumovax: Pneumococcal vaccination rates among adult patients age 65 years and older. [outcome]	HCFC-7, Annual, Outcome: Percent increase in coverage of pneumococcal vaccinations for adults; facility-level denominator	Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
27. Injury Intervention: Number of community-based injury prevention programs (Measure will reflect number of projects per area starting in FY 2007).		Goal 1: Build and Sustain Healthy Communities; Objective 1.2) Develop public health infrastructure with Tribes to sustain and support AI/AN communities Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
28. Unintentional Injury Rates: Unintentional injury mortality rate in AI/AN people. [outcome]	FAA-3, Annual, Outcome: Unintentional injury mortality rate in AI/AN population; denominator, federally administered sites	Goal 1: Build and Sustain Healthy Communities; Objective 1.2) Develop public health infrastructure with Tribes to sustain and support AI/AN communities Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services

HHS Strategic Plan 2004-2009	HHS 20 Department-Wide Objectives, 2006	HHS Secretary's 500 Day Plan 2005
Goal 1: Reduce the major threats to the health and well-being of Americans	1. Transform the Health Care System, a) Increase access to high quality effective health care that is predictably safe.	
Goal 1: Reduce the major threats to the health and well-being of Americans; 1.3 – Increase immunization rates among adults and children	19. Emphasize healthy living and prevention of disease, illness, and disability, b) Increase childhood and adult immunization rates.	
Goal 1: Reduce the major threats to the health and well-being of Americans; 1.3 – Increase immunization rates among adults and children	19. Emphasize healthy living and prevention of disease, illness, and disability, b) Increase childhood and adult immunization rates.	
Goal 1: Reduce the major threats to the health and well-being of Americans; 1.3 – Increase immunization rates among adults and children	19. Emphasize healthy living and prevention of disease, illness, and disability, b) Increase childhood and adult immunization rates.	
Goal 1: Reduce the major threats to the health and well-being of Americans; 1.6 – Reduce the incidence and consequences of injuries and violence	19. Emphasize healthy Living and Prevention of Disease, Illness, and Disability, c) Reduce the incidence and consequences of injuries, violence, substance abuse, mental health problems, unintended pregnancies and sexually transmitted diseases.	
Goal 1: Reduce the major threats to the health and well-being of Americans; 1.6 – Reduce the incidence and consequences of injuries and violence Goal 6: Improve the economic and social well-being of individuals, families, and communities, especially those most in need	19. Emphasize healthy Living and Prevention of Disease, Illness, and Disability, c) Reduce the incidence and consequences of injuries, violence, substance abuse, mental health problems, unintended pregnancies and sexually transmitted diseases.	

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IHS Performance Measure 2006	IHS Program Performance Measure, 2006	IHS Strategic Plan 2006-2011
29. Suicide Surveillance: Collection of comprehensive data on incidence of suicidal behavior. In 2006 changes to: Incidence of suicidal behavior [Changes to outcome in FY 2006]		Goal 1: Build and Sustain Healthy Communities; Objective 1.2) Develop public health infrastructure with Tribes to sustain and support AI/AN communities Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
30. CVD Prevention: Cholesterol: Proportion of patients ages 23 and older who receive blood cholesterol screening. In FY 2007 changes to CVD Prevention: Comprehensive Assessment: Proportion of at risk patients who have a comprehensive assessment for all CVD-related risk factors. [outcome]		Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
31. Obesity Assessment: Proportion of patients for whom BMI data can be measured. In 2006, changes to Childhood Weight Control: Proportion of children ages 2-5 years with a BMI of 95% or higher. [outcome]	FAA-1, Long Term/Annual: Children ages 2-5 years with a BMI of 95% or higher; denominator, federally administered sites	Goal 1: Build and Sustain Healthy Communities; Objective 1.2) Develop public health infrastructure with Tribes to sustain and support AI/AN communities Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
32. Tobacco Use Assessment: Proportion of patients ages 5 and above who are screened for tobacco use. In 2006, changes to Tobacco Cessation Intervention: Proportion of tobacco-using patients that receive tobacco cessation intervention. [outcome]	HCFC-8, Annual, Outcome: Percent increase in screening for tobacco usage; facility-level denominator	Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
33. HIV Screening: Proportion of pregnant women screened for HIV. [outcome]		Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services

HHS Strategic Plan 2004-2009	HHS 20 Department-Wide Objectives, 2006	HHS Secretary's 500 Day Plan 2005
Goal 1: Reduce the major threats to the health and well-being of Americans; 1.6 – Reduce the incidence and consequences of injuries and violence Goal 6: Improve the economic and social well-being of individuals, families, and communities, especially those most in need	19. Emphasize healthy Living and Prevention of Disease, Illness, and Disability, c) Reduce the incidence and consequences of injuries, violence, substance abuse, mental health problems, unintended pregnancies and sexually transmitted diseases.	
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices Goal 5: Improve the quality of health care services	1. Transform the Health Care System, e) Reduce disparities in ethnic and racial health outcomes. 19. Emphasize healthy Living and Prevention of Disease, Illness, and Disability, a) Reduce unhealthy behaviors and other factors that contribute to the development of chronic diseases.	Transform the health care system
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices	19. Emphasize healthy Living and Prevention of Disease, Illness, and Disability, a) Reduce unhealthy behaviors and other factors that contribute to the development of chronic diseases.	
Goal 1: Reduce the major threats to the health and well-being of Americans; 1.5 – Reduce tobacco use, especially among youth	19. Emphasize healthy Living and Prevention of Disease, Illness, and Disability, a) Reduce unhealthy behaviors and other factors that contribute to the development of chronic diseases.	
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices Goal 5: Improve the quality of health care services	1. Transform the Health Care System 19. Emphasize healthy Living and Prevention of Disease, Illness, and Disability, c) Reduce the incidence and consequences of injuries, violence, substance abuse, mental health problems, unintended pregnancies and sexually transmitted diseases.	Transform the health care system

IHS Performance Measure 2006	IHS Program Performance Measure, 2006	IHS Strategic Plan 2006-2011
34. Environmental Surveillance: Number of tribal programs with automated web-based environmental health surveillance data collection system (WebEHRS).		Goal 1: Build and Sustain Healthy Communities; Objective 1.3) Assist AI/AN communities in identifying and resolving community problems by improving access to appropriate information Goal 2: Provide Accessible Quality Health Care; Objective 2.6) Provide quality health information for decision making to patients, providers, and communities through improved information systems
35. Sanitation Improvement: Number of new or like-new AI/AN homes and existing homes provided with sanitation facilitie	SFC-1, Annual, Outcome: Number of new or like-new AI/AN homes and existing homes provided with sanitation facilities.	Goal 1: Build and Sustain Healthy Communities; Objective 1.2) Develop public health infrastructure with Tribes to sustain and support AI/AN communities
35A. Sanitation Improvement A. Percentage of existing homes served by the program at Deficiency Level 4 or above as defined by 25 USC 1632.	SFC-2, Annual, Outcome: Percentage of existing homes served by SFC Program at deficiency level 4 or above as defined by 25 USC 1632	Goal 1: Build and Sustain Healthy Communities; Objective 1.2) Develop public health infrastructure with Tribes to sustain and support AI/AN communities
36. Health Care Facility Construction: Number of Health Care Facilities Construction projects completed.		Goal 1: Build and Sustain Healthy Communities; Objective 1.2) Develop public health infrastructure with Tribes to sustain and support AI/AN communities
39. Public Health Infrastructure: Assure appropriate administrative and public health infrastructure is in place. (No longer a measure in 2006)		
42. Scholarships: Proportion of Health Profession Scholarship recipients placed in Indian health settings within 90 days of graduation.		Goal 2: Provide Accessible Quality Health Care; Objective 2.3) Expand and maintain an adequate workforc

HHS Strategic Plan 2004-2009	HHS 20 Department-Wide Objectives, 2006	HHS Secretary's 500 Day Plan 2005
Goal 1: Reduce the major threats to the health and well-being of Americans		
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices; 3.6 – Increase access to health services for AI/ANs		
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices; 3.6 – Increase access to health services for AI/ANs		
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices; 3.6 – Increase access to health services for AI/ANs	1. Transform the Health Care System, a) Increase access to high quality effective health care that is predictably safe.	Transform the health care system
Goal 5: Improve the quality of health care services	1. Transform the Health Care System, a) Increase access to high quality effective health care that is predictably safe.	Transform the health care system

IHS Performance Measure 2006	IHS Program Performance Measure, 2006	IHS Strategic Plan 2006-2011
	TOHP-E, Annual, Efficiency: Hospital admissions per 100,000 diabetics per year for long-term complications of diabetes; denominator TOHP facilities FAA-E, Annual, Efficiency: Hospital admissions per 100,000 diabetics per year for long-term complications of diabetes; denominator Federally Administered Facilities	Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
	TOHP-2, Annual, Outcome: Number of designated annual clinical performance goals met	Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services
	TOHP-1, Annual, Output: Percentage of TOHPs' clinical user population included in GPRA data	
	UIHP, Annual, Efficiency: Cost per service user in dollars per year	Goal 2: Provide Accessible Quality Health Care; Objective 2.5) Improve the safety and quality of health care
	HCFC-E, Annual, Efficiency: Percent of scheduled construction projects completed on time	Goal 1: Build and Sustain Healthy Communities; Objective 1.2) Develop public health infrastructure with Tribes to sustain and support AI/AN communities
	HCFC-9, Long Term, Outcome: Percent reduction of YPLL rate within 7 years of opening a new facility; denominator facility specific FAA-2, Long Term, Outcome: YPLL in AI/AN population; denominator federally administered sites TOHP-4, Long Term, Outcome: YPLL in the AI/AN population served by tribal health programs; denominator tribal sites	Goal 2: Provide Accessible, Quality Health Care; Objective 2.4) Provide comprehensive and effective primary health care services

HHS Strategic Plan 2004-2009	HHS 20 Department-Wide Objectives, 2006	HHS Secretary's 500 Day Plan 2005
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices Goal 5: Improve the quality of health care services	1. Transform the health care system, e) Reduce disparities in ethnic and racial health outcomes.	Transform the health care system
Goal 1: Reduce the major threats to the health and well-being of Americans		
Goal 1: Reduce the major threats to the health and well-being of Americans		
Goal 5: Improve the quality of health care services		
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices; 3.6 – Increase access to health services for AI/ANs	1. Transform the Health Care System, a) Increase access to high quality effective health care that is predictably safe.	
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices; 3.6 – Increase access to health services for AI/AN	1. Transform the health care system, e) Reduce disparities in ethnic and racial health outcomes.	Transform the health care system
HHS Strategic Plan 2004-2009	HHS 20 Department-Wide Objectives, 2006	HHS Secretary's 500 Day Plan 2005

IHS Performance Measure 2006	IHS Program Performance Measure, 2006	IHS Strategic Plan 2006-2011
	SFC-E, Annual, Efficiency: Average project duration from the execution of MOA to construction completion shall be at 4 years or less.	Goal 1: Build and Sustain Healthy Communities; Objective 1.2) Develop public health infrastructure with Tribes to sustain and support AI/AN communities
	SFC-3, Long Term, Outcome: Percentage of AI/AN homes with sanitation facilities	Goal 1: Build and Sustain Healthy Communities; Objective 1.2) Develop public health infrastructure with Tribes to sustain and support AI/AN communities
	RPMS-E, Annual, Efficiency: Development and Deployment of patient safety measurement system	Goal 1: Build and Sustain Healthy Communities; Objective 1.3) Assist AI/AN communities in identifying and resolving community problems by improving access to appropriate information Goal 2: Provide Accessible Quality Health Care; Objective 2.1) Provide accurate and timely clinical data on the health of AI/ANs, 2.5) Improve the safety and quality of health care, 2.6) Provide quality health information for decision making to patients, providers, and communities through improved information systems
	RPMS-1, Long Term, Outcome: Develop comprehensive EHR with clinical guidelines for select chronic diseases	Goal 1: Build and Sustain Healthy Communities; Objective 1.3) Assist AI/AN communities in identifying and resolving community problems by improving access to appropriate information Goal 2: Provide Accessible Quality Health Care; Objective 2.1) Provide accurate and timely clinical data on the health of AI/ANs, 2.5) Improve the safety and quality of health care, 2.6) Provide quality health information for decision making to patients, providers, and communities through improved information systems

HHS Strategic Plan 2004-2009	HHS 20 Department-Wide Objectives, 2006	HHS Secretary's 500 Day Plan 2005
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices; 3.6 – Increase access to health services for AI/ANs		
Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices; 3.6 – Increase access to health services for AI/ANs		
Goal 5: Improve the quality of health care services	1. Transform the Health Care System, a) Increase access to high quality effective health care that is predictably safe.	
Goal 5: Improve the quality of health care services	1. Transform the Health Care System, b) Accelerate the adoption and use of an electronic health information infrastructure in the U.S.	

IHS Performance Measure 2006	IHS Program Performance Measure, 2006	IHS Strategic Plan 2006-2011
	RPMS-2, Long Term Outcome: Derive all clinical indicators from RPMS and integrate with EHR	Goal 1: Build and Sustain Healthy Communities; Objective 1.3) Assist AI/AN communities in identifying and resolving community problems by improving access to appropriate information Goal 2: Provide Accessible Quality Health Care; Objective 2.1) Provide accurate and timely clinical data on the health of AI/ANs, 2.5) Improve the safety and quality of health care, 2.6) Provide quality health information for decision making to patients, providers, and communities through improved information systems
	RPMS-4, Long Term Outcome: Develop and deploy automated behavioral health system	Goal 1: Build and Sustain Healthy Communities; Objective 1.3) Assist AI/AN communities in identifying and resolving community problems by improving access to appropriate information Goal 2: Provide Accessible Quality Health Care; Objective 2.1) Provide accurate and timely clinical data on the health of AI/ANs, 2.5) Improve the safety and quality of health care, 2.6) Provide quality health information for decision making to patients, providers, and communities through improved information systems
	RPMS-3, Long Term Outcome: Number of sites to which electronic health record is deployed	Goal 2: Provide Accessible Quality Health Care; Objective 2.1) Provide accurate and timely clinical data on the health of AI/ANs, 2.5) Improve the safety and quality of health care, 2.6) Provide quality health information for decision making to patients, providers, and communities through improved information systems

HHS Strategic Plan 2004-2009	HHS 20 Department-Wide Objectives, 2006	HHS Secretary's 500 Day Plan 2005
Goal 5: Improve the quality of health care services	1. Transform the Health Care System, b) Accelerate the adoption and use of an electronic health information infrastructure in the U.S.	
Goal 5: Improve the quality of health care services	1. Transform the Health Care System, b) Accelerate the adoption and use of an electronic health information infrastructure in the U.S.	
Goal 5: Improve the quality of health care services	1. Transform the Health Care System, b) Accelerate the adoption and use of an electronic health information infrastructure in the U.S.	

IHS Strategic Plan Notes:

Focus is broad-based public health approaches
Organizational management perspective

The above measures are not designed to measure the community-based primary prevention public health largely described in Strategic Goal 1 with the exception of Objective 1.3: Assist AI/AN communities in identifying and resolving community problems by improving access to appropriate information. The following performance measures have been discontinued from 2006 on: 22, 37, 38, 40 and 41.

2006 National Dashboard (IHS-Tribal) FINAL

Diabetes	2006	2005	2004	2006 Target	Results
Diabetes Dx Ever[a]	11%	11%	10%	N/A[a]	N/A
Documented HbA1c[a]	79%	78%	77%	N/A[a]	N/A
Poor Glycemic Control	16%	15%	17%	15%	Not Met
Good Glycemic Control	31%	30%	27%	32%	Not Met
Controlled BP <130/80	37%	37%	35%	37%	Met
LDL Assessed	60%	53%	53%	56%	Met
Nephropathy Assessed	55%	47%	42%	50%	Met
Retinopathy Exam (All sites/pilots[b])	49%/52%[b]	50%[b]	55%[b]	baseline/50%[b]	Met
Dental	**2006**	**2005**	**2004**	**2006 Target**	
Access to Services	23%	24%	24%	24%	Not Met
Topical Fluoride–patients	95,439	85,318	N/A	85,318	Met
Sealants	246,645	249,882	230,295	249,882	Not Met
Immunizations	**2006**	**2005**	**2004**	**2006 Target**	
Influenza 65+	58%	59% (on hold)	54%	59%	Not Met
Pneumovax 65+	74%	69%	69%	72%	Met
Childhood Izs[c,d]	80%[c]/78%[d]	75%[c]	72%[c]	75%	Met
Prevention	**2006**	**2005**	**2004**	**2006 Target**	
Pap Smear Rates	59%	60%	58%	60%	Not Met
Mammogram Rates	41%	41%	40%	41%	Met
FAS Prevention	28%	11%	7%	12%	Met
DV/IPV Screen	28%	13%	4%	14%	Met
Childhood Weight Control (CWC)[e]	24%	64%	60%[e]	baseline	Met
Tobacco Cessation[f]	12%	34%	27%[f]	baseline	Met
Depression Screening	15%	N/A	N/A	baseline	Met
Prenatal HIV Screening	65%	54%	N/A	55%	Met
Colorectal Cancer Screening	22%	N/A	N/A	baseline	Met
Cholesterol Screening	48%	43%	N/A	44%	Met

[a] Not GPRA measures, used for context only
[b] Collected for pilot sites only
[c] Data collected through Immunization Report (National Immunization Program)
[d] BMI Assessed Measure (Changed to CWC – 2006)
[f] Tobacco Assessment Measure (Changed to Tobacco Cessation – 2006)

Measure Met	16
Measures Not Met	6
Total Measures	22

		IHS Strategic Goals		
		Build and sustain healthy communities	Provide accessible, quality health care	Foster Collaboration and Innovation
HHS Strategic Goals				
1	Reduce the major threats to the health and well-being of Americans	X	X	X
2	Enhance the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges	X		X
3	Increase the percentage of the Nation's children and adults who have access to health care services, and expand consumer choices	X	X	X
4	Enhance the capacity and productivity of the Nation's health science research enterprises			X
5	Improve the quality of health care services	X	X	X
6	Improve the economic and social well-being of individuals, families, and communities, especially those most in need	X	X	X
7	Improve the stability and healthy development of our Nation's children and youth	X	X	
8	Achieve excellence in management practices			X

APPENDIX E: TECHNICAL NOTES

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Data sources
for graphs

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AMERICAN INDIAN AND ALASKA NATIVE YPLL			
YEAR	POPLT 65	YPLL	YPLL RATE
2000–2002	4730536	333021	70.4
1997–1999	4423015	313711	70.9
1994–1996	4058227	307731	75.8
1992–1994	3786490	301014	79.5

NOTE: YPLL for Total Indian Health Service. Based on Populations Projections Developed December 2005.

MORTALITY DISPARITIES RATES	RATE	RATE	RATIO	RATE	RATE	RATIO	% CHANGE	RATE	RATE	RATIO
	AI/AN	U.S. All Races	AI/AN (00-02) U.S. All Races	AI/AN	U.S. All Races	AI/AN (96-98) U.S. All Races	AI/AN	AI/AN	U.S. All Races	AI/AN (72-74) U.S. All Races
	2000–2002	2001	2001	1996–1998	1997	1997	2000–2002	1972–1974	1973	1973
All Causes	1039.9	854.5	1.2	1070.8	888.5	1.2	-2.9	1433.7	1209.9	1.2
Alcohol-Induced[1]	42.1	6.9	6.1	45.0	7.3	6.2	-6.4	77.5	8.4	9.2
Breast Cancer	16.5	26.0	0.6	19.8	28.9	0.7	-16.7	16.9	35.0	0.5
Cerebrovascular Disease	59.9	57.9	1.0	62.8	65.6	1.0	-4.6	99.4	136.2	0.7
Cervical Cancer	4.5	1.4	3.2	5.2	3.2	1.6	-13.5	19.0	8.6	2.2
Diabetes	73.2	25.3	2.9	77.8	24.2	3.2	-5.9	47.3	23.2	2.0
Diseases of the Heart	236.2	247.8	1.0	272.4	278.1	1.0	-13.3	336.5	491.5	0.7
HIV Infection[2]	2.9	5.0	0.6	3.3	6.5	0.5	-12.1	1.4	7.2	0.2
Homicide (Assault)	11.4	7.1	1.6	12.9	7.3	1.8	-11.6	26.6	10.3	2.6
Infant Deaths[3]	8.5	6.8	1.3	8.9	7.2	1.2	-4.5	25.0	17.7	1.4
Malignant Neoplasms (All)	183.5	196.0	0.9	187.5	207.9	0.9	-2.1	150.0	202.2	0.7
Maternal Deaths[4]	12.5	9.9	1.3	7.8	8.4	0.9	60.3	34.8	16.4	2.1
Motor Vehicle Crashes	50.4	15.3	3.3	43.1	13.9	3.1	16.9	117.5	26.7	4.4
Pneumonia & Influenza	31.1	22.0	1.4	31.3	23.5	1.3	-0.6	50.7	38.4	1.3
Suicide (Intentional Self-harm)	17.3	10.7	1.6	18.0	11.4	1.6	-3.9	20.8	13.2	1.6
Tuberculosis	2.1	0.3	7.0	2.0	0.4	5.0	5.0	10.7	1.7	6.3
Unintentional Injuries	90.1	35.7	2.5	98.7	37.3	2.6	-8.7	223.1	59.5	3.7

American Indian and Alaska Native (AI/AN) age-adjusted rate.

U.S. all races age-adjusted rate.

Ratio between American Indian and Alaska Native (AI/AN) and U.S. all races.

Percent (%) Change for American Indian and Alaska Native (AI/AN).

NOTE: ICD-10 codes were introduced in 1999. Comparability ratios have been applied to the 1996-1998 age-adjusted data. ICD-9 codes were introduced in 1979. Comparability ratios have been applied to the 1972-1974 age-adjusted rate. The 1997 U.S. all races rates have been age-adjusted to the 2000 standard population. Comparability ratios have been applied. The 1973 U.S. all races rates have been age-adjusted to the 2000 standard population. Comparability ratios have been applied. American Indian and Alaska Native (AI/AN) rates are adjusted to compensate for misreporting of (AI/AN) race on state death certificates.

[1] Rate of alcohol-induced deaths is for the 1979-1981 three year period. The U.S. all races rate is for 1980. The % change represents change from 1979-1981 to 2000-2002.

[2] HIV was first classified in 1987. Rate of HIV is for the 1987-1989 three year period. The U.S. all races rate is for 1988. The % change represents change from 1987-1989 to 2000-2002.

[3] Per 1,000 live births.

[4] Rate per 100,000 live births. Rate does not meet the standards of reliability due to small numbers. The break in comparability for maternal mortality has not been quantified by NCHS.

Source: Unpublished data: OPHS/Division of Program Statistics (1996-1998 and 2000-2002 AI/AN rates are based on 2000 census with bridged-race categories).

p.18 CPOC:Community Oriented Primary Care Website at:
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12406800&dopt=Citation

p.21 Core Public Health Functions Website at:
http://www.apha.org/ppp/science/10ES.htm

p.28 Homeland Security Presidential Directive (HSPD) -5 Website at:
http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html

p.36
2005 IHS Expenditures Per Capita Compared to Other Federal Health Expenditure Benchmarks; Data Sources for Health Care Expenditures Per Capita Chart

1. Medicare Expenditures Per Enrollee:

Source – Centers for Medicare and Medicaid Services website, 2/6/2006 [http://www.cms.hhs.gov/MedicareMedicaidStatSupp/05_2004%20Edition.asp#TopOfPage]. Table 16 reports $6,784 as the average Medicare payment per beneficiary in 2002 (the last year of published data). The historical average growth rate has varied. The 2002 per beneficiary payment is extrapolated to $7,631 in 2005 assuming payments grew at an annual rate of 4%.

2. Medical Care for Veterans and Administration Users:

Source – Veteran's Administration website, 2/6/2006 [http://www.va.gov/vetdata/Program-Statics/stat_app02/Table%2011%20(02).xls]. Table 1 reports $4,653 as the national average health cost per user in 2002 (the last year of published data). The historical average growth rate has varied. The 2002 per beneficiary payment is extrapolated to $5,234 in 2005 assuming costs grew at an annual rate of 4%.

3. National Health Care Expenditures Per Capita:

Source – Centers for Medicare and Medicaid Services website, 2/6/2006 [http://www.cms.hhs.gov/NationalHealthExpendData/downloads/nheprojections2004-2014.pdf]. Table 1 reports $5,670 as the national average health care expenditure per person in 2003 (the last year of published data). CMS also projects future expenditures considering various economic factors. CMS projects $6,423 in 2005.

4. Medicaid Payments Per Beneficiary:

Source – Centers for Medicare and Medicaid Services website, 2/6/2006 [http://www.cms.hhs.gov/MedicareMedicaidStatSupp/05_2004%20Edition.asp#TopOfPage]. Table 111 reports $4,328 as the average Medicaid payment per person in 2002 (the last year of published data). The historical average growth rate has varied. The 2002 per beneficiary payment is extrapolated to $5,010 in 2005 assuming payments grew at an annual rate of 5%.

5. Medical Care for Federal Prison Inmates:

Source – General Accounting Office, Report and Testimony GAO/T-GGD-00-112, Federal Prisons-Containing Health Care Costs for an Increasing Inmate Population, April 2000. According to GAO, the medical care expenditures for federal prison inmates was $3,242 per capita in 1999. Data for subsequent years is unavailable. Assuming a conservative growth of 3.5% annually (< ½ the medical inflation average), the amount is extrapolated to $3,986 in 2005.

6. FEHB Medical Care Benchmark per IHS User:

Source – Indian Health Service, Level of Need Funded Report (later renamed the Federal Disparity Index Report) by the LNF Workgroup, 1999 – IHS website. The LNF study used insurance premiums for the Federal Employee Health Benefits program as a benchmark for actuarial projections for costs of equivalent benefits to IHS users. The study found an initial benchmark cost of $2,980 for equivalent FEHB benefits when characteristics and cost risks of Indian people were considered. The annual rate of increase the BLS medical CPI was applied to the 1999 benchmark to forecast $3,903 for 2005.

6. IHS Expenditures per User:

Source – The Indian Health Service budget and appropriations tables for 2005. Expenditures from appropriations plus collections are divided by the 2005 IHS user population to compute actual expenditures per user. The breakout for "medical care" and "non-medical" IHS programs is based on a detailed line-item analysis in 2001. These data are current and no forecast to 2005 are necessary.

p.43 Joslin Vision Network Website at:
http://www.joslin.org/joslin_vision_network.asp

p.43 Aberdeen Mobile Digital Mammography Unit report at:
http://64.233.161.104/search?q=cache:0dm4ZRPRmMUJ:www.mtwytlc.com/BCCBest%2520Practices%2520Paper.doc+Aberdeen+Mobile+Mammography&hl=en&gl=us&ct=clnk&cd=8&lr=lang_en

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James Ray Shaw, M.D.
(1908-2002)

Carruth J. Wagner, M.D.
(1916-2002)

Erwin S. Rabeau, M.D.
(1920-1984)

Emery A. Johnson, M.D.

1955   1960   1965   1970   1975

1954
The "Transfer Act" (PL 83-568) transfers responsibility for Indian health services from the Department of the Interior to the Department of Health, Education and Welfare

1955
Health Services are transferred from the Bureau of Indian Affairs (BIA) to the Public Health Service (PHS), and the newly created Indian Health Service (IHS)

1959
Passage of Indian Sanitation Facilities Act (PL 86-121)

1965
Funds from the Office of Economic Opportunity (OEO) lead to the initiation of the Community Health Representative Program at Pine Ridge, the first step toward tribal control of health affairs

1970
President Richard Nixon's White Paper on Indian Policy, proclaims an end to the policy of termination and the beginning of the policy of Indian self-determination

1972
OEO provides funds for urban Indian clinics in Minneapolis, Rapid City, and Seattle

1975
Passage of the Indian Self-Determination and Educational Assistance Act (PL 93-638), changes an executive proclamation into the law of the land

1976
Passage of the Indian Health Care Improvement Act (PL 94-437), spells out the federal government's responsibilities for Indian health

Everett R. Rhoades, M.D.

Michael H. Trujillo, M.D., M.P.H., M.S.

Charles W. Grim, D.D.S., M.H.S.A.

INDIAN HEALTH SERVICE · PHS · 1955 ·

1980   1985   1990   1995   2000   2005

In the first 25 years of the Indian Health Service program, infant mortality dropped by 82 percent, the maternal death rate decreased by 89 percent, the mortality rate from tuberculosis diminished by 96 percent, and deaths from diarrhea and dehydration fell by 93 percent

1988
Encouraged by the passage of the Indian Health Care Amendments (PL 100-713), tribal and urban organizations increasingly administer their own programs, and the role of the IHS in providing direct health services diminishes

1994
Congress passes legislation to extend Tribal self-governance on a demonstration basis to allow Tribes to contract for the programs, services, functions, and activities

HISTORY
OF THE INDIAN HEALTH SERVICE