DEPARTMENT of HEALTH and HUMAN SERVICES

Indian Health Service

FY 2008 Annual Performance Report

Introduction

This FY 2008 Annual Performance Report provides information on the Indian Health Service's actual performance and progress in achieving the goals established in the FY 2008 Annual Performance Plan, which was published in February 2007.

The goals and objectives contained within this document support the *US Department of Health and Human Services Strategic Plan - FY 2007-2012* (available at http://aspe.hhs.gov/hhsplan/2007/).

Transmittal Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

JAN 12 2009

TRANSMITTAL MEMO

TO: Secretary
Department of Health and Human Services

FROM: Director
Indian Health Service

SUBJECT: FY 2008 Annual Performance Report – Data Quality Assurance Statement

This FY 2008 Annual Performance Report provides information on the Indian Health Service's actual performance and progress in achieving the goals established in the FY 2008 Annual Performance Plan. To the best of my knowledge, the performance data reported by my Operating/Staff Division for inclusion in the FY 2008 Annual Performance Report is accurate, complete, and reliable.

Robert G. McSwain

Attachment

Table of Contents

Summary of Measures and Results Table

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2005	35[1]	34	97%	29	85%
2006	34[2]	33	97%	27	82%
2007	51[3]	47	92%	39	83%
2008	52	45	87%	35	78%
2009	47				

[1] 2005 total measures reduced by 2 from 2006 CJ for the following reasons: (a) consumer satisfaction measure, which was reported as discontinued in Exhibit W Changes and Improvements, was not deleted from Exhibit DD Summary of Measures and Results Table in the 2006 CJ; (b) influenza measure was placed on hold for 2005 based on projected national vaccine shortages, reducing total measures to 35.
[2] Total measures in 2006 were reduced by 1 from the 2008 CJ due to the Sanitation Improvement measure changing from two separate measures into a combined measure.
[3] Total measures in 2007 increased to 53 due to inclusion of program measures in the overall count (Retired, Developmental, and Long term measures were excluded as required).

CLINICAL SERVICES: HH&C, CHS, Dental, Mental Health, Alcohol and Substance Abuse

The following measures are overarching measures that are accomplished through several programs and activities in the IHS Services budget.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
21/ RPMS – E	**Patient Safety[1]:** Development and deployment of patient safety measurement system	All Areas	3 Areas	7 Sites	64 Sites	74 Sites	94 Sites	84 Sites

[1] In FY 2005 this measure tracked the number of Areas with a medication error reporting system. In FY 2006 this measure changed to track the number of Areas that developed and deployed a medical error reporting system. In FY 2007, this measure changed to track the number of sites that develop and deploy a Patient Safety Measurement System.

The FY 2008 target for this measure was met and exceeded. In FY 2008, the IHS developed and deployed a patient safety measurement system at 94 sites; the target was 74 sites. In FY 2007, this measure replaced the previous measures (medication error reporting system and medical error reporting system). The patient safety measurement system is broader than either of the two prior systems and is specifically developed to meet IHS needs. The FY 2009 target is 84 sites. This target was set before FY 2008 results were available.

The target for development and initial deployment of this new system was based on the previous deployment experiences with the WebCident Occupational Safety and Health System. However, a number of factors contributed to a much higher than anticipated deployment rate: deployment of this system was added as an Area Director measure of performance; there was excellent support of the development and deployment process at the headquarters, Area, and service unit levels; and customer feedback about cost savings obtained by use of the system, as well as its ease of use, motivated additional sites to move quickly.

The successful deployment of this system has worked to improve patient safety and create cost savings to sites by tracking adverse incidents in a systematic way that will allow them to be addressed more quickly. The lessons learned from the data collected will be used to design safer healthcare systems to reduce risk and prevent errors and patient harm.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
TOHP-4	Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) populations served by tribal health programs	N/A	N/A	N/A	N/A	N/A	N/A	N/A

This measure is long term and does not have annual targets. Years of Potential Life Lost (YPLL) data is not available for three years and is reported four years later as the midyear of a three-year rate. The most current available data for Tribally-Operated Health Programs (TOHP) is from FY 2003, with a rate of 62.5 per population of 100,000. The long term target for this measure is to reduce the YPLL in the American Indian/Alaska Native (AI/AN) populations served by tribal health programs to 55.3 by 2012, which will be reported in 2015.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
RPMS-2	Derive all clinical measures from RPMS and integrate with EHR[1]	41/12	41/12	41/12	41/12	59/12	59/12	61/12

[1]*Note on display: The first item represents the number of clinical measures and the second represents the number of Areas (Clinical Measures/Area).*

The FY 2008 target for this measure was met. IHS met this measure by deriving 59 clinical measures from the Resource and Patient Management System (RPMS) and integrating the Electronic Health Record (EHR) in all 12 Areas. This measure is designed to improve the quality of care through the use of appropriate technology and to improve passive extraction of GPRA clinical data from RPMS health information system. The FY 2009 target is to assure that 61 clinical performance measures based on RPMS data can be reported by CRS software. Deriving clinical data from RPMS will be a priority in FY 2009. Increasing the number of medical conditions that can be tracked using the Clinical Reporting System (CRS) allows clinicians to provide better patient care. Standardized extraction of clinical data assures comparability between providers, facilities, and is consistent with other Federal agencies.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
FAA-2	Years of Potential Life Lost in American Indian/Alaska Native population	N/A	N/A	N/A	N/A	N/A	N/A	N/A

This measure is long term and does not have annual targets. Years of Potential Life Lost (YPLL) data is not available for three years and is reported four years later as the midyear of a three-year rate. The most current data available for Federally-Administered (FAA) programs is for FY 2003, with a rate of 79.2 per population of 100,000. The long term target for this measure is to reduce the YPLL in the American Indian/Alaska Native (AI/AN) populations served by federally-administered programs to 62.3 by 2012, which will be reported in 2015.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
28	**Unintentional Injury Rates[1]:** Unintentional injuries mortality rate in AI/AN population	Dec/2009	Dec/2010	94.8	Dec/2011	94.8	Dec/2012	Changed to Long Term Measure
FAA-3	**Unintentional Injury Rates1:** Unintentional injuries mortality rate in AI/AN population	Dec/2009	Dec/2010	92.2	Dec/2011	92.2	Dec/2012	Changed to Long Term Measure

[1]*Long Term Measure; reportable in 2016.*

FY 2005 results are not available until December 2009 due to data lags inherent in national mortality statistics. These measures will become long-term measures in FY 2009. The long term 2012 target for unintentional injuries mortality rates for all IHS sites is 94.8. The long term 2012 target for IHS Federal sites only is to achieve an unintentional injuries mortality rate of 92.2.

Hospitals and Health Clinics & Contract Health Services

The following measures are accomplished primarily through the activities and programs of Hospitals & Health Clinics and Contract Health Services, both of which support the provision of clinical care.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase the proportion of diagnosed diabetic patients assessed for nephropathy.								
5	**Diabetes: Nephropathy Assessment:** Proportion of patients with diagnosed diabetes assessed for nephropathy IHS-All[1]	68%[2]/ 47%	61%[2]/ 55%	61%/ Baseline	62%/ 40%	Baseline /40%	NA/50%	47%
5	Tribally Operated Health Programs	48%	52%	Baseline	28%	28%	35%	33%

[1]*First figure in results column is Diabetes audit data; second is CRS.*
[2]*DDTP changed the methodology for nephropathy assessment in 2006 to coincide more closely with the CRS methodology. In order to compare nephropathy audit data on the same basis, reports using this methodology have been generated for 2003, 2004, and 2005 as follows: 2003 – 53%, 2004 – 55%, 2005 – 57%.*

The FY 2008 CRS target for nephropathy (kidney disease) assessment was met and exceeded. In FY 2008 50% of patients were screened based on the 2006 Diabetes Standards of Care, which require an estimated glomerular filtration rate (GFR is a measure of the kidney's ability to filter blood) and quantitative urinary protein assessment; the previous standard required a positive urine

protein test or any microalbuminuria test. The 50% rate represents an increase of 10 percentage points above the FY 2007 rate of 40%. This change was adopted for CRS data in FY 2007 following three years of improving rates based on the previous standard (between 2004 and FY 2006 the CRS rate rose from 42% to 55%). Tribal involvement, collaboration with other Federal agencies, and community emphasis all contributed to measure improvement. The 2009 performance target is to achieve a rate of 47%, a 5% relative decrease from the FY 2008 result. The target reflects the challenges of providing nephropathy screenings, which involve high-cost laboratory testing procedures.

The FY 2008 Diabetes Audit target was to set a baseline based on new standards of care. However, audit data based on these new requirements for an estimated GFR and a quantitative urinary protein assessment was deemed not reliable by the Diabetes program and no Audit result is available for this measure this year. CRS and Audit data are based on different collection methods and exclusion criteria. The FY 2009 audit target was to maintain the FY 2008 target, but will need to be revisited in light of the absence of FY 2008 results.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Maintain 100 percent accreditation of all IHS hospitals and outpatient clinics.								
20	**Accreditation:** Percent of hospitals and outpatient clinics accredited (excluding tribal and urban facilities)	100%	100%	100%	100%	100%	100%	100%

The FY 2008 target for this measure was met. IHS maintained 100 percent accreditation of all IHS hospitals and ambulatory clinics. The 100 percent accreditation target has been met consistently over the last four years, which is important because accreditation contributes both directly and indirectly to improved clinical quality and is essential for maximizing third-party collections. The local IHS multidisciplinary team approach to accreditation and ongoing quality management, with guidance and support from Area staff, has been the mainstay of success in maintaining this rate. This is one of the most demanding measures to meet, given the growing clinical quality of care assessments that are required as well as issues related to health facilities maintenance and renovation that are critical to accreditation. The FY 2009 target is to maintain 100% accreditation at all IHS-operated hospitals and outpatient clinics (excluding tribally-operated facilities).

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase the proportion of diagnosed diabetic patients who receive an annual diabetic retinal examination.								

6	**Diabetic Retinopathy:** Proportion of patients with diagnosed diabetes who receive an annual retinal examination IHS - All	50%	52/ 49%[1]	49%	49%	49%	50%	47%
6	Tribally Operated Health Programs	50%	48%	48%	48%	48%	48%	46%

[1]*For FY 2006, two numbers were required and reported: first figure represents results at designated sites, second is results for all sites. FY 2006 target is to maintain at designated pilot sites and establish baseline at all sites. As of FY 2007, examination rates at designated pilot sites are not reported separately.*

The FY 2008 target for retinopathy screening was met and exceeded. During FY 2008, the proportion of patients with diabetes that received an annual diabetic retinal exam increased from 49% in FY 2007 to 50%. Measure results have been relatively stable over the past four years; until FY 2006, results were only reported from pilot sites, but starting in FY 2007, results represent all sites. The FY 2009 target is to achieve a rate of 47 percent, a 5% relative decrease from the FY 2008 result. The target reflects the challenges of providing retinopathy screenings, which are high-cost tests dependent on equipment, staffing, and contract health services that may not be available in all sites.

Diabetic eye disease is a leading cause of blindness in the United States. Early detection of diabetic retinopathy (DR) is a fundamental part of the effort to reduce visual disability in diabetic patients. Meeting performance targets for FY 2009 will be challenging in the face of increases in diabetes prevalence and the steadily increasing optometry program vacancy rates. IHS will face these challenges by improving performance through heightened attention to DR, disseminating best practices of high performing sites, and continued expansion of the IHS-JVN Teleophthalomology program.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase the proportion of eligible women who have had a Pap screen within the previous three years.								
7	**Pap Smear Rates:** Proportion of eligible women who have had a Pap screen within the previous three years IHS - All	60%	59%	60%	59%	59%	59%	59%
7	Tribally Operated Health Programs	61%	61%	61%	61%	61%	60%	60%

The FY 2008 target for this measure was met. In FY 2008 the proportion of eligible women who have had a Pap screen within the previous three years was 59 percent, unchanged from FY 2007. Results for this measure have been consistent over the past four reporting years. Regular

screening with a pap smear lowers the risk of developing invasive cervical cancer by detecting pre-cancerous cervical lesions that can be treated. If cervical cancer is detected early, the likelihood of survival is almost 100 percent with appropriate treatment and follow- up. Pap screening contributes to reduced mortality rates, treatment costs, and quality of life of AI/AN women. The FY 2009 target is to achieve a rate of 59%, maintaining the FY 2008 result. The target is ambitious, given the fact that pap screening is a high-cost procedure and maintaining previous levels will be challenging.

To meet the FY 2009 target, IHS will continue to encourage the use of RPMS electronic tools to more efficiently and effectively identify and schedule patients eligible for screening. These include a Clinical Reporting System (CRS) function that links patient lists with the scheduling package, iCare case management software, the women's health package, and Electronic Health Record reminders.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase the proportion of eligible women who have had a mammogram screening within the previous two years.								
8	**Mammogram Rates:** Proportion of eligible women who have had mammography screening within the previous two years IHS - All	41%	41%	41%	43%	43%	45%	45%
8	Tribally Operated Health Programs	44%	44%	44%	45%	45%	47%	47%

The FY 2008 target for this measure was met and exceeded. In FY 2008, the proportion of eligible women who have had mammography screening within the previous two years was 45 percent, an increase of two percentage points over the FY 2007 rate of 43 percent. The increase reflects increased provider and patient awareness of the value of regular screening. The FY 2009 target is to achieve a rate of 45 percent, maintaining the FY 2008 result. The target is ambitious, given the fact that mammograms are high-cost procedures dependent on funding available for screening.

Biennial mammogram screening of women between the ages of 50 and 69 has been shown to be a cost effective way to decrease the breast cancer mortality rate. Regular mammography screening can reduce breast cancer mortality by 20 to 25 percent. AI/AN women diagnosed with breast cancer have lower 5-year survival rates in comparison to whites, mainly because their cancers are less likely to be found in earlier stages. It is because of this disparity that breast cancer screening remains an IHS priority. This measure has made steady progress over the past four reporting years.

To meet the FY 2009 target IHS will continue to encourage the use of RPMS electronic tools to more efficiently and effectively identify and schedule patients eligible for screening. These include a new Clinical Reporting System (CRS) function that links patient lists with the scheduling package, the new iCare case management software, the women's health package, and Electronic Health Record reminders.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase the proportion of eligible patients who have had appropriate colorectal cancer screening.								
9	**Colorectal Cancer Screening Rates:** Proportion of eligible patients who have had appropriate colorectal cancer screening IHS - All	N/A	22%	22%	26%	26%	29%	29%
9	Tribally Operated Health Programs	N/A	26%	26%	29%	29%	32%	32%

The FY 2008 target for this measure was met and exceeded. In FY 2008, the proportion of eligible patients who have had appropriate colorectal cancer screening was 29 percent, an increase of three percentage points above the FY 2007 rate of 26 percent. The increase reflects increased provider and patient awareness of the value of regular screening. The target for FY 2009 is to achieve a rate of 29 percent, maintaining the FY 2008 result. The target is ambitious, given that colorectal cancer screening is a high-cost procedure dependent on available funding.

Colorectal cancers are the third most common cancer in the United States, and are the third leading cause of cancer deaths. Colorectal cancer rates among the Alaska Native population are well above the national average and rates among American Indians are rising. Improving timely detection and treatment of colorectal cancer screening will reduce undue morbidity and mortality associated with this disease.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase childhood combined immunization rates.								
24	**Combined (4:3:1:3:3) Childhood immunization rates:** AI/AN children patients aged 19-35 months IHS - All	75%	78/ 80[1]%	78%	78%	78%	78%	78%
24	Tribally Operated Health Programs	54%	74%	74%	72%	72%	72%	72%

[1] *Rate reflects National Immunization Report.*

The IHS-All FY 2008 target for this measure was met. In FY 2008, the percentage of children ages 19-35 months receiving the recommended vaccine series (4:3:1:3:3) was 78 percent, maintaining the rate from FY 2007. The FY 2009 target is to achieve a rate of 78 percent,

maintaining the FY 2008 result. This target is ambitious, given that immunizations are relatively high-cost procedures and reaching the measure target relies on provider coordination of care and follow-up by patients.

Routine immunizations represent a cost-effective public health measure that significantly improves the health of children by preventing a number of serious illnesses and associated treatment costs. The Healthy People 2010 goal is 90 percent coverage for all routine immunizations for children aged 19-35 months and 80 percent coverage for the combined (4:3:1:3:3) series of vaccinations. The combined series includes coverage with 4 doses of Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP), 3 doses of Inactivated Poliovirus (IPV), 1 dose of Measles, mumps and rubella vaccine (MMR), 3 doses of Hepatitis B and 3 doses of Haemophilus influenzae type b conjugate vaccine (Hib).

Childhood immunizations are a high priority for IHS. The agency will work to meet the FY 2008 and FY 2009 targets by encouraging use of the immunization package to identify immunizations that are due for each patient, sharing data with state immunization registries, and collaborating with local health agencies to assure availability of vaccines.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
31	**Childhood Weight Control:** Proportion of children, ages 2-5 years, with a BMI at the 95th percentile or higher IHS - All	64%[1]	24%	24%	24%	24%	24%	N/A
31	Tribally Operated Health Programs	63%[1]	25%	25%	25%	25%	25%	N/A

[1] *Measure tracked the proportion of patients for whom BMI (Body Mass Index) data can be measured.*

The FY 2008 target for this measure was met. In FY 2008, 24% of children ages 2-5 had a BMI at or above the 95th percentile, unchanged from FY 2007. In FY 2009 the measure will become a long term measure. In FY 2012 the long term target is to maintain the rate at 24%.

Rates of overweight among American Indian and Alaska Native children exceed the national averages. Children who are overweight tend to show related signs of morbidity, including elevated blood pressure, cholesterol, triglyceride, and insulin levels. One major result of rising childhood overweight rates is the growing prevalence of type 2 diabetes among children. In order to address this problem of childhood obesity, the IHS has created a guidance document "Promoting a Healthy Weight in Children in Youth" with specific best practices strategies covering BMI assessment, breastfeeding, patient health education, counseling, and community strategies. This guidance, along with provider toolkits, will be distributed widely across the IHS provider network.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
FAA-E	Hospital admissions per 100,000 service population for long term complications of diabetes in federally administered facilities[1]	185.4	171.3	169.6	9/2009	167.9	9/2010	167.9

[1]FY 2005 data, the data systems were switched from Legacy NPIRS to National Data Warehouse. 2004 data was recalculated for the new baseline year for comparability. There were also methodology changes for tribal hospitals to reflect changes in ownership and to correct geographic errors.

Reporting for this measure has a two-year time lag and FY 2008 data will not be available until September 2010. This measure tracks hospitalization admissions per 100,000 service population for long term complications of diabetes in federally administered activities. The FY 2008 target for this measure is 167.9 per 100,000 and the 2009 target is to maintain the FY 2008 target rate. Rates from FY 2005-2006 reflect a decline in hospital admissions for long term complications of diabetes. FY 2007 results have not yet been reported. This measure is designed to demonstrate the overall effectiveness of diabetes management by documenting the reductions in costly in-patient care, which indirectly reflects improved patient care efficiency in the face of increasing rates of diabetes in AI/AN populations.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
FAA-1	Children ages 2-5 years with a BMI at the 95th percentile or higher	N/A	23.2%	23.2%	24%	23.2%	23.9%	Change to long term measure/ 23.2

The FY 2008 target for this measure was not met. The target was to reduce the rate of children ages 2-5 with a BMI at the 95th percentile or greater from 24 to 23.2. The result was 23.9%. Results from FY 2005-2007 show a gradual, small increase in the proportion of children, ages 2-5 years, with a BMI at the 95th percentile or higher. In FY 2009 the target is to achieve the FY 2008 target rate of 23.2 percent.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
TOHP-2	Number of designated annual clinical performance goals met	11/14	10/13	13/16	14/16	14/17	14/17	14/17

The FY 2008 target for this measure was met. TOHPs met 14 out of 17 annual clinical performance goals. Past trends for this measure show an overall increase in both the number of clinical measures met and the number of measures included in the target over the past four reporting years. In FY 2009 the target is to maintain performance at the same level of 14/17. Meeting the majority of evidence-based clinical performance measures directly contributes to the IHS mission of improving the health status of AI/AN people.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
TOHP-3	Percentage of AI/AN patients with diagnosed diabetes served by tribal health programs that achieve ideal blood sugar control[1]	33%	33%	N/A	33%	N/A	34%	N/A

There is no annual target for this measure. Past trends for this measure show a stable rate for 3 years, followed by an increase of one percentage point from FY 2007 to FY 2008. This is a long term measure to increase the proportion of patients with ideal blood sugar control to forty percent in 2014, reportable in 2014. Further analysis will be available at that time. This performance measure will reduce the cost of diabetic care while improving health outcomes, in addition to improving the health status of AI/AN people.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase screening rates for intimate partner violence.								
16	**Domestic (Intimate Partner) Violence Screening:** Proportion of women who are screened for domestic violence at health care facilities IHS-All	13%	28%	28%	36%	36%	42%	42%
16	Tribally Operated Health Programs	9%	24%	24%	30%	30%	36%	36%

The 2008 target for this measure was met and exceeded. In FY 2008, the proportion of women who are screened for domestic violence (DV) was 42 percent, an increase of 6 percentage points above the FY 2007 rate of 36 percent. The increase can be attributed to increasing provider awareness of the importance of screening, as well as improved documentation. The FY 2009 target is to maintain the FY 2008 result of 42%.

This measure is designed to identify and assist AI/AN women who experience domestic violence. Screening identifies women at risk for DV and refers these individuals for services aimed at reducing the prevalence and impact of domestic violence.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase adult influenza and pneumococcal vaccination rates.								
25	**Adult Immunizations: Influenza:** Influenza vaccination rates among adult patients aged 65 years and older IHS-All	59%	58%	59%	59%	59%	62%	62%
25	Tribally Operated Health Programs	54%	53%	54%	55%	55%	57%	57%
26	**Adult Immunizations: Pneumovax:** Pneumococcal vaccination rates among adult patients aged 65 years and older IHS-All	69%	74%	76%	79%	79%	82%	82%
26	Tribally Operated Health Programs	62%	69%	69%	73%	73%	77%	77%

The FY 2008 target for the Influenza Vaccination measure was met and exceeded. In FY 2008, the influenza vaccination rate among adult patients aged 65 years and older increased by 3 percentage points to 62%. Measure results for Influenza were relatively consistent between FY 2005-FY 2007; the increase in FY 2008 was likely due to increased provider and patient awareness of the importance of vaccination. The FY 2009 target is to achieve a rate of 62 percent, maintaining the FY 2008 result. The target is ambitious, given the challenges of ensuring vaccinations, such as provider coordination of care, cost of vaccines, and patient follow up.

The FY2008 target for the Pneumococcal Vaccination measure was also met and exceeded. In FY 2008, the Pneumococcal vaccination rates among adult patients aged 65 years and older increased by 3 percentage points to 82%. Measure results for Pneumococcal vaccination have steadily improved from FY 2005 to FY 2008. This is due to increased provider awareness of the measure, improved documentation, and targeted prevention campaigns. The FY 2009 target is to achieve a rate of 82 percent, maintaining the FY 2008 result. These targets also reflect the challenges of ensuring vaccinations mentioned above.

Vaccination of the elderly against Pneumococcal disease is one of the few medical interventions found to improve health and save on medical costs. Increasing Pneumococcal vaccination rates will provide significant improved health and quality of life among this patient population.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Decrease Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) population.								
33	**HIV Screening:** Proportion of pregnant women screened for HIV	54%	65%	65%	74%	74%	75%	75%

The FY 2008 target for the Prenatal HIV measure was met and exceeded. In FY 2008, the prenatal HIV screening rate was 75%, a 1 percentage point increase over the FY 2007 rate of 74%. Although this measure showed large increases in previous years due to higher provider awareness of the clinical guidelines and improved documentation, there was less dramatic improvement within the past year. The main obstacle to further improvement is the fact that many sites refer all prenatal patients out for care, and primary care providers do not always receive documentation of HIV testing. The FY 2009 target is to achieve a FY 2009 rate of 75 percent, maintaining the FY 2008 result.

The HIV/AIDS epidemic represents a growing threat to American women of childbearing age. Timely detection and treatment of HIV in pregnant women significantly reduces the potential for transmission and associated treatment costs.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Reduce the proportion of children ages 2-5 with a BMI of 95 percent or higher.								
FAA-4	**Breastfeeding Rates:** Proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed	N/A	N/A	N/A	N/A	Baseline	28%	28%

This measure is new as of FY 2008. The FY 2008 target was to set a baseline for the proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed at Federally Administered programs. The FY 2008 result is 28%. The FY 2009 target is to maintain the FY 2008 baseline rate of 28%. There is evidence that breastfeeding contributes to lower rates of infectious disease, asthma, and Sudden Infant Death Syndrome, and is associated with lower childhood obesity rates.

Dental

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Improve the oral health of the AI/AN population.								
12	**Topical Fluorides:** Number of American Indian and Alaska Native patients receiving at least one topical fluoride application	85,318	95,439	95,439	107,934	107,934	120,754	114,716
13	**Dental Access:** Percent of patients who receive dental services	24%	23%	24%	25%	25%	25%	24%
14	**Dental Sealants:** Number of sealants placed per year in AI/AN patients	249,882	246,645	246,645	245,449	245,449	241,207	229,147

The FY 2008 target for topical fluorides was met and exceeded. In FY 2008 120,754 patients received at least one topical fluoride application, an increase of 12,820 patients over FY 2007 results. Since FY 2005 the number of patients has increased steadily by about 10,000-12,000 patients per year; however, due to high vacancy rates for dental positions, it is difficult to predict performance in a given year. The FY 2009 target is 114,716, a relative 5% reduction from the FY 2008 result.

Patients who receive at least one fluoride application have fewer new caries, reducing cost of subsequent dental care and improving oral health.

The FY 2008 target for dental access was met. In FY 2008, 25 percent of patients received dental care, maintaining the rate from FY 2007. The target for FY 2009 is to achieve a rate of 24%, a relative 5% reduction from the FY 2008 result. This target reflects the challenges of ensuring continued access to dental services, given high provider vacancy rates.

The FY 2008 target for sealants was not met. In FY 2008 a total of 241,207 sealants were placed in patients, a decrease of 4,242 from the FY 2007 result of 246,645 sealants. The number of sealants has decreased consistently from FY 2005-FY 2008, reflecting both high dental vacancy rates, and the fact that many programs report they have few new patients eligible for sealants. The FY 2009 target is 229,147, a relative 5% reduction from the FY 2008 result.

The dental program contributes to the Hospital and Health Clinics (H&HC) measures listed above.

Mental Health

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Decrease Years of Potential Life Lost (YPLL) in the AI/AN population.								
29	**Suicide Surveillance:** Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals	Integrated (Met)[1]	1,603	1,603	1,674	1,758	1,598	1,678

[1] *In FY 2005 the target for this measure was to integrate the Behavioral Health suicide reporting tool into RPMS.*

The FY 2008 target for this measure was not met. The target was to increase the completion of suicidal behavior reporting forms from 1,674 in FY 2007 to 1,758 in FY 2008. The number of forms completed dropped to 1,598. The suicide surveillance measure has evolved from the FY 2004 target of deploying a suicide reporting form into the behavioral health package to integrating the form into the Resource Patient Management System in FY 2005 to setting a baseline level of use in FY 2006. The suicide surveillance tool captures data related to a specific incident of suicide, such as date and location of act, method, contributing factors, and other useful epidemiological information. Local and national reports can be sorted by a number of different variables including the number of suicide events by sex, age, community, tribe, and others. The FY 2009 target is to increase 5% over the FY 2008 result to 1,678 forms completed.

While the Behavioral Health-Management Information System was deployed widely in FY 2007, there were few additional sites added in FY 2008. Moreover, because this measure tracks forms completed, it is difficult to tell whether a decrease reflects lower usage of a form, or fewer events to record. The FY 2008 target was increased based on the FY 2007 performance results; however, targets for this measure are difficult to set, as it is also contingent on broader trends within AI/AN communities.

Completion of forms should provide more complete information about the incidence of suicidal ideation and attempts as well as completions, which will provide far more accurate data to national policy makers and will allow interventions to be evaluated for effectiveness in ways not previously possible.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long Term Objective: Increase the proportion of adults screened for depression.								
18	**Depression Screening[1]:** Proportion of adults ages 18 and over who are screened for depression IHS-All	+4%	15%	15%	24%	24%	35%	35%

18	Tribally Operated Health Programs	N/A	14%	14%	21%	21%	29%	29%

[1]*Prior to 2006 this measure tracked the number of programs reporting minimum agreed-to behavioral health-related data to warehouse.*

In FY 2008 the targets for this measure were met and exceeded. In FY 2008, 35% of patients age 18 and older were screened for depression, an increase of 11 percentage points over the FY 2007 rate of 24%. This measure has seen significant increases in results from the baseline result of 15% in FY 2006. Higher screening rates reflect increasing provider awareness of the importance of universal screening for depression among adults. The FY 2009 target is to maintain the screening rate at the FY 2008 results of 35%. This is a lower-cost screening measure with potential high return on investment.

Depression is often an underlying component contributing to suicide, accidents, domestic/intimate partner violence, and alcohol and substance abuse. Early identification of depression will contribute to reducing their incidence, as well as allow providers to plan interventions and treatment to improve the mental health and well-being of AI/AN people who experience depression.

Alcohol and Substance Abuse

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Assure quality and effectiveness of Youth Regional Treatment Centers.								
10	**RTC Improvement/ Accreditation:** Accreditation rate for Youth Regional Treatment Centers (in operation 18 months or more)	100%	100%	100%	91%	100%	91%	100%

The FY 2008 target of 100% accreditation of all Youth Regional Treatment Centers was not met. As in FY 2007, all but one facility continued to be accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF) and two are State-certified. The FY 2009 is to achieve a 100 percent accreditation rate for all YRTCs.

IHS continues to collaborate with tribal programs regarding licensure and accreditation issues. Strong recommendations to continue with the accreditation process are always a top priority within the program, and the agency is confident that the facility will meet the required certification standards of the appropriate health accreditation authority.

These programs provide alcohol and substance abuse treatment and prevention services within rural and urban communities, with a focus on holistic and culturally-based approaches. The program exists as part of an integrated Behavioral Health Team (BHT) that works collaboratively to reduce the incidence of alcoholism and other drug dependencies in AI/AN communities.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Reduce the rate of Fetal Alcohol Syndrome Disorders through appropriate screening and intervention for alcohol dependence in women of childbearing age.								
11	**Alcohol Screening (FAS Prevention):** Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients IHS-All	11%	28%	28%	41%	41%	47%	47%
11	Tribally Operated Health Programs	11%	27%	27%	37%	37%	41%	41%

In FY 2008 the target for this measure was met and exceeded. In FY 2008 the proportion of women screened for alcohol to prevent Fetal Alcohol Syndrome (FAS) increased by 6 percentage points, from 41% in FY 2007 to 47% in FY 2008. This measure has seen significant increases in results since FY 2005, due to increased provider awareness, and an agency emphasis on behavioral health screening. The FY 2009 target for this measure is to maintain the FY 2008 result of 47%. Alcohol Screening is a lower-cost screening measure with potential high return on investment.

Heavy drinking during pregnancy can cause significant birth defects, including FAS. FAS is the leading known, and preventable, cause of mental retardation. Rates of FAS are higher among American Indians and Alaska Natives than the general population. Screening with intervention has been shown to be effective in reducing alcohol misuse in pregnancy and to reduce the incidence of FAS. Continued increases in screening rates for this measure will have a significant impact on AI/AN communities.

This program contributes to the Hospital and Health Clinics (H&HC) measures listed above.

Contract Health Service

This program contributes to the Hospital and Health Clinics (H&HC) measures listed above.

Special Diabetes Program for Indians

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Reduce the number of Years of Potential Life Lost (YPLL) due to diabetes.								
	Diabetes: A1c Measured[1]: Proportion of patients who have had an A1c test IHS-All	78%	79%	N/A	79%	N/A	79%	N/A
	Tribally Operated Health Programs	76%	77%	N/A	77%	N/A	76%	N/A
1	**Diabetes: Poor Glycemic Control:** Proportion of patients with diagnosed diabetes that have poor glycemic control (A1c > 9.5) IHS-All[2]	18/15%	18/16%	18/15%	19/16%	19/16%	18/17%	19/18%
1	Tribally Operated Health Programs	12%	13%	12%	13%	13%	14%	15%

[1]*There is no measure or goal; this information is provided for context.*
[2]*First figure in results column is Diabetes audit data; second is CRS.*

There is no target for the Diabetes: A1c Measured measure; results are provided for context only. The FY 2008 CRS target for Diabetes: Poor Glycemic Control was not met. In FY 2008, the proportion of patients with diabetes with poor glycemic control (A1c>9.5) was 17%, an increase of one percentage point over FY 2007 results. The FY 2008 Audit target of 19% was met and exceeded. In FY 2008, 18% of patients diagnosed with diabetes in the Diabetes Audit had poor glycemic control. CRS and Audit data are based on different collection methods and exclusion criteria. The FY 2009 CRS target is 18%, a relative 6% decrease from the FY 2008 result. The Audit target is 19%. The target reflects the challenges of reducing the proportion of patients with poor glycemic control, given that it is a high-cost measure, which requires frequent medical visits, medications, and laboratory testing. Reducing the number of poorly controlled diabetics is strongly associated with decreasing the incidence of costly diabetic complications and mortality.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase the percentage of patients with diagnosed diabetes with ideal glycemic control.								

2	**Diabetes: Ideal Glycemic Control:** Proportion of patients with diagnosed diabetes with ideal glycemic control (A1c <7.0) IHS-All[1]	36/30%	37/31%	37/32%	38/31%	38/31%	39/32%	38/30%
2	Tribally Operated Health Programs	33%	33%	33%	33%	33%	34%	32%

[1]*First figure in results column is Diabetes audit data; second is CRS.*

The FY 2008 CRS target for Diabetes: Ideal Glycemic Control was met and exceeded. In FY 2008, the proportion of patients with diabetes with ideal glycemic control was 32%, an increase of one percentage point over FY 2007 results. The FY 2008 Audit target of 38% was also met and exceeded by one percentage point. In FY 2008, 39 percent of patients diagnosed with diabetes in the Diabetes Audit had ideal glycemic control. CRS and Audit data are based on different collection methods and exclusion criteria. The FY 2009 CRS target is 30%, a relative 6% decrease from the FY 2008 result. The Audit target is 38%. The targets reflect the fact that this is a high-cost measure, which requires frequent medical visits, medications, and laboratory testing.

The Special Diabetes Program for Indians has demonstrated positive outcomes showing steady improvements, quantitatively and qualitatively, over the past four years. By increasing the number of diabetics in ideal glycemic control, complications of diabetes are reduced, thus improving the health status of the AI/AN population.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase the proportion of patients with diagnosed diabetes with ideal blood pressure control.								
3	**Diabetes: Blood Pressure Control:** Proportion of patients with diagnosed diabetes that have blood pressure control (<130/80) IHS-All[1]	36/37%	38/37%	38/37%	38/39%	38/39%	36/38%	38/36%
3	Tribally Operated Health Programs	36%	37%	37%	38%	38%	36%	34%

[1]*First figure in results column is Diabetes audit data; second is CRS.*

The FY 2008 CRS target for Diabetes: Blood Pressure Control was not met. In FY 2008, the proportion of patients with diabetes with blood pressure control was 38%, a decrease of one percentage point from FY 2007 results. The FY 2008 Audit target of 39% was also not met. In FY 2008, 36% of patients diagnosed with diabetes in the Diabetes Audit had blood pressure control. CRS and Audit data are based on different collection methods and exclusion criteria. The FY 2009 CRS target is 36%, a relative 6% decrease from the FY 2008 result. The Audit target is 38%. The FY 2008 result and FY 2009 target reflects the fact that this is a high-cost measure,

which requires frequent medical visits, multiple medications, patient compliance, lifestyle adaptation, laboratory testing and monitoring.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase the proportion of patients with diagnosed diabetes who have been assessed for dyslipidemia (LDL cholesterol).								
4	**Diabetes: Dyslipidemia Assessment:** Proportion of patients with diagnosed diabetes assessed for dyslipidemia (LDL cholesterol) IHS-All[1]	70/53%	73/60%	76/60%	74/61%	74/61%	75/63%	74/60%
4	Tribally Operated Health Programs	48%	58%	58%	58%	58%	61%	58%

[1]*First figure in results column is Diabetes audit data; second is CRS.*

The FY 2008 CRS target for Diabetes: LDL Assessed was met and exceeded. In FY 2008, the proportion of patients with diabetes with LDL assessed was 63%, an increase of two percentage points over FY 2007 results. The FY 2008 Audit target of 74% was also met and exceeded. In FY 2008, 75 percent of patients diagnosed with diabetes in the Diabetes Audit had their LDL assessed. CRS and Audit data are based on different collection methods and exclusion criteria. The FY 2009 CRS target is 60%, a relative 5% decrease from the FY 2008 result. The Audit target is 74%. The targets reflect the challenges of assessing LDL, which is a high-cost measure requiring frequent medical visits and laboratory testing.

PREVENTIVE HEALTH: Public Health Nursing, Health Education, Community Health Representatives, and Immunization Alaska.

Public Health Nursing

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Decrease Years of Potential Life Lost (YPLL) in the AI/AN population.								

23	**Public Health Nursing[1]:** Implement a data system capable of recording the nature of public health activities with an emphasis on activities that serve groups or the entire community	438,376	Data System	Baseline	427,700	449,085	415,945	427,700

[1]*Prior to FY 2006 this measure tracked the number of public health nursing services (primary and secondary treatment and preventive services) provided by public health nursing.*

The FY 2008 target for this measure was not met. The target was to increase the number of public health activities recorded within the Public Health Nursing data system by 5%, from the baseline of 427,700 set in FY 2007, to 449,085 in FY 2008. The program recorded 415,945 encounters for FY 2008. In FY 2009, the target is to increase the rate by 2.8 percent to 427,700. PHN clinical activities will continue to focus on and address health disparities, and at the same time provide access to health care services in the community. This myriad of activities contributes towards an overall improvement in health outcomes in the AI/AN population.

This measure is dependent on funding and vacancy rates for PHNs and involved travel outside clinics. Rising fuel and transportation costs force programs to curtail outreach activities. The FY 2009 target will be to increase the rate by approximately 3%, yet it is difficult to predict whether increasing costs to programs will allow them to improve the rate in FY 2009.

This program contributes to the Hospital and Health Clinics (H&HC) measures listed above.

Health Education

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Decrease Years of Potential Life Lost (YPLL) in the AI/AN population.								
32	**Tobacco Cessation Intervention[1]:** Proportion of tobacco-using patients that receive tobacco cessation intervention IHS-All	34%	12%	12%	16%	16%	21%	21%
32	Tribally Operated Health Programs	34%	10%	10%	12%	12%	17%	17%

[1]*In FY 2005 this measure tracked the proportion of patients ages 5 and above who are screened for tobacco use.*

The FY 2008 target for this measure was met and exceeded. In FY 2008, 21 percent of tobacco—using patients received tobacco cessation intervention, exceeding the target by 5 percentage points. The increase is due to growing provider awareness of the measure, and improved data

entry for patient education and counseling. In FY 2004 and FY 2005, this measure tracked the number of patients screened for tobacco use. In FY 2006 the focus of the measure changed from screening the number of users to intervening in order to reduce the number of smokers. The FY 2009 target is to maintain the FY 2008 result of 21%.

The use of tobacco represents the second largest cause of preventable deaths for American Indian and Alaska Native people. Lung cancer is the leading cause of cancer death among AI/ANs. Cardiovascular disease is the leading cause of death among AI/ANs, and tobacco use is a significant risk factor for this disease. Increasing the number of patients receiving tobacco cessation intervention will reduce the number of patients who smoke, contributing to a reduction in death and disease.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Decrease Years of Potential Life Lost (YPLL) in the AI/AN population.								
30	**CVD Comprehensive Assessment[1]:** Proportion of at risk patients who have a comprehensive assessment for all CVD-related risk factors IHS-All	43%	48%	Baseline	30%	30%	30%	30%
30	Tribally Operated Health Programs	N/A	N/A	Baseline	24%	24%	25%	25%

[1]*In FY 2005 and FY 2006, this measure tracked the proportion of patients ages 23 and older who receive blood cholesterol screening. Prior to FY 2005 measure was: Number of community-directed pilot cardiovascular disease (CVD) prevention programs. In FY 2007, this measure was changed to track the proportion of patients with IHD who were assessed for five CVD-related risk factors.*

The FY 2008 target for this measure was met. In FY 2008, 30% of at risk patients had a comprehensive assessment for five CVD-related risk factors (Blood Pressure control, LDL assessed, tobacco cessation, lifestyle counseling, and BMI assessed), maintaining the FY 2007 rate. In FY 2005 and FY 2006 this measure tracked proportion of patients ages 23 and older who received blood cholesterol screening. The FY 2009 target is to maintain the FY 2008 result of 30%.

Agency initiatives, such as the Chronic Care initiative, assist in promoting overall CVD prevention and case management Assuring that patients are appropriately screened for risk factors and receiving patient education is essential given the increasing rates of cardiovascular disease in the AI/AN population..

This program contributes to the Hospital and Health Clinics (H&HC) measures listed above.

Community Health Representatives

This program contributes to the Hospital and Health Clinics (H&HC) measures listed above.

Immunization Alaska

This program contributes to the Hospital and Health Clinics (H&HC) measures listed above.

Urban Indian Health Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
UIHP-4	Increase the number of sites utilizing an electronic reporting system	N/A	9 sites	+6 sites	+9 sites	+7 sites	+6	+5 sites
UIHP-E	Cost per service user in dollars per year	776	737	767	1/2008	805	7/2009	845

The FY 2008 target for this measure was to increase the number of sites that are utilizing an electronic reporting system by 7 sites. The result was 6 sites. The system provides integrated patient care into a single automated data processing system that collects and stores a core set of health and management data that cuts across disciplines and facilities. This system will assist urban healthcare professionals in providing the type of care that addresses all of a patient's known health problems and preventive health needs. Funded RPMS and site manager training as well as Area level information technology funding for equipment and support contributed to this success. The FY 2009 performance target is to establish RPMS in 5 additional urban programs.

FY 2008 performance data for the UIHP-E measure has not yet been reported. Cost per service user was relatively stable from FY 2005 to FY 2006. The FY 2007 target was to achieve a cost per service user of $767 and the FY 2008 target was to achieve a cost per service user of $805, reflecting the rising cost of providing medical care. FY 2007 and 2008 results have not been reported. The FY 2009 target is to achieve a cost per service user of $845.

Indian Health Professions

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase the number of scholarship placements within 90 days of graduation.								

42	**Scholarships:** Proportion of Health Professional Scholarship recipients placed in Indian health settings within 90 days of graduation	30%	37%	42%	47%	52%	61%	69%

The FY 2008 target for this measure was met and exceeded by 9 percent. The placement rate increased significantly more than expected as a result of increased communication between the scholars and their scholarship coordinators and clinical programs, as well as improvements with the scholar tracking system. Over the past four years, the placement rate has been steadily increasing, from 30 percent in 2005 to 61 percent in 2008. The FY 2009 target is to achieve a placement rate of 69%.

Improving the placement rate of scholarship recipients has a major impact on meeting the staffing needs at hard-to-fill sites and helping to address high vacancy rates for dentists, nurses, and dentists. Filling these vacancies will help improve the health care delivery system at I/T/U facilities.

This program contributes to the Hospital and Health Clinics (H&HC) measures listed above.

CRITICAL MANAGEMENT & PERFORMANCE INFRASTRUCTURE: Tribal Management, Direct Operations, Self-Governance, Contract Support Costs.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
TOHP-1	Percentage of TOHP clinical user population included in GPRA data	74%[1]	77%	78%	76%	76%	73%	74%

[1] *Results not comparable to subsequent years; new methodology for changes in data collection and analysis; adjusted targets are at the same incremental increase for performance.*

The FY 2008 target for this measure was not met. The FY 2008 target for this measure is to maintain the percentage of the Tribally Operated Health Programs (TOHP) clinical user population included in GPRA data at the FY 2007 rate of 76 percent. The program achieved a rate of 73 percent. The FY 2009 target is 74 percent.

In FY 2008, non-RPMS data systems were introduced at additional locations. Standards for data integration are being developed for new data systems so that targets for this measure can be maintained.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
TOHP-E	**Tribally Operated Health Programs:** Hospital admissions per 100,000 diabetics per year for long-term complications of diabetes	165.1	149.7	161.8	9/2009	146.7	9/2010	146.7

The FY 2008 target for this measure is to achieve a rate for hospital admissions of 146.7 per 100,000 diabetics per year for long term complications of diabetes; it will not be reported on until September 2010. There is a two-year reporting lag for this measure and data now available for FY 2005 and FY 2006 show a decrease in the rate. Further trend analysis will be available after FY 2007 and FY 2008 results are available. The FY 2009 target is to achieve a rate of 146.7. This measure is designed to demonstrate the overall effectiveness of diabetes management by documenting the reductions in costly in-patient care, which indirectly reflects improved patient care efficiency in the face of increasing rates of diabetes in the AI/AN population.

FACILITIES: Sanitation Facilities Construction, Healthcare Facilities Construction.

Sanitation Facilities Construction (SFC)

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective 1: Increase the number of American Indian/Alaska Native (AI/AN) homes provided with sanitation facilities.								
(35) SFC-1	**Sanitation Improvement:** Number of new or like-new and existing AI/AN homes provided with sanitation facilities	24,072	24,090	23,000	21,819	21,800	21,811	21,500
(35A) SFC-2	Percent of existing homes served by the program at Deficiency Level 4 or above as defined by 25 USC 1632	38%	35%	35%	45%	35%	42%	40%

The FY 2008 targets for both SFC measures were met and exceeded. In FY 2008, 21,811 homes were provided with sanitation (water, sewage disposal, and/or solid waste water) facilities; the target was 21,800 homes. The FY 2009 target will be 21,500 homes. The target reflects the challenge of providing homes with sanitation facilities given the need for adjustments for inflation. Since the program funds projects using a priority system that balances cost with health need and tribal wishes, the more cost-effective projects are more likely to be funded first, leaving more expensive projects for future funding. Population served is also based on the aggregation of projects funded in partnership with other agencies, and funding from other agencies has been reduced.

The FY 2008 target of achieving 35 percent of existing homes served by the program was met and exceeded. The FY 2008 rate was 42 percent. The FY 2009 targets are to achieve a rate of 40 percent. The target reflects the challenge of providing homes with sanitation facilities given that the projects chosen for funding are chosen through a priority system that balances cost with health need and tribal wishes. The projects with the highest health need or deficiency level are typically more costly to construct and do not always rank as the highest priority.

SFC projects provide resources for building and sustaining healthy communities through disease prevention; achieving parity in access by attempting to increase the number of AI/AN homes with potable water to 94 percent by 2015; providing compassionate quality health care through the provision of sanitation; and embracing innovation through prevention activities and increased partnerships with other federal agencies, states and tribes. These facilities will provide safe drinking water supplies and adequate waste disposal facilities that are essential preconditions for most health promotion and disease preventions efforts, as well as being a major factor in the quality of life of Indian people.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
SFC-E	Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion	3.8 yrs	3.6 yrs	3.9 yrs	4.13	4.0 yrs	4/2009	4.1 yrs

This efficiency measure will not have a FY 2008 result until April 2009. Previous trends show a slight decrease in the average project duration from the Project Memorandum of Agreement execution to construction completion from 3.8 yrs FY 2005 to 3.6 yrs in FY 2006, but an increase to 4.13 in FY 2007. The FY 2008 target is to attain a project duration of 4.0 years and the FY 2009 target is to attain a project duration of 4.1 years. Program strategies have been implemented to ensure these projected targets are maintained at a minimum. Any reduction in the length of time a project takes to complete will yield cost savings in both construction inflation costs and project related staffing costs, allowing the program to provide more services to more homes, thus improving water quality and sanitation facilities for the population served.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase the percentage of American Indian/Alaska Native (AI/AN) homes with sanitation facilities.								
SFC-3	Percentage of AI/AN homes with sanitation facilities[1]	N/A	88%	N/A	89%	N/A	90%	N/A

[1]Long Term Measure; no targets until 2010.

This long term measure does not have associated targets until 2010. The FY 2010 target is 90 percent. The percent of AI/AN homes with sanitation facilities has increased slightly, by 1 percent, from 89 percent in FY 2007 to 90 percent in FY 2008.

Healthcare Facilities Construction (HCFC)

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
36	**Health Care Facility Construction:** Number of health care facilities construction projects completed	4/[1]	3[1]	2	3	0	N/A	1

[1]Target and result numbers reflect the number of construction projects being tracked for performance purposes. However, because the projects vary dramatically in terms of complexity, cost, and timeline, these numerical targets alone do not provide a meaningful picture of the work represented by this measure. A complete list of projects for any given year is available upon request.

The FY 2008 target for this measure was reduced to zero, as a result of projects either being completed ahead of schedule or delayed due to Tribal contract negotiations. . In FY 2009 the target will be to complete the 1 construction project delayed in FY 2008. The project originally planned for completion in FY 2009 is now scheduled for completion in FY 2010 due to a delay for contract negotiations.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
HCFC-E	**Health Care Facilities Construction:** Percent of health care facilities construction projects completed on time	80%	100%	100%	100%	100%	N/A	100%

The efficiency measure for the IHS Health Care Facility Construction program is the percent of health care facilities construction projects completed on time. For 2008, however, projects initially scheduled for completion were either completed early or delayed because of Tribal contract negotiations. The FY 2009 target is to attain a rate of 100 percent. The program will continue to implement strategies that have previously proven successful to meet the FY 2009 target. Facility construction projects completed in a timely manner contribute towards increased access to health services and improved health outcomes.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase proportion of patients with diagnosed diabetes with ideal blood sugar control (A1c<7) within 7 years of opening a new facility Reduce the YPLL rate within 7 years of opening a new facility.								
HCFC-1	**Diabetes: Ideal Glycemic Control:** Proportion of patients with diagnosed diabetes with ideal glycemic control[1]	32/47	30/58	30	33/73	33	31/88	30
		N/A	42/23	44	43/34	43	44/43	43
		N/A	29/16	30	32/30	32	27/224	26
		N/A	N/A	15	38/24	38	40/30	39
		24	N/A	24	23/28	23	29/41	28
		N/A	N/A	21	41/35	41	31/37	30
HCFC-2	**Pap Smear Rates:** Proportion of eligible women who have had a Pap screen within the previous three years	65/41	62/43	62	61/47	61	63/51	62
		N/A	36/25	37	38/24	38	39/24	38
		N/A	55/14	56	56/15	56	45/242	44
		N/A	N/A	58	60/2	60	61/5	60
		61	N/A	61	61/10	61	62/10	61
		N/A	N/A	73	72/17	72	81/21	80
HCFC-3	**Mammogram Rates:** Proportion of eligible women who have had mammography screening within the previous two years	41/52	44/60	44	48/77	48	51/93	50
		N/A	47/33	48	49/33	49	47/25	46
		N/A	22/28	23	38/38	38	34/260	33
		N/A	N/A	43	82/8	82	68/17	67
		30	N/A	30	28/21	28	36/27	35
		N/A	N/A	66	62/17	62	89/21	87
HCFC-4	**Alcohol Screening (FAS Prevention):** Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients	3/39	35/39	35	33/39	33	45/39	45
		N/A	29/11	30	69/12	69	74/8	74
		N/A	18/9	19	40/11	40	69/211	69
		N/A	N/A	1	60/4	60	74/7	74
		9	N/A	9	40/9	40	53/7	53
		N/A	N/A	6	67/14	67	65/16	65
HCFC-5	**Combined* immunization rates for AI/AN children patients aged 19-35 months[2]:** Immunization rates for AI/AN children patients aged 19-35 months	79/12	98	98	93	93	95	94
		N/A	100	100	85	85	97	96
		N/A	94	95	74	74	84	83
		N/A	N/A	26	86	86	90	89
		88	N/A	Baseline	84	84	77	76
		N/A	N/A	Baseline	95	95	97	96
HCFC-6	**Adult Immunizations: Influenza:** Influenza	65/66	67/74	67	62/95	62	67/111	66
		N/A	60/23	61	64/26	64	62/35	61
		N/A	58/18	59	68/18	68	58/218	57

	vaccination rates among adult patients age 65 years and older	N/A	N/A	41	72/-6	72	89/-5	88
		69	N/A	69	68/17	68	72/20	71
		N/A	N/A	93	91/24	91	94/32	93

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase proportion of patients with diagnosed diabetes with ideal blood sugar control (A1c<7) within 7 years of opening a new facility. Reduce the YPLL rate within 7 years of opening a new facility.								
HCFC-7	**Adult Immunizations: Pneumovax:** Pneumococcal vaccination rates among adult patients aged 65 years and older	67/66	77/74	77	81/95	81	83/111	82
		N/A	55/23	56	78/26	78	84/35	83
		N/A	52/18	53	75/18	75	81/215	80
		N/A	N/A	42	87/-6	87	100/-5	99
		83	N/A	83	84/17	84	85/20	84
		N/A	N/A	90	97/24	97	96/32	95
HCFC-8	**Tobacco Cessation Intervention[2,3]:** Proportion of tobacco-using patients that receive tobacco cessation intervention	4/38	1	3	1	1	2	2
		N/A	3	5	9	9	25	25
		N/A	13	15	14	14	18	18
		N/A	N/A	Baseline	40	40	18	18
		6	N/A	Baseline	1	1	7	7
		N/A	N/A	Baseline	14	14	24	24

Measures are reported by facility in ascending order (i.e. Facility A, B, C, D, E, F).
[1]First figure in results column is performance measure results; second is increased access from baseline.
[2]Rate changes prior to 2006 are not comparable due to CRS logic changes; increase in access rates could not be calculated.
[3]In FY 2005, this measure tracked the proportion of patients ages 5 and above who are screened for tobacco use

The IHS Health Care Facilities Construction (HCFC) funds are to provide access to a modern health care delivery system with optimum availability of functional, well-maintained IHS and tribally operated health care facilities. New facility construction should improve clinical quality and increase access to the health care. These services are necessary to maintain and promote the health status and overall quality of life for the residents of the communities that surround the new healthcare facility.

The group of measures above outline clinical performance and access to care for eight clinical performance topics and include: Diabetes Glycemic control, Cancer Screening (breast and cervical), Alcohol Screening to prevent Fetal Alcohol Syndrome, Tobacco Cessation, and Immunizations (childhood and adult). Overall trends for these measures show moderate improvement but variations across facilities and across measures were noted. The high cost of glycemic control, cancer screenings, and tobacco cessation measures account for some of the variation in results across measures. In addition, increases in access to care (i.e. service population) have been observed for all measures and are not unique to one individual facility. Due to the inflation of the service population, clinical results can have an artificial appearance of declining performance. In other words, increases in the denominator (or growth of the service population) can dilute the true performance result (i.e. the overall number of patients being served has increased). All in all, the biggest attribute noted for these performance measures are the vast gains in access to quality healthcare across all topic areas outlined above.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Increase proportion of patients with diagnosed diabetes with ideal blood sugar control (A1c<7) within 7 years of opening a new facility. Reduce the YPLL rate within 7 years of opening a new facility.								
HCFC-9	Percent reduction of the YPLL rate within 7 years of opening the new facility[1]	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HCFC-10	Percent increase in the proportion of diagnosed diabetics demonstrating ideal blood sugar control within 7 years of opening the new facility[1]	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[1]*Long Term Measure; HCFC – 9 and HCFC – 10 will be reported in 2010.*

Because this is a long term measure, prior results are not yet available for the percent reduction of YPLL within 7 years of opening a new facility (HCFC – 9) or the percent increase in the proportion of diagnosed diabetics demonstrating ideal blood sugar control within 7 years of opening a new facility (HCFC – 10). The results for these measures will be reported for HCFC - 9 and HCFC – 10 in January and October of 2010, respectively.

CRITICAL MAINTENANCE, MANAGEMENT, & PERFORMANCE INFRASTRUCTURE: M&I, Equipment, Facilities & Environmental Health Support.

Facilities & Environmental Health Support

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective 1: Decrease YPLL from the 2002 level.								
27	**Injury Intervention**: Occupant protection restraint use	37	Web System Implemented	3 projects per Area	3 projects/12 Areas	Survey/11 Areas	Survey/11 Areas	1 Pilot/ Area

The FY 2008 target for this measure was met. The measure changed in FY 2008 to Injury Intervention: Occupant protection restraint use (which refers to the use of motor vehicle occupant protection e.g., seatbelts). The target for FY 2008 was for 11 Areas to administer an occupant-protection survey, which collected data on rate of seatbelt use in a community. Identifying baseline seatbelt use rates is important because it will provide a rate to compare to once an intervention has been implemented. This allows us to measure the effectiveness of an

intervention. This measure has had considerable success in the past at meeting targets. The FY 2007 target was to implement three community injury prevention projects and report them using an automated tracking system. In FY 2009, the measure is to conduct 1 pilot program implementing a comprehensive intervention designed to increase restraint use in each of 11 Areas.

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 PB Target
Long-Term Objective: Provide quality health information for decision making to patients, providers and communities through improved information systems.								
34	**Environmental Surveillance:** Number of environmental health programs with automated web-based environmental health surveillance data collection system (webEHRS)	12	20	29	32	Baseline	Baseline established in 12 Areas	3 Interventions / Area

The measure changed in FY 2008 to establish a baseline of common environmental risk factors in communities in 11 IHS Areas. Identifying baseline incidence or rates of risk factors is important because it will provide a number or rate to compare to after an intervention is implemented. This allows us to measure the effectiveness of an intervention. The previous measure tracked the number of environmental health programs using a web-based environmental health data surveillance system (WebEHRS); that system is now in wide use. The FY 2009 target is for each Area to implement at least three interventions to address one of the environmental risk factors identified in FY 2008.

Link to HHS Strategic Plan

The entire IHS budget and all performance measures support the HHS strategic goals and objectives. In particular, the mission and function of IHS supports seven of the HHS Strategic Objectives: to eliminate racial and ethnic health disparities, and to increase access to health services for American Indians and Alaska Natives.

- 1.2 Increase health care service availability and accessibility.
- 1.3 Improve health care quality, safety, cost and value.
- 1.4 Recruit, develop and retain a competent health care workforce.
- 2.1 Prevent the spread of infectious diseases.
- 2.2 Protect the public against injuries and environmental threats.
- 2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors, and recovery.
- 2.4 Prepare for and respond to natural and manmade disasters.

These objectives are also supported by the following IHS Strategic Goals:

- Build and sustain healthy communities;
- Provide accessible, quality health care; and
- Foster collaboration and innovation across the Indian health network.

The Department-wide and IHS Strategic Plans provide the framework for carrying out the Federal commitment to raising the health status of American Indians and Alaska Natives. IHS accomplishes these goals through the provision of clinical and preventive health services, public health initiatives, health education, and the support of Tribal self-determination in the administration of health programs.

HHS Strategic Goals	IHS Strategic Goals: Build and sustain healthy communities	IHS Strategic Goals: Provide accessible quality health care	IHS Strategic Goals: Foster collaboration and innovation across the Indian health network
Goal 1: Improve the safety, quality, affordability, and accessibility **of** health care, including behavioral health and long-term care.			
1.1 Broaden health insurance and long-term care coverage		X	
1.2 Increase health care service availability and accessibility		X	X
1.3 Improve health care quality, safety, cost, and value		X	X
1.4 Recruit, develop, and retain a competent health care workforce		X	X
Goal 2: Prevent and control disease, injury, illness, and disability across the lifespan, and protect the public from infectious, occupational, environmental, and terrorist threats.			
2.1 Prevent the spread of infectious diseases	X	X	
2.2 Protect the public against injuries and environmental threats	X	X	
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors, and recovery	X	X	X
2.4 Prepare for and respond to natural and manmade disasters	X	X	
Goal 3: Promote the economic and social well-being of individuals, families, and communities.			
3.1 Promote the economic independence and social well-being of individuals and families across the lifespan			X
3.2 Protect the safety and foster the well-being of children and youth	X	X	
3.3 Encourage the development of strong, healthy, and supportive communities	X		X
3.4 Address the needs, strengths, and abilities of vulnerable populations	X		X
Goal 4: Advance scientific and biomedical research and development related to human services.			
4.1 Strengthen the pool of qualified health and behavioral science researchers	X		X
4.2 Increase basic scientific knowledge to improve human health and human development			
4.3 Conduct and oversee applied research to improve health and well-being			X
4.4 Communicate and transfer research results into clinical, public health, and human service practice		X	X

List of Program Evaluations

Report Title: Ten Year Follow-Up Evaluation: White Earth Health Center
Agency Sponsor: IHS, Indian Health Service
Federal Contact: Lucie Vogel, 301-443-1133
Performer: Staff; Indian Health Service
PIC ID: 8920

To review the implementation of a new IHS health care facility and its impact on patient health status, service delivery and the community

The Indian Health Service Division of Planning, Evaluation and Research initiated a ten year evaluation of the White Earth Health Center built in 1998. This first effort at long term follow-up sought to identify information and establish tools for evaluation building on the model of the Post Occupancy Evaluation and extending its breadth and timeframe. In addition to findings on the impact of the new health center, the report included recommendations for planning and implementing new health service facilities and guidelines for future evaluation studies. The study team included regional and headquarters staff with expertise in clinical services, facility planning, statistical analysis, epidemiology, and organization development. The team used a combination of qualitative and quantitative methods including reviewing of original planning documents and recent plans; analysis of IHS and other are data on new registrants, user population, outpatient and primary provider visits, service use rates and mortality statistics pre and post construction where available; review of center operations and satisfaction reports; analysis of an in-house written survey; on-site observation and interviews; and telephone interviews. Data gathered for the report suggests that the White Earth Center has had an impact on many areas including a significant increase in patient workload, more services available, improved health outcomes, increased staff, additions to the physical structure, increased revenues and increased investment and infrastructure. Recommendations from the study address administrative needs at new health centers, the planning process for new facilities and guidelines for future long term evaluation studies.

Data Source and Validation Table Template

Measure Unique Identifier	Data Source	Data Validation
1, 2 , 3, 4, 5	Clinical Reporting System (CRS); yearly Diabetes care and outcome audit	Comparison of CRS and audit results; CRS software testing; quality assurance review of site submissions
6, 7, 8, 9	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions
10	Youth Regional Treatment Center reports	Review by Division of Behavioral Health
11, 12, 13, 14, 16	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions
17	Clinical Reporting System (CRS)	CRS software testing
18	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions
20	Reports from hospitals and clinics	JCAHO and AAAHC web sites
21	WebCident patient safety adverse event reporting system deployment records	Adverse event report submissions and program site reviews
23	Extraction of data from Resource and Patient Management System	Data verification by Public Health Nursing
24, 25, 26	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions; Immunization program reviews
27	OEHE Environmental Health Program automated tracking system	Environmental Health Program reviews
28	National Center on Vital Health Statistics	IHS Division of Program Statistics
29	Extraction of data from Resource and Patient Management System (RPMS)	Division of Behavioral Health reviews
30, 31, 32, 33	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions
34	Web-based Environmental Health Reporting System (WebEHRS)	Environmental Health Program site inspections
35, 35A	SFC Sanitation Deficiency System (SDS) and Project Data System	Sanitation Facilities Construction Program site inspections
36,	Health Facilities Construction Project Data System	Health Facilities Construction Program site inspections
42	Scholarship program data system	Clinic employment records
FAA-1	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions
FAA-2	IHS service population data; 2000 Census bridged-race file; Mortality data from CDC National Center for Health Statistics	IHS Division of Program Statistics
FAA-3	National Center on Vital Health Statistics	IHS Division of Program Statistics

Measure Unique Identifier	Data Source	Data Validation
FAA-4	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions
FAA-5	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions
FAA-E	National Health Disparities Report	IHS Division of Program Statistics
HCFC -1, 2, 3, 4, 5, 6, 7, 8, 10	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions
HCFC-9	2000 /Census bridged-race file; mortality data from CDC National Center for Health Statistics	IHS Division of Program Statistics review
HCFC-E	SFC Sanitation Deficiency System (SDS) and Project Data System	Sanitation Facilities Construction Program site inspections
RPMS-1, 2, 3	RPMS data; Office of Information Technology (OIT) records	RPMS software; OIT program reviews
RPMS-E	Clinical Reporting System (CRS)	CRS software testing
SFC-1, 2, 3, E	SFC Sanitation Deficiency System (SDS) and Project Data System	Sanitation Facilities Construction Program site inspections
TOHP-1	IHS Service Population data	Area planners and statisticians
TOHP-2, 3	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions
TOHP-4	2000 Census bridged-race file; mortality data from CDC National Center for Health Statistics	IHS Division of Program Statistics
TOHP-E	National Health Disparities Report	IHS Division of Program Statistics
UIHP-1	2000 Census bridged-race file; mortality data from CDC National Center for Health Statistics	IHS Division of Program Statistics
UIHP-2	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions
UIHP-3	Clinical Reporting System (CRS)	CRS software testing; quality assurance review of site submissions
UIHP-4	RPMS data; Office of Information Technology (OIT) records	RPMS software; OIT program reviews
UIHP-E	-Uniform Data System (UDS)	Office of Urban Programs

Discontinued Performance Measures Table

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Result	FY 2009 Target
RPMS -1	Develop comprehensive electronic health record (EHR) with clinical guidelines for select chronic diseases	Met	Met	Maintain All	Met	Comp-rehensive EHR	Met	Eliminate
RPMS -3	Number of sites to which electronic health record is deployed	20	40	40	50	All	All	Eliminate