Online Performance Appendix - Indian Health Service

Introduction

The Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS') performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through HHS agencies' FY 2009 Congressional Justifications and Online Performance Appendices, the Agency Financial Report and the HHS Performance Highlights. These documents can be found at: http://www.hhs.gov/budget/docbudget.htm and http://www.hhs.gov/afr/.

The Performance Highlights briefly summarizes key past and planned performance and financial information. The Agency Financial Report provides fiscal and high-level performance results. The FY 2009 Department's Congressional Justifications fully integrate HHS' FY 2007 Annual Performance Report and FY 2009 Annual Performance Plan into its various volumes. The Congressional Justifications are supplemented by the Online Performance Appendices. Where the Justifications focus on key performance measures and summarize program results, the Appendices provide performance information that is more detailed for all HHS measures.

This ***Indian Health Service*** Congressional Justification and Online Performance Appendix can be found at http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/bf_cong_justifications.asp.

Summary of Measures and Results Table

FY	Total Targets	Results Reported		Targets			
		Number	%	Met	Not Met		% Met
					Total	Improved	
2004	39	38	97%	28[1]	10		74%
2005	35[2]	34	97%	29	5	1	85%
2006	34[3]	33	97%	27	6	1	82%
2007	51[4]	47	92%	39	8[5]	0	83%
2008	52						
2009	47						

[1] Results of one measure revised from Not Met to Met in May 2005 based on provision of additional data.
[2] 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.
[3] Total measures in 2006 were reduced by 1 from the 2008 CJ due to the Sanitation Improvement measure change from two distinct measures into a combined measure.
[4] 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).
[5] HCFC measures 1-8 were considered not met if <67% of the facilities reporting for that measure met their target.

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

Summary Table

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

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
21/ RPMS – E	**Patient Safety[1]:** Development and deployment of patient safety measurement system.	4 Areas	All Areas	3 Areas	3 Areas	7 Sites	64 Sites	74 Sites	84 Sites

[1]In FY 2006 this measure tracked the number of Areas with a medical error reporting system. Prior to FY 2006, this measure tracked the number of Areas with a medication error reporting system.

The FY 2007 target for this measure was met and exceeded. In FY 2007, the IHS developed and deployed a patient safety measurement system at 64 sites; the FY 2007 target was 7 sites. This measure replaced the previous related measures of first implementing a medication error reporting system, followed by a 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 2008 and FY 2009 targets are to implement the system at 10 more sites per year, increasing to 74 and 84 sites respectively.

- Reason for Performance Result: 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, 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. All of these factors contributed to a much higher than anticipated initial deployment rate.
- Steps Being Taken to Better Match Targets with Program Performance: None at this time. IHS does not believe that it will be able to support continued deployment at the initial rate. IHS has adjusted targets for FY 2008 and FY 2009 to include all major facilities in the system.
- Impact of Result: Faster deployment of this system will improve patient safety and result in cost savings to sites by tracking adverse incidents in a systematic way that will allow them to be addressed more quickly. Also 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 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
TOHP -4	Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) populations served by tribal health programs[1,2]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Jan/2015 55.3

[1]Long Term Measure; reportable in 2015 for FY 2012. The FY 2012 target is 55.3.
[2]Three year rate centered on mid-year

This measure is long term and as such does not have annual targets. YPLL data is not available for three years and is reported four years later as the midyear of a three-year rate. FY 2003 data is the most current available, with a rate of 62.5 per 100,000 pop. The long term target for this measure is to reduce the Years of Potential Life Lost (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 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
RPMS -2	Derive all clinical measures from RPMS and integrate with EHR[1].	37/12	41/12	38/12	41/12	41/12	41/12	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).*

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. In FY 2007, IHS met this measure by deriving 41 clinical measures from RPMS and integrating EHR in all 12 Areas. The FY 2008 target is to assure that 59 clinical performance measures based on RPMS data can be reported by CRS software and will increase to 61 in FY 2009. Deriving clinical data from RPMS will be a priority for FY 2008 and FY 2009. Increasing the number of medical conditions that can be tracked using 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 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
FAA-2	Years of Potential Life Lost in American Indian/Alaska Native population[1,2]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	62.3

[1]*Long Term Measure; reportable in 2015 for FY 2012. The FY 2012 target is 62.3.*
[2]*Three year rate centered on mid-year.*

This measure is long term and does not have annual targets. YPLL data is calculated as a 3-year average based on mortality data from the CDC and there is a 3 year lag time. The most current data available at this time is for FY 2003 with a rate of 79.2.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out- Year Target
				Target	Actual	Target	Actual			
28	**Unintentional Injury Rates[1]:** Unintentional injuries mortality rate in AI/AN population	Dec/ 2008	Dec/2009	94.8	Dec/ 2010	94.8	Dec/2011	94.8	Changed to Long Term Measure	Dec/2011 694.8
FAA-3	**Unintentional Injury Rates[1]:** Unintentional injuries mortality rate in AI/AN population.	Dec/ 2008	Dec/2009	92.2	Dec/ 2010	92.2	Dec/2011	92.2	Changed to Long Term Measure	Dec/2016 92.2

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

FY 2004 results are not available until December 2008 due to time lags inherent in National mortality statistics. As such, these measures will become long-term measures in FY 2009 The long term 2012 target for unintentional injuries mortality rates for IHS-All is 94.8. The long term 2012 target for IHS Federal 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 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: By 2010, increase to 70% 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]	63%[2]/42%	68%[2]/47%	68%/50%	61%[2]/55%	61%/ Baseline	62%/40%	Baseline/ 40%	Maintain/38%
5	Tribally Operated Health Programs	44%	48%	48%	52%	Baseline	28%	28%	27%

[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 2007 CRS target to establish a new baseline for nephropathy (kidney disease) assessment was met. Forty percent of patients were screened based on the 2006 Diabetes Standards of Care, which require quantitative testing in addition to or instead of the previous screening method. This is a significant change that will ensure patients at risk are accurately identified. This change was adopted following three years of improving rates based on the previous standard. (In 2004 the CRS rate was only 42 percent. By FY 2006 that rate had risen to 55 percent, exceeding the FY 2006 target by 5 percentage points.) Key Tribal involvement, collaboration with other Federal agencies, and community emphasis all contributed to this success. The 2008 performance target is to maintain this performance level. The FY 2009 target is 38 percent.

The diabetes audit target of 61percent for nephropathy was met. The FY 2008 audit target is to establish a new baseline rate, based on adopting the revised Diabetes Standards of Care. The FY 2009 target is to maintain the FY 2008 rate. Audit data is based on different collection methods and exclusion criteria.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 2: 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%	100%

The FY 2007 target to attain 100 percent accreditation of all IHS hospitals and ambulatory clinics was also met. The 100 percent accreditation target has been met consistently over the last four years, which is important since accreditation contributes both directly and indirectly to improve 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 2008 target is to maintain 100% accreditation. During FY 2009, the IHS will maintain 100 percent accreditation of all IHS-operated hospitals and outpatient clinics (excluding tribally operated facilities).

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: By 2010, increase to 70 percent 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	55%	50%	50%/Baseline[1]	52/49%[1]	49%	49%	49%	47%
6	Tribally Operated Health Programs	45%	50%	50%[2]	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 will not be reported separately.*
[2]*FY 2005 results reported to OMB in PART submission are the established baseline for TOHP.*

Past trends for this measure have been consistent over the past four reporting years and have progressed from reporting only on designated demonstrations sites to reporting on all sites in 2006. The IHS-All FY 2007 target for this measure was met. During FY 2007, the proportion of patients with diabetes that received an annual diabetic retinal exam was maintained at 49 percent. The FY 2008 target is to maintain this rate at 49 percent and the FY 2009 target is 47 percent.

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 2008 and FY 2009 will be challenging in the face of increases in diabetes prevalence and the steadily increasing optometry program vacancy rates. The Indian Health Service 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 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2010, increase to 90 percent 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	58%	60%	60%	59%	60%	59%	59%	56%
7	Tribally Operated Health Programs	59%	61%	61%	61%	61%	61%	61%	58%

Past trends for this measure have remained consistently between 58 and 60 percent over the past four reporting years. The IHS-All FY 2007 target for this measure was not met. The FY 2007 the proportion of eligible women who have had a Pap screen within the previous three years was 59 percent, unchanged from FY 2006; the FY 2007 target was to increase this rate to 60 percent. The FY 2008 target is to maintain this rate at 59 percent and the FY 2009 target is 56 percent. 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.

To meet FY 2008 and FY 2009 targets IHS will 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 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: By 2010, increase to 70 percent 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	40%	41%	41%	41%	41%	43%	43%	40%
8	Tribally Operated Health Programs	43%	44%	44%	44%	44%	45%	45%	42%

Past trends for this measure have steadily progress over the past four reporting years. The FY 2007 target for this measure was met and exceeded. In FY 2007, the proportion of eligible women who have had mammography screening within the previous two years was 43 percent, an increase of two percentage points over the FY 2006 rate of 41 percent. The FY 2008 target is to maintain this rate at 43 percent and FY 2009 target is 40 percent. 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 Agency priority.

To meet FY 2008 and FY 2009 targets IHS will 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 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: By 2010, increase to 50 percent 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	N/A	Baseline	22%	22%	26%	26%	24%
9	Tribally Operated Health Programs	N/A	N/A	Baseline	26%	26%	29%	29%	27%

Past trends for this measure are not available since a baseline was recently established in 2006. The FY 2007 target for this measure was met and exceeded. In FY 2007, the proportion of

eligible patients who have had appropriate colorectal cancer screening was 26 percent, an increase of four percentage points above the FY 2006 baseline rate of 22 percent. The target for FY 2008 is to maintain this rate at 26 percent and the FY 2009 target is 24 percent.

- Reason for Performance Result: The target for this measure was set at an approximate level based on the baseline level of performance. A baseline was set to determine the proportion of eligible patients who have had appropriate colorectal cancer screening in FY 2006.
- Steps Being Taken to Better Match Targets with Program Performance: Targets were raised in FY 2008 based on actual performance.
- Impact of Result: 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 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2010, increase childhood combined immunization rates to 80 percent.									
24	**Combined (4:3:1:3:3) immunization rates:** AI/AN children patients aged 19-35 months. IHS - All	81[1]/72%	75%	75%	78/80[2]%	78%	78%	78%	76%
24	Tribally Operated Health Programs	N/A	54%	54%	74%	74%	72%	72%	70%

[1] *Vaccination rates for children ages 3-27 months.*
[2] *Rate reflects National Immunization Report.*

Past trends for this measure have steadily progressed over the past four reporting years. The IHS-All FY 2007 target for this measure was met. In FY 2007, 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 2006. The FY 2008 is to maintain this rate at 78 percent and the FY 2009 target is 76 percent.

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 DTaP, 3 doses of IPV, 1 dose of MMR, 3 doses of Hep B and 3 doses of 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 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target	Out-Year Target
31	**Childhood Weight Control:** Proportion of children, ages 2-5 years, with a BMI of 95 percent or higher. IHS - All	60%[1]	64%[1]	Baseline	24%	24%	24%	24%	n/a	Oct/2010 24%
31	Tribally Operated Health Programs	59%[1]	63%[1]	Baseline	25%	25%	25%	25%	n/a	Oct/2010 25%

[1]Measure tracked the proportion of patients for whom BMI (Body Mass Index) data can be measured.
2 Measure changed to long-term measure in FY 2009. The FY 2010 target is 24 percent for IHS-All and 25 percent for TOHP.

Prior results (< FY 2006) are not comparable to current rates due to measure logic changes. However, the past two years have shown a steady rate of the proportion of children, ages 2 – 5 years, with a Body Mass Index (BMI) of 95 percent or higher. The FY 2007 target was met, and a rate of 24 percent was maintained. In FY 2008 the target is to maintain the FY 2007 rate of 24 percent and in FY 2009 the measure will become a long term measure. The FY 2012 long term target is to maintain the rate at 24 percent.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
FAA-E	Hospital admissions per 100,000 service population for long term complications of diabetes in federally administered facilities[1].	194.3	185.4	183.5	Sep/2008	181.7	Sep/2009	179.9	179.9

[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.

Past trends for this efficiency measure are not available, but the rates in 2004 and 2005 are starting to reflect a steady decline in hospital admissions for long term complications of diabetes. The status for the FY 2007 target of 181.7 is unknown due to the reporting nature of this dataset. In FY 2009, the status of the hospitalization admissions per 100,000 service population for long term complications of diabetes in federally administered activities will be reported. The FY 2008 target is to achieve a rate of 179.9 and maintain that rate in FY 2009. 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.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out- Year Target
				Target	Actual	Target	Actual			
FAA -1	Children ages 2-5 years with a BMI of 95 percent or higher.	N/A	N/A	Base-line	23.2%	23%	24%	24%	Change to long term measure	Dec/2010 24%

Prior results show a slight increase in the proportion of children, ages 2 – 5 years, with a BMI of 95 percent or higher. The FY 2007 target of a 23 percent rate was not met, and a rate of 24 percent was attained. In FY 2008 the target is to maintain the FY 2007 rate of 24 percent. In FY 2009 this measure will become a long term measure. The FY 2012 long term target is to maintain the rate at 24 percent.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: Reduce the Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) populations served by tribal health programs to 55.3 by 2012.									
TOHP-2	Number of designated annual clinical performance goals met.	7/10	11/14	11/13	10/13	13/16	14/16	14/17	14/17

[1]*Long Term Measure; reportable in 2015. The FY 2014 target is 40 percent.*

TOHP-2: Past trends for this measure show a steady increase in the percentage of clinical performance goals met over the past four reporting years. The FY 2007 target for this measure was met. In FY 2007, the number of designated clinical performance goals was 14/16, increasing from FY 2006. The FY 2008 target is to achieve 14/17 and to maintain 14/17 in FY 2009. Meeting the majority of evidence-based clinical performance measures directly contributes the IHS mission of improving the health status of AI/ANs.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out- Year Target
				Target	Actual	Target	Actual			
TOHP-3	Percentage of AI/AN patients with diagnosed diabetes served by tribal health programs that achieve ideal blood sugar control[1].	28.1%	33%	None	33%	N/A	N/A	N/A	N/A	Oct/2014 40%

TOHP-3: Past trends for this measure show a slight increase from FY 2004 to FY 2005. 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. Accomplishing this performance measure has an evidence-based link to reducing the cost of diabetic care while improving health outcomes, in addition to improving the health status of AI/ANs.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 2: By 2010, increase screening rates for intimate partner violence to 40 percent.									
16	**Domestic (Intimate Partner) Violence Screening:** Proportion of women who are screened for domestic violence at health care facilities. IHS-All	14%	13%	14%	28%	28%	36%	36%	36%
16	Tribally Operated Health Programs	5%	9%	10%	24%	24%	30%	30%	30%

Past trends for this measure show stagnant rates through FY 2005 and then a significant increase in FY 2006 and FY 2007, 15 percent and 12 percent respectively. The FY 2007 target for this measure was met. In FY 2007, the proportion of women who are screened for domestic violence at healthcare facilities was 36 percent, significantly improving on the FY 2006 rate of 28 percent. The FY 2008 target is to maintain this rate of 36 percent and to maintain again in FY 2009.

- Reason for Performance Result: The FY 2007 rate of 36 percent significantly exceeded the FY 2007 target of 28 percent. The 12 percent increase is due to a combination of higher (primary) provider awareness of the measure, and improved documentation.
- Steps Being Taken to Better Match Targets with Program Performance: The large increases in screening for this measure were due to provider education on the measure and improved documentation practices. Rates are expected to be stable in FY 2008 and FY 2009.
- Impact of Result: 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 of domestic violence.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 3: By 2010, increase adult influenza and pneumococcal vaccination rates to 90 percent.									
25	Influenza vaccination rates among adult patients aged 65 years and older. IHS-All	54%	59%[1]	59%	58%	59%	59%	59%	58%
25	Tribally Operated Health Programs	53%	54%[1]	54%	53%	54%	55%	55%	54%
26	Pneumococcal vaccination rates among adult patients aged 65 years and older. IHS-All	69%	69%	72%	74%	76%	79%	79%	77%
26	Tribally Operated Health Programs	69%	62%	63%	69%	69%	73%	73%	71%

[1] *Measure on hold in FY 2005 due to influenza vaccine shortage.*

Past trends for the influenza measure show a steady increase in FY 2005 and then a slight increase from FY 2006 to FY 2007, by 1 percent. The FY 2007 target for this measure was met.

In FY 2007, the influenza vaccination rates among adult patients aged 65 years and older was 59 percent. The FY 2008 target is to maintain the FY 2007 rate of 59 percent and to achieve a rate of 58 percent in FY 2009.

Past trends for the Pneumococcal measure show steady increases from FY 2004 to FY 2007. The FY 2007 target for this measure was met. In FY 2007, the Pneumococcal vaccination rates among adult patients aged 65 years and older was 79 percent. The FY 2008 target is to maintain the FY 2007 rate of 79 percent and to achieve a rate of 77 percent in FY 2009.

- Reason for Performance Result: The FY 2007 Pneumococcal vaccinations rate of 79 percent significantly exceeded the FY 2007 target of 74 percent. The 2 percent increase is due to a combination of higher (primary) provider awareness of the measure, improved documentation, and target prevention campaigns for this at-risk population.
- Steps Being Taken to Better Match Targets with Program Performance: Although this is a high cost measure, ambitious targets have been set for FY 2008 at 79 percent. The FY 2009 target is 77 percent.
- Impact of Result: 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 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2010 decrease YPLL by 20 percent over the 2002 level.									
33	**HIV Screening:** Proportion of pregnant women screened for HIV.	Not Met[1]	54%	55%	65%	65%	74%	74%	72%

[1]*Prior to FY 2005, measure was: Screen for HIV infections in high risk groups at designated sites.*

Past trends for this measure show an average increase of 10 percent from FY 2005 to FY 2007. The FY 2007 target for this measure was met. In FY 2007, the proportion of pregnant women screened for HIV was 74 percent, significantly improving on the FY 2006 rate of 65 percent. The FY 2008 target is to maintain the FY 2007 rate of 74 percent and the FY 2009 target is 72 percent.

- Reason for Performance Result: The FY 2007 rate of 74 percent significantly exceeded the FY 2007 target of 65 percent. The 9 percent increase is due to a combination of IHS standard guidelines, higher provider awareness of universal screening recommendations, improved documentation, and targeted interventions. In addition, this screening is a priority and is part of a standard set of laboratory screenings recommended for prenatal patients across the Indian Health Network.
- Steps Being Taken to Better Match Targets with Program Performance: Although this is a high cost measure, an ambitious target has been set for FY 2008 to maintain the FY 2007 rate of 74 percent. The FY 2009 target is 72 percent.
- Impact of 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 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: By FY 2010, reduce the proportion of children ages 2-5 with a BMI of 95 percent or higher by 16 percent.									
FAA-4	Proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed.	N//A	N/A	N/A	N/A	N/A	N/A	Baseline	Maintain

There are no past trends for this measure. The FY 2008 target is to set a baseline for the proportion of infants 2 months old (45-89 days old) that are exclusively or mostly breastfed. The FY 2009 target is to maintain the FY 2008 baseline rate. There is evidence that breastfeeding contributes to improved childhood outcomes in terms of reduced rates of infectious disease and a link to a reduced incidence of Sudden Infant Death Syndrome, and reduced childhood obesity rates.

Dental

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: By 2010, improve the oral health of the AI/AN population.									
12	**Topical Fluorides[1]:** Number of American Indian and Alaska Native patients receiving at least one topical fluoride application**.**	+0.1%	113,324[2]/ 85,318	85,318	95,439	95,439	107,934	107,934	102,537
13	**Dental Access:** Percent of patients who receive dental services.	24%	24%	24%	23%	24%	25%	25%	24%
14	**Dental Sealants[3]:** Number of sealants placed per year in AI/AN patients.	287,158	249,882	249,882	246,645	246,645	245,449	245,449	233,177

[1]*The FY 2005 measure target included both number of applications and number of patients. Prior to FY 2005 this measure calculated increase in number of individuals with access to fluoridated water.*
[2]*The number of topical fluoride **applications**. In 2006, (measure changed to only track number of patients).*
[3]*Data source changed from NPIRS to CRS in FY 2005; the FY 2004 CRS sealant result is 230,295.*

The FY 2007 target for topical fluorides was met and exceeded. In FY 2007 107,934 patients received at least one topical fluoride application. Since FY 2005 the number of patients has increased steadily by about 10,000 patients per year. (Prior to FY 2005 this measure tracked increased access of the AI/AN population to fluoridated water.) The FY 2008 target is to maintain the number of patients receiving at least one topical fluoride application, and the FY 2009 target is to provide fluoride applications to 102,537 patients.

- Reason for performance result: The Dental Clinical and Preventive Support Centers contributed to high achievement. The FY 2007 activities contributing to this measure of the Support Center included coordinating dental referral and recall appointments for expectant

mothers and preschoolers and increasing access through partnership with public/private organizations to provide dental care.

- Steps being taken to better match targets with program performance: The Dental Program adjusted the FY 2008 target upward based on FY 2007 performance. The new target is to maintain the FY 2007 result, providing 107,934 patients with topical fluoride. Because of continuing high dental vacancy rates, a higher projection is not being proposed.
- Impact of result: Higher numbers of patients receiving at least one fluoride application will result in fewer new caries, reducing cost of subsequent dental care and improving oral health.

The FY 2007 target for dental access was met and exceeded by 1 percent. In FY 2007 25 percent of patients received dental care. This increase is an improvement over the previous three years. In FY 2004 and FY 2005 24 percent of patients received dental care, and in FY 2006 the rate dropped to 23 percent. The target for FY 2008 is to maintain the FY 2007 rate of 25 percent. The FY 2009 target is 24 percent.

The FY 2007 target for sealants was not met. In FY 2007 a total of 245,449 sealants were placed in patients. The FY 2007 target was to maintain performance at the FY 2006 performance level of 246,645 sealants. The number of sealants placed has been trending downward since FY 2005, when 249,882 sealants were placed, but the drops have been slight – the program missed the FY 2007 target by just 0.5 percent. (Prior to FY 2005, results were reported from a different data source.) In FY 2008, the Dental program will maintain performance by placing 245,449 sealants. In FY 2009, the program expects to place 233,177 sealants.

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

Mental Health

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: By 2010 decrease YPLL by 20 percent over the 2002 level.									
29	**Suicide Surveillance:** Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals.	Plan[1]	Integrated (Met)[2]	Baseline	1,603	1,603	1,674	1,758	1,846

[1] *In 2004 this indicator committed to implementing the national reporting plan to support national performance management of AI/AN suicide by deploying the suicide reporting form in the BH package.*
[2] *In FY 2005 the target for this measure was to integrate the Behavioral Health suicide reporting tool into RPMS.*

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 FY 2007 target for use of the suicide surveillance form was met and exceeded. 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. In FY 2008 the target is to increase the number of forms prepared to 1,758 and to 1,846 in FY 2009.

- Reasons for performance result: Increased deployment of the Behavioral Health-Management Information System to over 250 clinical sites across the country contributed to a higher than projected use of the form
- Steps being taken to better match targets with program performance: The FY 2008 target has been increased based on the FY 2007 performance results and expected additional deployments in the Aberdeen and Alaska Areas.
- Impact of result: An increased number of forms will 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 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
18	**Behavioral Health[1]:** Proportion of adults ages 18 and over who are screened for depression. IHS-All	+7%[2]	+4%	Baseline	15%	15%	24%	24%	24%
18	Tribally Operated Health Programs	N/A	N/A	Baseline	14%	14%	21%	21%	21%

[1]*Prior to 2006 this measure tracked the number of programs reporting minimum agreed-to behavioral health-related data to warehouse.*
[2]*Revised from 2.3 percent, 5/2005; changes FY 2004 performance from Not Met to Met.*

IHS has only been assessing the depression screening rate since FY 2006, when a baseline rate of 15 percent was established. (In FY 2004 and FY 2005 the measure tracked the number of programs reporting certain behavioral health-related data.) In FY 2007 the target for this measure was exceeded by 9 percentage points. The FY 2008 target is to maintain the screening rate at the FY 2007 level of 24 percent. The FY 2009 target is to maintain the rate at 24 percent, as this is a low cost screening measure with potential high return on investment.

- Reason for performance result: FY 2007 was the first year IHS established a target after a baseline screening rate was set in FY 2006. There was no trend data to reference in setting a target for FY 2007.
- Steps being taken to better match targets with program performance: The FY 2008 target for this measure was increased for FY 2008. The agency will review trends as they develop before making additional adjustments.
- Impact of result: 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.

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

Alcohol and Substance Abuse

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: 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).	+2%	100%	100%	100%	100%	91%	100%	100%

Past trends for results for this program show consistent achievement of a 100 percent accreditation rate for Youth Regional Treatment Centers (YRTC), in operation 18 months or longer. In FY 2007, this measure was not met. An accreditation rate of 91 percent was achieved where 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. In FY 2008 and FY 2009 the target is to achieve and maintain the 100 percent accreditation rate for all YRTC's.

- Reasons for Performance Result: One facility failed to be accredited in FY 2007 causing a decrease from 100 percent to 91 percent. 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.
- Steps being Taken to Better Match Targets with Program Performance: The FY 2007 target for this measure, to maintain a 100 percent accreditation rate, is quite reasonable and will be continued through to FY 2008 and FY 2009.
- Impact of Results: 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 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 2: By 2010, reduce the rate of Fetal Alcohol Syndrome 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	7%	11%	12%	28%	28%	41%	41%	41%
11	Tribally Operated Health Programs	9%	11%	12%	27%	27%	37%	37%	37%

Past trends of results for this program show increasingly significant improvements for this measure. The FY 2007 target of achieving a rate 28 percent of women screened for alcohol to prevent Fetal Alcohol Syndrome (FAS) was met. In FY 2007, the target was exceeded by 13 percent and attainted a rate of 41 percent. The FY 2008 target for this measure is to maintain the FY 2007 rate of 41 percent. The FY 2009 target is to maintain the rate at 41 percent; this is a low cost screening measure with potential high return on investment.

- Reasons for Performance Result: Significant increases in the FY 2007 results of this measure can be attributed to the fact that it is low cost, as well as to specific agency initiatives that emphasize behavioral health screenings.
- Steps being taken to Better Match Targets with Program Performance: The FY 2008 target for this measure is to maintain the FY 2007 rate at 41 percent which is the previous year actual result, and is quite ambitious. In addition, continued projections of maintaining this rate are set for, to reflect FY 2009.
- Impact of Results: 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 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: By 2010, 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	77%	78%	N/A	79%	N/A	79%	N/A	N/A
	Tribally Operated Health Programs	74%	76%	N/A	77%	N/A	77%	N/A	N/A
1	**Diabetes: Poor Glycemic Control:** Proportion of patients with diagnosed diabetes that have poor glycemic control (A1c > 9.5). IHS-All[1]	16/17%	18/15%	18/15%	18/16%	18/15%	19/16%	19/16%	19/17%
1	Tribally Operated Health Programs	15%	12%	12%	13%	12%	13%	13%	14%

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

The FY 2007 target of 18 percent was not met, based on audit data. In FY 2007, 19 percent of patients diagnosed with diabetes had poor (>9.5) glycemic control, as measured by the Hemoglobin A1c test. The rate represents an increase of 1 percent in the number of patients with diabetes whose blood sugar is in poor control. The FY 2008 target is to maintain this percentage

at the FY 2007 rate of 19 percent, and the FY 2009 target is to maintain the FY 2007 performance level at 19 percent as well. The FY 2007 CRS target of maintaining the percentage of patients with diabetes with poor glycemic control at 15 percent was not met and was missed by 1 percent. The FY 2008 target for the CRS data is to maintain this percentage at 16 percent. The FY 2009 target is 17 percent. Reducing the number of poorly controlled diabetics is strongly associated with decreasing the incidence of costly diabetic complications and mortality.

Note: CRS data is based on different collection methods and exclusion criteria.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2010, increase the percentage of patients with diagnosed diabetes with ideal glycemic control to 40 percent.									
2	**Diabetes: Ideal Glycemic Control:** Proportion of patients with diagnosed diabetes with ideal glycemic control (A1c <7.0). IHS-All[1]	34/27%	36/30%	36/32%	37/31%	37/32%	38/31%	38/31%	38/29%
2	Tribally Operated Health Programs	28%	33%	33%	33%	33%	33%	33%	31%

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

Program results for the Special Diabetes Program for Indians is one that has demonstrated positive outcomes and a proven track record has continued to show steady improvements, quantitatively and qualitatively, over the past four years. The FY 2007 target of 37 percent was met, based on audit data. In FY 2007, 38 percent of patients diagnosed with diabetes achieved ideal glycemic control (A1c <7.0). The FY 2008 and FY 2009 targets are to maintain the FY 2007 rate of 38 percent. The FY 2007 CRS target to increase the percentage of patients with diabetes with ideal glycemic control to 32 percent was not met. The FY 2008 target for the CRS data is to maintain the proportion at 31 percent and the FY 2009 target is to achieve a rate of 29 percent. 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.

Note: CRS data is based on different collection methods and exclusion criteria.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: By 2010, increase to 50 percent 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 achieved blood pressure control (<130/80). IHS-All[1]	34/35%	36/37%	36/37%	38/37%	38/37%	38/39%	38/39%	38/37%
3	Tribally Operated Health Programs	33%	36%	36%	37%	37%	38%	38%	36%

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

Diabetes – Blood Pressure Control: The FY 2007 target of 38 percent was met, based on audit data. In FY 2007, 38 percent of patients diagnosed with diabetes achieved blood pressure control. The FY 2008 and FY 2009 targets are to maintain the FY 2007 rate of 38 percent.
The FY 2007 CRS target of maintaining the percentage of patients with diabetes that achieved blood pressure control at 37 percent was exceeded. The FY 2007 CRS rate for blood pressure control was 2 percent over the FY 2006 level at 39 percent. The FY 2008 target is to maintain the FY 2007 rate at 39 percent. The FY 2009 target is 37 percent.
Note: CRS data is based on different collection methods and exclusion criteria.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: By 2010, increase to 70 percent 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]	69/53%	70/53%	72/56%	73/60%	76/60%	74/61%	74/61%	74/58%
4	Tribally Operated Health Programs	52%	48%	49%	58%	58%	58%	58%	55%

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

The FY 2007 target of 76 percent was not met, based on audit data. In FY 2007, 74 percent of patients diagnosed with diabetes were assessed for Dyslipidemia, LDL cholesterol, which represents a 1 percent increase from FY 2006 in the number of patients with diabetes who were assessed for Dyslipidemia. The FY 2008 and FY 2009 targets are to maintain the FY 2007 rate of 74 percent.
The FY 2007 CRS target of maintaining the percentage of patients with diabetes that were assessed for Dyslipidemia at 60 percent was met and exceeded by 1 percent with a FY 2007 result of 61 percent. The FY 2008 target is to maintain the FY 2007 rate at 61 percent. The FY 2009 target is 58 percent.

- Reasons for Performance Result: This measure is considered high cost, which requires frequent medical visits, medications, and laboratory testing.
- Steps being Taken to Better Match Targets with Program Performance: The FY 2007 target for this measure, to increase 3 percent above the FY 2006 result was ambitious and IHS worked hard to reach it. In addition, the rates achieved by this measure have surpassed the Healthy People 2010 goal of 70 percent. The agency has changed this target for FY 2008 and 2009 to maintain high performance and ensure the best possible health outcomes.
- Impact of Results: This population is especially prone to develop heart disease and therefore identification and treatment of elevated lipids in diabetic patients is extremely important. The results achieved in FY 2007 have contributed to the prevention of cardiovascular disease among diabetic patients.

Note: CRS data is based on different collection methods and exclusion criteria.

PREVENTIVE HEALTH: Public Health Nursing, Health Education, CHR, and Immunization AK.

Public Health Nursing

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2010, decrease YPLL by 20 percent over the 2002 level.									
23	**Public Health Nursing[1]:** Implement a data system capable of recording the nature of public health activities other than one-on-one patient care, with an emphasis on activities that serve groups or the entire community.	423,379	438,376	Data System	Data System	Baseline	427,700	449,085	449,085

[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 2007 target, to establish a baseline of public health activities and link them to specific IHS clinical performance measure, was met. In 2007, PHNs recorded 427,700 encounters that contributed toward twelve agency measures. Achievement of this measure demonstrates the utility of the data system that was developed to meet last year's target. In 2004, this measure captured the number of visits, which were trending upward but did not provide information about the specific purpose, which are now available. In 2008, the program has set an aggressive target to exceed baseline activities established in FY 2007 by 5 percent to 449,085. In FY 2009, the target is to maintain FY 2008 rates. FY 2008 and FY 2009 targets will build upon current knowledge of what areas PHN activities are utilized and assist in planning future program efforts. 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 program contributes to the Hospital and Health Clinics (H&HC) measures listed above.

Health Education

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: By 2010 decrease YPLL by 20 percent over the 2002 level.									
32	**Tobacco Cessation Intervention[1]:** Proportion of tobacco-using patients that receive tobacco cessation intervention. IHS-All	27%	34%	Baseline	12%	12%	16%	16%	16%
32	Tribally Operated Health Programs	28%	34%	Baseline	10%	10%	12%	12%	12%

[1]*In FY 2004 and FY 2005 this measure tracked the proportion of patients ages 5 and above who are screened for tobacco use.*

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, and a baseline rate of 12 percent was established. In FY 2007 16 percent of users received tobacco cessation intervention, exceeding the target by 4 percent. The FY 2008 and FY 2009 targets are to maintain the 16 percent rate.

- Reasons for performance result: FY 2007 was the first year IHS established a target after a baseline screening rate was set in FY 2006. There was no trend data to reference in setting a target for FY 2007.
- Steps being taken to better match targets with program performance: The FY 2008 target for this measure was increased for FY 2008.
- Impact of result: 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 an important 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 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 2: By 2010 decrease YPLL by 20 percent over the 2002 level.									
30	**CVD Comprehensive Assessment[1]:** Proportion of at risk patients who have a comprehensive assessment for all CVD-related risk factors**.** IHS-All	2 sites	43%	44%	48%	Baseline	30%	30%	30%
30	Tribally Operated Health Programs	N/A	N/A	N/A	N/A	Baseline	24%	24%	24%

[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 six CVD-related risk factors.*

The CVD Comprehensive Assessment measure has been evolving over the past four years. In FY 2004, this measure tracked the number of community-directed pilot cardiovascular disease prevention programs. In FY 2005 and FY 2006 this measure grew into tracking the proportion of patients ages 23 and older who received blood cholesterol screening and marked improvements were seen in that short time. In FY 2007, the target to establish a baseline of the proportion of at risk patients who have a comprehensive assessment for all CVD-related risk factors (Blood Pressure control, LDL assessed, tobacco cessation, lifestyle counseling, and BMI assessed) was met. This is the first performance measure to take a comprehensive approach within a single domain. The FY 2008 target is to maintain the FY 2007 rate of 30 percent. The FY 2009 target is also to maintain the FY 2007 rate of 30 percent. The FY 2008 and FY 2009 targets are quite ambitious, noting that there are currently no other comprehensive screening measures tracked. 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 pertinent patient education is a hallmark for quality of care given the increasing rates of cardiovascular disease in the AI/AN population, and contributes towards improving health outcomes.

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 AK

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

Urban Indian Health Program

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2010, decrease Years of Potential Life Lost in AI/AN population.									
UIHP-4	Increase the number of sites utilizing an electronic reporting system	N/A	N/A	Baseline	9 sites	+6 sites	+9 sites	+7 sites	N/A
UIHP-E	Cost per service user in dollars per year.	557	776	601	737	767	1/2008	805	N/A

The FY 2007 target to increase the number of sites that are utilizing an electronic reporting system was met. An additional nine sites were included in the overall count in FY 2007. This is a significant change (3 sites above the FY 2007 target) that will provide integrated patient care and cost data 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 OIT funding for equipment and support all contributed to this success. The

FY 2008 performance target is to establish RPMS in 7 more urban programs. The FY 2009 performance target is to continue to expand this system to an additional 6 urban sites.

Cost per service user increased dramatically from FY 2005 to FY 2005 and remained constant into FY 2006. The program will not be able to report the FY 2007 results on this efficiency measure until January 2008. At this time further analysis with comparisons to the FY 2007 target will be provided. The FY 2008 target is to increase the cost per service user to 805 and further increases, 845, are projected in FY 2009.

Indian Health Professions

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2010, increase the number of scholarship placements within 90 days of graduation to 50 percent.									
42	**Scholarships:** Proportion of Health Professional Scholarship recipients placed in Indian health settings within 90 days of graduation.	20%	30%	32%	37%	42%	47%	52%	60%

The FY 2007 target to increase to 42 percent the proportion of health professional scholarship recipients placed in Indian health settings within 90 days of completion of their health profession degree was met and exceeded by 5 percentage points. Over the past four years, the placement rate has been steadily increasing, from 20 percent in 2004 to 47 percent in 2007. The FY 2008 target is to increase the placement rate to 52 percent, and the FY 2009 target is 60 percent.

- Reason for Performance Result: The placement rate increased significantly more than expected as a result of increased communication between the scholarship coordinators and clinical programs with scholars and improvements with the scholar tracking system.
- Steps Being Taken to Better Match Targets with Program Performance: The FY 2008 target has been increased from 45 percent to 52 percent and the FY 2009 target projects an 8 percent increase over the FY 2008 result to reflect program improvements of increased communication and discipline tracking through the scholar tracking system and priority placement of students who are in the most needed health professions.
- Impact of Result: 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 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: Increase the percent of AI/AN patients with diagnosed diabetes served by tribal health programs (TOHP) that achieve ideal blood sugar control to 40 percent by FY 2014. Reduce the Years of Potential Life Lost (YPLL) in the American Indian/Alaska Native (AI/AN) populations served by tribal health programs to 55.3 by 2012.									
TOHP-1	Percentage of TOHP clinical user population included in GPRA data.	78%[1]	74%[1]	77%	77%	78%	76%	76%	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.*

Past trends for this measure are not available due to the methodology changes that occurred in FY 2006. The FY 2007 target for this measure is to increase the percentage of the Tribally Operated Health Programs (TOHP) clinical user population included in GPRA data to 78 percent, a 1 percent increase over the FY 2006 rate. The FY 2007 target was not met and the program achieved a rate of 76 percent. The FY 2008 target is to maintain the FY 2008 rate of 76 percent. The FY 2009 target is 74 percent.

- Reason for Performance Result: In FY 2007, selected service unit boundaries underwent anticipated realignment to ensure unduplicated patient populations across that region. In addition, new data systems foreign to the IHS standards were introduced.
- Steps Being Taken to Better Match Targets with Program Performance: These types of changes are inherent to the electronic system and cannot always be anticipated. However, data integration steps are being pursued so that targets for this measure can be maintained.
- Impact of Result: A 1percent reduction in the percent of TOHP clinical user population included in GPRA over the FY 2006 level did not have a significant impact on program performance or activity.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
TOHP-E	**Tribally Operated Health Programs[1]:** Hospital admissions per 100,000 diabetics per year for long-term complications of diabetes.	142.8	165.1	163.4	Sep/2008	161.8	Sep/2009	160.2	160.2

[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.*

Past trends for this measure are not available due to the reporting lag for this measure. The FY 2007 target for this measure is to achieve a rate for hospital admissions per 100,000 diabetics per year for long term complications of diabetes and will not be reported on until September 2009. Further trend analysis will be available at that time. The FY 2008 target is to achieve a rate of

160.2 and to maintain that rate for FY 2009. 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 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: Increase the percentage of American Indian/Alaska Native (AI/AN) homes with sanitation facilities to 90 percent by 2010.									
(35) SFC-1	**Sanitation Improvement:** Number of new or like-new and existing AI/AN homes provided with sanitation facilities.	24,928	24,072	22,000	24,090	23,000	21,819	21,800	21,375
(35A) SFC-2	Percent of existing homes served by the program at Deficiency Level 4 or above as defined by 25 USC 1632.	N/A	38%	20%	35%	35%	45%	35%	35%

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.

In FY 2007, the IHS provided service to 21,819 homes, which slightly missed the FY 2007 target to provide sanitation facilities projects to serve 24,000 AI/AN homes with water, sewage disposal, and/or solid waste water facilities. The FY 2008 target is set to 21,800 homes being served followed by 21,375 in FY 2009.

The FY 2007 target of achieving 35 percent of existing homes served by the program was met. The FY 2007 rate achieved was 45 percent, a 10% absolute increase. The FY 2008 and FY 2009 targets are to achieve a rate of 35 percent.

- Reason for Performance Result: Current backlogs of projects have caused a slight decrease in the number of new or like new and existing AI/AN homes that were provided with sanitation facilities.
- Steps Being Taken to Better Match Targets with Program Performance: FY 2007 funds were appropriated for sanitation facilities to address the backlog of existing homes.
- Impact of Result: 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 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
SFC-E	Track average project duration from the Project Memorandum of Agreement (MOA) execution to construction completion.	N/A	3.8 yrs	4.1 yrs	3.6 yrs	3.9 yrs	Apr/2008	4.0 yrs	4.1 yrs

This efficiency measure will not have a FY 2007 result until April 2008. 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. The FY 2008 target is to attain a rate of 4.0 years and increase to 4.1 years in FY 2009. Target increases have been projected for both FY 2008 and FY 2009. 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 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: Increase the percentage of American Indian/Alaska Native (AI/AN) homes with sanitation facilities to 90 percent by 2010.									
SFC-3	Percentage of AI/AN homes with sanitation facilities[1].	88%	N/A	N/A	88%	N/A	89%	N/A	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 88 percent in FY 2006 to 89 percent in FY 2007.

Healthcare Facilities Construction (HCFC)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
36	**Health Care Facility Construction:** Number of health care facilities construction projects completed.	4[1]	15[1]	3	3[1]	2	2	1[2]	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.*
[2]*The FY 2008 target was reduced by 2, from 3 to1 because one project was completed ahead of schedule and one project was delayed due to 638 Tribal contract negotiations.*

Past trends for this measure have been steady with the exception of FY 2005, where 15 project phases were completed. In FY 2006 the measure was changed to track completion of projects

instead of phases of projects. In FY 2007, the target to have 2 healthcare facilities construction projects completed was met. In FY 2008 the target decreases to 1 construction project completed, followed by 1 in FY 2009.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
HCFC-E	**Health Care Facilities Construction:** Percent of health care facilities construction projects completed on time.	100%	80%	100%	100%	100%	100%	100%	100%

This efficiency measure shows a very steady trend over the past four years. In FY 2007, the target of 100 percent of healthcare facilities constructions projects completed on time was met. The FY 2008 and FY 2009 targets are to continue to maintain the rate of 100 percent. The program will continue to implement strategies that have previously proven successful to meet the FY 2008 and FY 2009 targets. Facilities completed in a timely manner contribute towards increased access to health services and improved health outcomes.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: Increase proportion of patients with diagnosed diabetes with ideal blood sugar control (A1c<7) within 7 years of opening a new facility, achieving a 10 percent increase by 2010. Reduce the YPLL rate within 7 years of opening a new facility, achieving a 10 percent decrease by 2010.									
HCFC-1	**Diabetes: Ideal Glycemic Control:** Proportion of patients with diagnosed diabetes with ideal glycemic control.	N/A	32/47	32	30/58	30	33/73	33	32
		N/A	N/A	6	42/23	44	43/34	43	42
		N/A	N/A	33	29/16	30	32/30	32	31
		15	N/A	Exempt	N/A	15	38/24	38	37
		N/A	24	Exempt	N/A	24	23/28	23	23
		21	N/A	Exempt	N/A	21	41/35	41	40
HCFC-2	**Pap Smear Rates:** Proportion of eligible women who have had a Pap screen within the previous three years.	N/A	65/41	65	62/43	62	61/47	61	60
		N/A	N/A	32	36/25	37	38/24	38	37
		N/A	N/A	58	55/14	56	56/15	56	55
		58	N/A	Exempt	N/A	58	60/2	60	59
		N/A	61	Exempt	N/A	61	61/10	61	60
		73	N/A	Exempt	N/A	73	72/17	72	71
HCFC-3	**Mammogram Rates:** Proportion of eligible women who have had mammography screening within the previous two years.	N/A	41/52	41	44/60	44	48/77	48	47
		N/A	N/A	44	47/33	48	49/33	49	48
		N/A	N/A	32	22/28	23	38/38	38	37
		43	N/A	Exempt	N/A	43	82/8	82	80
		N/A	30	Exempt	N/A	30	28/21	28	27
		66	N/A	Exempt	N/A	66	62/17	62	61
HCFC-4	**Alcohol Screening (FAS Prevention}:** Alcohol-use screening (to prevent Fetal Alcohol Syndrome) among appropriate female patients.	N/A	3/39	4	35/39	35	33/39	33	33
		N/A	N/A	5	29/11	30	69/12	69	69
		N/A	N/A	50	18/9	19	40/11	40	40
		0	N/A	Exempt	N/A	1	60/4	60	60
		N/A	9	Exempt	N/A	9	40/9	40	40
		6	N/A	Exempt	N/A	6	67/14	67	67
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.	N/A	79/12	Baseline	98	98	93	93	92
		N/A	N/A	Baseline	100	100	85	85	84
		N/A	N/A	Baseline	94	95	74	74	73
		26	N/A	Exempt	N/A	26	86	86	85
		N/A	88	Exempt	N/A	Baseline	84/13	84	83
		66	N/A	Exempt	N/A	Baseline	95	95	94
HCFC-6	**Influenza vaccination rates among adult patients aged 65 years and older.**	N/A	65/66	65	67/74	67	62/95	62	61
		N/A	N/A	46	60/23	61	64/26	64	63
		N/A	N/A	49	58/18	59	68/18	68	67
		41	N/A	Exempt	N/A	41	72/-6	72	71
		N/A	69	Exempt	N/A	69	68/17	68	67
		93	N/A	Exempt	N/A	93	91/24	91	90

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: Increase proportion of patients with diagnosed diabetes with ideal blood sugar control (A1c<7) within 7 years of opening a new facility, achieving a 10 percent increase by 2010. Reduce the YPLL rate within 7 years of opening a new facility, achieving a 10 percent decrease by 2010.									
HCFC-7	**Pneumococcal vaccination rates among adult patients aged 65 years and older.**	N/A	67/66	70	77/74	77	81/95	81	80
		N/A	N/A	24	55/23	56	78/26	78	77
		N/A	N/A	53	52/18	53	75/18	75	74
		42	N/A	Exempt	N/A	42	87/-6	87	86
		N/A	83	Exempt	N/A	83	84/17	84	83
		90	N/A	Exempt	N/A	90	97/24	97	96
HCFC-8	**Tobacco Cessation Intervention[2,3]:** Proportion of tobacco-using patients that receive tobacco cessation intervention.	N/A	4/38	Baseline	1	3	1	1	1
		N/A	N/A	Baseline	3	5	9	9	9
		N/A	N/A	Baseline	13	15	14	14	14
		12	N/A	Exempt	N/A	Baseline	40	40	40
		N/A	6	Exempt	N/A	Baseline	1	1	1
		16	N/A	Exempt	N/A	Baseline	14	14	14

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. Prior to 2004, measure was Support local level initiatives directed at reducing tobacco usage.

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. High cost measures such as Glycemic control, cancer screenings, and tobacco cessation can be attributed to the varied 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. With that said, over inflation of the denominator (or increase in 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 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-Year Target
				Target	Actual	Target	Actual			
Long-Term Objective 1: Increase proportion of patients with diagnosed diabetes with ideal blood sugar control (A1c<7) within 7 years of opening a new facility, achieving a 10 percent increase by 2010. Reduce the YPLL rate within 7 years of opening a new facility, achieving a 10 percent decrease by 2010.										
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	N/A	Jan/2010 -10%
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	N/A	Oct/2010 10%

[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). This measure 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 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2010 decrease YPLL by 20 percent over the 2002 level.									
27	**Injury Intervention**: Number of community-based injury prevention programs[1].	37	37	Implement Web System	Web System Implemented	3 projects per Area	3 projects/12 Areas	Survey	1 Pilot/Area

[1]*Measure will reflect number of projects per area starting in FY 2007. In FY 2008 measure changes to Injury Intervention (Motor Vehicle Injuries): Occupant protection restraint use.*

Past trends for this measure have show positive outcomes in meeting set targets. The FY 2007 target was to implement three community injury prevention projects and report them using an automated tracking system, and the target was met. The FY 2008 target is for each Area to conduct a seat belt observation survey using an automated tracking system. In FY 2009, the measure is 1 pilot in 11 Areas (implementing a comprehensive intervention designed to increase restraint use) per Area.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target
Long-Term Objective 1: 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)[1].	15	12	18	20	29	32	Baseline[1]	3Interventions/Area

[1]*In FY 2008 measure changes to Environmental Surveillance: Identify and address environmental risk factors in communities.*

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Past trends for this measure have shown an increase in the number of environmental health programs with automated web-based environmental health surveillance data collect system (WebEHRS). The FY 2007 target of 29 was met and a result of 32 was achieved. Because this system is now in wide use, the FY 2008 target is to set a baseline rate for identifying and addressing environmental risk factors in communities. The FY 2009 target is for each of 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 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.

	IHS Strategic Goals		
	Build and sustain healthy communities	Provide accessible quality health care	Foster collaboration and innovation across the Indian health network
HHS Strategic Goals			
1: Health 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
2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness			
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	
3: Human Services*			
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
4: Scientific Research and Development*			
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

Summary of Full Cost Table

(Budgetary Resources in Millions)

	Indian Health Service		
HHS Strategic Goals and Objectives	**FY 2007**	**FY 2008**	**FY 2009**
1: Health Care Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.			
1.1 Broaden health insurance and long-term care coverage.			
1.2 Increase health care service availability and accessibility.	$3,018.4	$3,168.6	$3,156.8
Measures: (1-6) – Diabetic Care: Combined	*1,154.80*	*1,226.10*	*1,300.60*
Measure: (7) – Cancer Screening, Pap Smear Rates	*9.2*	*9.7*	*9.6*
Measure: (8) – Cancer Screening, Mammography Rates	*0.8*	*0.9*	*0.8*
Measure: (9) – Cancer Screening, Colorectal	*8.9*	*9*	*9.2*
Measure: (12-15) – Oral Health Care – Combined	*128.4*	*137.8*	*134.3*
Measure: (36) – Health Care Facilities Construction	*25.7*	*36.6*	*15.8*
1.3 Improve health care quality, safety and cost/value.	$175.1	$178.1	$178.1
Measure: (10) – RTC Improvement/Accreditation			
Measure: (18) – Behavioral Health: Depression Screening	*10.6*	*10.8*	*11*
Measure: (20) – Health Care Accreditation	*706.6*	*706.6*	*706.6*
Measure: (21) – Patient Safety Monitoring System	*6.1*	*6.6*	*6.7*
1.4 Recruit, develop, and retain a competent health care workforce.	$100.2	$107.4	$93.4
Measure: (42) – Placement of Scholarship Recipients			
2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness 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.	$302.4	$310.1	$312.8
Measure: (24) – Childhood Immunizations	*26.8*	*27.3*	*26*
Measure: (25) – Adult Immunizations, Influenza	*6.6*	*6.7*	*6.4*
Measure: (26) – Adult Immunizations, Pneumovax	*1.7*	*1.7*	*1.8*
Measure: (33) – HIV Screening in Pregnancy	*1.1*	*1.1*	*1.1*
2.2 Protect the public against injuries and environmental threats.	$202.3	$207.3	$208.3
Measure: (27) – Injury Intervention			
Measure: (28) – Unintentional Injury Mortality Rate (Long Term Measure)			
Measure: (34) – Environmental Surveillance	*0.2*	*0.2*	*0.2*
Measure: (35) – Sanitation Facilities Construction	*95*	*95.8*	*87.6*
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.	$304.6	$310.5	$312.8
Measure: (11) – Alcohol Screening (FAS Prevention)	*16.2*	*16.6*	*16.9*
Measure: (16) – Domestic (Intimate Partner) Violence Screening	*7.3*	*7.4*	*7.5*
Measure: (23) – Public Health Nursing Priorities	*53.6*	*57*	*56.2*
Measure: (29) – Suicide Surveillance	*0.1*	*0.1*	*0.1*
Measure: (30) – Cardiovascular Disease Prevention	*342.3*	*362.7*	*384.4*
Measure: (31) – Childhood Weight Control (Long Term Measure)	*9.2*	*9.4*	*9.5*
Measure: (32) – Tobacco Cessation Intervention	*23.5*	*24*	*21.7*
2.4 Prepare for and respond to natural and man-made disasters.	$0.3	$0.3	$0.3
3: Human Services 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.			
3.2 Protect the safety and foster the well being of children and youth.			
3.3 Encourage the development of strong, healthy and supportive communities.			
3.4 Address the needs, strengths and abilities of vulnerable populations.			
Strategic Goal 4: Scientific Research and Development Advance scientific and biomedical research and development related to health and human services.			
4.1 Strengthen the pool of qualified health and behavioral science researchers.			
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.			
4.4 Communicate and transfer research results into clinical, public health and human service practice.			
Total	$4,103.3	$4,282.2	$4,260.9

The summary of Full Cost table represents IHS' professional judgment of how its budget supports the HHS strategic objectives. The methodology is an estimate of how much of each budget line item is spent on activities that fall under each strategic objective.

While no IHS funding is directly allocated to the HHS Strategic Goals 3: Health Services or 4: Scientific Research and Development, the IHS does contribute to the realization of may elements of these two strategic objectives as noted in the links to HHS Strategic Plan table on the previous page. This occurs because funding that supports the activities and performance measures included in the **Summary of Full Cost** over time certainly contribute to improving "Human Services" and support "Scientific Research and Development. However it is difficult if not impossible to approximate the amounts or which investments to health care, public health, prevention, and to emergency preparedness will contribute to the broadly defined objectives.

Specific measure calculations are either based on line item budget items, or calculated using peer-reviewed published clinical costs, when available. If this cost data is not available, IHS used best estimates to arrive at full cost data.

Full cost data for the measures under each strategic objective are shown as non- adds. The sum of full costs of performance measures may not equal the full cost of the strategic objective. This reflects the extent to which the program has elements that have no current performance measures. Many of the cost estimates are evolving and will not be precise until more sophisticated cost estimates are developed.

List of Program Evaluations

There were no program evaluations conducted during this fiscal year.

Discontinued Performance Measures Table

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
RPMS-1	Develop comprehensive electronic health record (EHR) with clinical guidelines for select chronic diseases.	Not Met	Met	Cardio-vascular	Met	Maintain All	Met	Comp-rehensive EHR	Eliminate
RPMS-3	Number of sites to which electronic health record is deployed.	N/A	20	40	40	40	50	All	Eliminate

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective 1: By 2010, improve treatment and prevention effectiveness through development and deployment of enhanced automated health systems to all IHS direct, Tribal and Urban sites using RPMS.									
17	**Data Quality Improvement:** Number of GPRA clinical measures that can be reported by CRS software.	+2	+4	Increase	+1	All	All	Eliminated	N/A

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

Measure Unique Identifier	Data Source	Data Validation
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
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

Measure Unique Identifier	Data Source	Data Validation
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	UCRR	Office of Urban Programs

Target vs. Actual Performance
Performance Measures with Slight Differences

The performance target for the following measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.	
Program	**Measure Unique Identifier**
Hospitals and Health Clinics & Contract Health Services	7
Hospitals and Health Clinics & Contract Health Services	TOHP-2
Dental	13
Dental	14
Special Diabetes Program for Indians (SDPI)	1