



DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



January 18, 2013

**TO:** Yvette Roubideaux, M.D., M.P.H.  
Director  
Indian Health Service

**FROM:** /Gloria L. Jarmon/  
Deputy Inspector General for Audit Services

**SUBJECT:** Independent Attestation Review: Indian Health Service Fiscal Year 2012  
Performance Summary Report for National Drug Control Activities and  
Accompanying Required Assertions (A-03-13-00356)

This report provides the results of our attestation review of the Indian Health Service (IHS) Performance Summary Report for National Drug Control Activities and accompanying required assertions for fiscal year (FY) 2012.

Each National Drug Control Program agency must submit to the Director of the Office of National Drug Control Policy (ONDCP) an annual evaluation of the progress of the agency with respect to drug control program goals using the performance measures established for that agency (21 U.S.C. § 1703(b)(13)). The Federal statute authorizes ONDCP to “monitor implementation of the National Drug Control Program, including – (A) conducting program and performance audits and evaluations.” ONDCP may request “assistance from the Inspector General of the relevant agency in such audits and evaluations” (section 1703(d)(7)). Section 7 of the ONDCP Circular entitled *Drug Control Accounting*, dated May 1, 2007, provides the reporting requirements to comply with section 1703(b)(13). Section 8 of the ONDCP Circular requires that each report defined in section 7 be provided to the Office of Inspector General to express a conclusion about the reliability of each assertion made in each Performance Summary Report for National Drug Control Activities.

As authorized by section 1703(d)(7) of the Federal statute, and in compliance with the Circular, ONDCP requested that we perform this review. Accordingly, we reviewed the attached IHS report entitled “FY 2012 Performance Summary Report: National Drug Control Activities—Indian Health Service” and accompanying required assertions, dated December 10, 2012. We conducted our attestation review in accordance with attestation standards established by the American Institute of Certified Public Accountants and the standards applicable to attestation engagements contained in *Government Auditing Standards* issued by the Comptroller General of the United States. A review is substantially less in scope than an examination, the objective of which is to express an opinion on management’s assertions contained in its report; accordingly, we do not express such an opinion.

## **INDIAN HEALTH SERVICE PERFORMANCE SUMMARY REPORT**

IHS's report included assertions for five measures of National Drug Control Program activities. The five measures were (1) regional treatment center improvement/accreditation: accreditation rate for youth regional treatment centers in operation 18 months or more; (2) domestic violence (intimate partner) screening: proportion of women who are screened for domestic violence at health care facilities; (3) behavioral health: proportion of adults aged 18 and over who are screened for depression; (4) alcohol screening (fetal alcohol syndrome prevention): alcohol-use screening (to prevent fetal alcohol syndrome) among appropriate female patients; and (5) suicide surveillance: increase the incidence of suicidal behavior reporting by health care (or mental health) professionals.

In accordance with ONDCP requirements, IHS made the following assertions:

- IHS's performance reporting system was sufficient;
- IHS's explanations for not meeting performance targets, and plans and recommendations for meeting targets, were reasonable;
- IHS's methodology to establish performance targets was reasonable; and
- performance measures exist for all significant drug control activities.

We performed review procedures on the performance summary report and accompanying required assertions. In general, we limited our review procedures to inquiries and analytical procedures appropriate for our attestation review.

## **OFFICE OF INSPECTOR GENERAL CONCLUSION**

Based on our review, nothing came to our attention that caused us to believe that IHS's performance summary report for FY 2012 and management's assertions accompanying its report were not fairly stated, in all material respects, based on the ONDCP Circular.

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Although this report is an unrestricted public document, the information it contains is intended solely for the information and use of Congress, ONDCP, and IHS and is not intended to be, and should not be, used by anyone other than these specified parties. If you have questions or comments about this report, please do not hesitate to call me, or your staff may contact Kay L. Daly, Assistant Inspector General for Audit Services, at (202) 619-1157 or through email at [Kay.Daly@oig.hhs.gov](mailto:Kay.Daly@oig.hhs.gov). Please refer to report number A-03-13-00356 in all correspondence.

Attachment

**ATTACHMENT**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

DEC 10 2012

Indian Health Service  
Rockville MD 20852

**MEMORANDUM TO:** Director  
Office of National Drug Control Policy

**THROUGH:** Norris Cochran  
Deputy Assistant Secretary, Budget

**FROM:** Yvette Roubideaux, M.D., M.P.H.  
Director  
Indian Health Service

**SUBJECT:** Assertions Concerning Performance Summary Report

In accordance with the requirements of the Office of National Drug Control Policy circular "Drug Control Accounting," I make the following assertions regarding the attached Performance Summary Report for National Drug Control Activities:

Performance Reporting System

I assert that the Indian Health Service (IHS) has a system to capture performance information accurately and that this system was properly applied to generate the performance data presented in the attached report.

Explanations for Not Meeting Performance Targets

I assert that the explanations offered in the attached report for failing to meet a performance target are reasonable and that any recommendations concerning plans and schedules for meeting future targets or for revising or eliminating performance targets are reasonable.

Methodology to Establish Performance Targets

I assert that the methodology used to establish performance targets presented in the attached report is reasonable given past performance and available resources.

Performance Measures Exist for All Significant Drug Control Activities

I assert that adequate performance measures exist for all significant drug control activities.

*Yvette Roubideaux*

Yvette Roubideaux, M.D., M.P.H.

Attachment

## FY 2012 Performance Summary Report National Drug Control Activities--Indian Health Service

**Decision Unit 1:** Office of Clinical and Preventive Services, Division of Behavioral Health, IHS

**Measure 1: RTC Improvement/Accreditation: Accreditation Rate for Youth Regional Treatment Centers (YRTC) in operation 18 months or more**

| Table 1: Measure No. 1 |                   |                   |                   |                   |                   |                   |
|------------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|
| FY 2008<br>Actual      | FY 2009<br>Actual | FY 2010<br>Actual | FY 2011<br>Actual | FY 2012<br>Target | FY 2012<br>Actual | FY 2013<br>Target |
| 91%                    | 91%               | 81%               | 91%               | 100%              | 91%               | 100%              |

**(1) Describe the measure--(In doing so, provide an explanation of how the measure (1) reflects the purpose of the program; (2) contributes to the National Drug Control Strategy; and (3) is used by management of the program. This description should include sufficient detail to permit non-experts to understand what is being measured and why it is relevant to the Agency's drug control activities.)**

Measure No. (1) reflects an evaluation of the quality of care associated with accreditation status by either the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), State certification, or regional Tribal health authority certification. This measure contributes to the *National Drug Control Strategy* by providing alcohol and substance abuse services to "heal America's drug users." These programs provide alcohol and substance abuse treatment and prevention services to rural and urban communities, with a focus on holistic and culturally-based approaches. The existing performance measure of 100% accreditation of Youth Regional Treatment Centers (YRTC) addresses the quality of services for program management. This measure establishes the goal of optimal program management that results in 100% attainment and maintenance of accreditation and/or certification. The review process ensures that quality indicators are assessed and thereby bring areas of needed improvement to program management's attention. The review process is on a continuous basis.

**(2) Provide narrative that examines the FY 2012 actual performance results with the FY 2012 target, as well as prior year actuals. If the performance target was not achieved for FY 2012, the Agency should explain why this is the case. If the Agency has concluded it is not possible to achieve the established target with available resources, the Agency should include recommendations on revising or eliminating the target.**

The 100% accreditation performance measure was not met in FY 2012 as a result of ongoing difficulties with one YRTC program. The Navajo YRTC, located on the Navajo Reservation in Shiprock New Mexico, is a Tribally operated YRTC that is continuing to experience difficulties with scheduling and completing CARF accreditation.

In November 2011, the Shiprock YRTC participated in a conference call with their designated CARF Resource Specialist and planned a survey site visit in August 2012. Due to turnover in staff with approval authority, the Shiprock YRTC was unable to receive the necessary approvals to proceed with the site visit. In November 2012, the YRTC resubmitted the request for approval to proceed with obtaining CARF accreditation. In addition, the YRTC has developed an action plan with a tentative CARF site visit scheduled for March-April 2013.

**(3) The Agency should describe the performance target for FY 2013 and how the Agency plans to meet this target. If the target in FY 2012 was not achieved, this explanation should detail how the Agency plans to overcome prior year challenges to meet targets in FY 2012.**

The FY 2013 performance target for the YRTCs will remain unchanged at 100% accreditation/certification status.

The Navajo Nation and Shiprock YRTC are being provided ongoing follow up and support to address these problems. However, we believe that the challenges around accreditation represent some of the difficulties inherent in transitioning programs from Federal to Tribal management, as the Tribe must increase operational responsibility while at the same time navigate new and significant external requirements, i.e., CARF. While the IHS will continue to support them, the Navajo Nation is the lead for operations and accreditation. We believe in the program and believe the Navajo Nation is taking the necessary but difficult steps to finalize the accreditation. Thus, we believe the target for the measure should be maintained at 100%. Working with Tribes to develop positive leadership and program services is essential for the ongoing transition from Federal to Tribal management of clinical programs.

**(4) The Agency should describe the procedures used to ensure performance data for this measure are accurate, complete, and unbiased in presentation and substance. The Agency should also describe the methodology used to establish targets and actuals, as well as the data source(s) used to collect information.**

On an annual basis, the Indian Health Service (IHS) Office of Clinical and Preventive Services, Division of Behavioral Health requires all YRTCs to verify their accreditation/certification status by forwarding a copy of this documentation to Agency Headquarters in Rockville, Maryland. Using verified program documents, this methodology ensures that standards for continued accreditation/certification are continually being met and deficiencies addressed. To ensure data for this performance measure are accurate, complete, and unbiased, the IHS Division of Behavioral Health collects, evaluates, and monitors individual program files for each YRTC. Program Directors are required to submit the appropriate documentation to support FY 2012 data.

Program measures are the result of evaluations by CARF, the Joint Commission, States, or Regional Behavioral Health Authorities and measured against CARF, Joint Commission, States, or Regional Behavioral Health Authorities' standards for accreditation/certification.

**Decision Unit 2: Office of Clinical and Preventive Services, Division of Behavioral Health, IHS****Measure 2: Domestic Violence (Intimate Partner) Screening: Proportion of women who are screened for domestic violence at health care facilities.**

| Table 1: Measure 2 |                   |                   |                   |                   |                   |                   |
|--------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|
| FY 2008<br>Actual  | FY 2009<br>Actual | FY 2010<br>Actual | FY 2011<br>Actual | FY 2012<br>Target | FY 2012<br>Actual | FY 2013<br>Target |
| 42%                | 48%               | 53%               | 55.3%             | 55.3%             | 61.5%             | 58.3%             |

**(1) Describe the measure--In doing so, provide an explanation of how the measure (1) reflects the purpose of the program; (2) contributes to the *National Drug Control Strategy*; and (3) is used by management of the program. This description should include sufficient detail to permit non-experts to understand what is being measured and why it is relevant to the Agency's drug control activities.**

This measure is designed to identify and assist AI/AN women who experience domestic violence. Screening assists in the identification of women at risk for domestic violence so that such women can be appropriately treated and/or referred for services aimed at terminating the cycle of violence. Significant increases in the rate of domestic violence screens reflect higher care team awareness. Research has shown that alcohol and drug use can worsen and, in some cases, accelerate domestic violence situations. This measure contributes to the *National Drug Control Strategy* by identifying alcohol and/or drug use factors in relationships in an effort to "stop drug use before it starts" and "healing America's drug (and alcohol) users."

In FY 2011, the IHS continued our support and technical assistance to Tribes in developing programs to address violence against women. The IHS Domestic Violence Prevention Initiative provides approximately \$10,000,000 to implement a nationally coordinated domestic violence prevention initiative. The initiative includes direct service provision for expanding Sexual Assault Nurse Examiner, Sexual Assault Forensic Examiner, and Sexual Assault Response Team programs, as well as more robust epidemiological capabilities. The initiative directly supports the development and implementation of domestic violence screening policies and procedures creating model practices which the entire system can utilize.

**(2) Provide narrative that examines the FY 2012 actual performance results with the FY 2012 target, as well as prior year actuals. If the performance target was not achieved for FY 2012, the Agency should explain why this is the case. If the Agency has concluded it is not possible to achieve the established target with available resources, the Agency should include recommendations on revising or eliminating the target.**

The FY 2012 performance target for this measure was exceeded by 6.2% percent. It reflects the ongoing commitment from the Agency and its Tribal partners to incorporate domestic violence screening into the provision of routine women's health care.

**(3) The Agency should describe the performance target for FY 2013 and how the Agency plans to meet this target. If the target in FY 2012 was not achieved, this explanation should detail how the Agency plans to overcome prior year challenges to meet targets in FY 2013.**

The performance target for FY 2013 is 58.3% screening rate. The measure is categorized as high priority, but low cost, which means health care team providers can conduct the screening in conjunction with any health care visit or encounter. Within the context of the Agency's current overall health services funding, projections based on increasing the existing performance rate may ultimately prove ambitious, but are achievable.

**(4) The Agency should describe the procedures used to ensure performance data for this measure are accurate, complete, and unbiased in presentation and substance. The Agency should also describe the methodology used to establish targets and actuals, as well as the data source(s) used to collect information.**

#### Clinical Reporting System (CRS) Documentation

##### Data Collection

The IHS relies on the Resource and Patient Management System (RPMS) to track and manage data at facilities and clinical sites. The RPMS Clinical Reporting System (CRS) software automates the data extraction process using data from patient records in the IHS health information system (RPMS) at the individual clinic level. CRS is updated at least annually to reflect changes in clinical guidelines for existing measures as well as adding new measures to reflect new healthcare priorities. Software versions are tested first on developmental servers on large data bases and then are beta tested at facilities, before submission to IHS Software Quality Assurance, which conducts a thorough review prior to national release. The new version of the application is released as Class 1 software throughout the IHS. In 2005, the Healthcare Information and Management Systems Society selected the Clinical Reporting System for the Davies Award of Excellence in public health information technology.

##### Completeness

After local sites submit their data, IHS Area coordinators use CRS to create Area level reports, which are forwarded to the national data support team for a second review and final aggregation. CRS software automatically creates a special file format of Area data for use in national aggregation, which eliminates potential errors that could occur if manual data extraction were required. These national aggregations are thoroughly reviewed for quality and accuracy before final submission. Specific instructions for running quarterly reports are available for both local facilities and each IHS Area.

CRS generated data reports are comprehensive representations of patient data and clinical performance for those facilities that participate and include data from 100 percent of all IHS direct facilities. At this time however, not all Tribes have elected to participate in the RPMS. Because Tribal participation is voluntary, results include data for only those Tribal clinics and hospitals that utilize RPMS.

Reliability

Electronic collection, using CRS, ensures that performance data is comparable across all facilities and is based on a review of 100 percent of all patient records rather than a sample. Facility reports are submitted on a quarterly and annual basis to the Government Performance and Results Act (GPRA) coordinator for their Area, who is responsible for quality reviews of the data before forwarding reports for national aggregation. Because the measure logic and reporting criteria are hard coded in the CRS software, these checks are primarily limited to assuring all communities assigned to a site are included in the report and to identifying measure results that are anomalous, which may indicate data entry or technical issues at the local level. Comprehensive information about CRS software and logic is at [www.ihs.gov/cio/crs/](http://www.ihs.gov/cio/crs/).

**Decision Unit 3: Office of Clinical and Preventive Services, Division of Behavioral Health, IHS*****Measure 3: Behavioral Health: Proportion of adults ages 18 and over who are screened for depression***

| Table 1: Measure 3 |                   |                   |                   |                   |                   |                   |
|--------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|
| FY 2008<br>Actual  | FY 2009<br>Actual | FY 2010<br>Actual | FY 2011<br>Actual | FY 2012<br>Target | FY 2012<br>Actual | FY 2013<br>Target |
| 35%                | 44%               | 52%               | 56.5%             | 56.5%             | 61.9%             | 58.6%             |

**(1) Describe the measure. In doing so, provide an explanation of how the measure (1) reflects the purpose of the program, (2) contributes to the *National Drug Control Strategy*, and (3) is used by management of the program. This description should include sufficient detail to permit non-experts to understand what is being measured and why it is relevant to the Agency's drug control activities.**

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 the *National Drug Control Strategy* by "stopping drug use before it starts" and "healing America's drug users."

**(2) Provide narrative that examines the FY 2012 actual performance results with the FY 2012 target, as well as prior year actuals. If the performance target was not achieved for FY 2012, the Agency should explain why this is the case. If the Agency has concluded it is not possible to achieve the established target with available resources, the Agency should include recommendations on revising or eliminating the target.**

The FY 2012 performance target for this measure was exceeded by 5.4%. Since FY 2006, the IHS has increased the screening rate four-fold, from 15% in 2006 to 61.9 % in FY 2012, through informational campaigns and incorporating depression screening as a routine part of AI/AN health care.

**(3) The Agency should describe the performance target for FY 2013 and how the Agency plans to meet this target. If the target in FY 2012 was not achieved, this explanation should detail how the Agency plans to overcome prior year challenges to meet targets in FY 2013.**

The performance target for FY 2013 is 58.6%. The rationale for increasing the target is based on several factors. The measure is categorized as high priority, but low cost, which means health care providers can conduct the screening in conjunction with any health care visit or encounter. Within the context of the Agency's current overall health services funding, projections based on increasing the existing performance rate may ultimately prove ambitious, but are achievable.

**(4) The Agency should describe the procedures used to ensure performance data for this measure are accurate, complete, and unbiased in presentation and substance. The Agency should also describe the methodology used to establish targets and actuals, as well as the data source(s) used to collect information.**

#### Clinical Reporting System (CRS) Documentation

##### Data Collection

The IHS relies on the RPMS to track and manage data at facilities and clinical sites. The RPMS CRS software automates the data extraction process using data from patient records in the IHS health information system (RPMS) at the individual clinic level. CRS is updated at least annually to reflect changes in clinical guidelines for existing measures as well as adding new measures to reflect new healthcare priorities. Software versions are tested first on developmental servers on large data bases and then are beta tested at facilities, before submission to IHS Software Quality Assurance, which conducts a thorough review prior to national release. The new version of the application is released as Class 1 software throughout the IHS. In 2005, the Healthcare Information and Management Systems Society selected the Clinical Reporting System for the Davies Award of Excellence in public health information technology.

##### Completeness

After local sites submit their data, IHS Area coordinators use CRS to create Area level reports, which are forwarded to the national data support team for a second review and final aggregation. CRS software automatically creates a special file format of Area data for use in national aggregation, which eliminates potential errors that could occur if manual data extraction were required. These national aggregations are thoroughly reviewed for quality and accuracy before final submission. Specific instructions for running quarterly reports are available for both local facilities and each IHS Area.

CRS generated data reports are comprehensive representations of patient data and clinical performance for those facilities that participate and include data from 100 percent of all IHS direct facilities. At this time however, not all Tribes have elected to participate in the RPMS. Because Tribal participation is voluntary, results include data for only those Tribal clinics and hospitals that utilize RPMS.

Reliability

Electronic collection, using CRS, ensures that performance data is comparable across all facilities and is based on a review of 100% of all patient records rather than a sample. Facility reports are submitted on a quarterly and annual basis to the GPRA coordinator for their Area, who is responsible for quality reviews of the data before forwarding reports for national aggregation. Because the measure logic and reporting criteria are hard coded in the CRS software, these checks are primarily limited to assuring all communities assigned to a site are included in the report and to identifying measure results that are anomalous, which may indicate data entry or technical issues at the local level. Comprehensive information about CRS software and logic is at [www.ihs.gov/cio/crs/](http://www.ihs.gov/cio/crs/).

**Decision Unit 4:** Office of Clinical and Preventive Services, Division of Behavioral Health, IHS**Measure 4:** *Alcohol Screening (FAS Prevention): Alcohol-use screening (to prevent fetal alcohol syndrome) among appropriate female patients*

| Table 1: Measure 4 |                   |                   |                   |                   |                   |                   |
|--------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|
| FY 2008<br>Actual  | FY 2009<br>Actual | FY 2010<br>Actual | FY 2011<br>Actual | FY 2012<br>Target | FY 2012<br>Actual | FY 2013<br>Target |
| 47%                | 52%               | 55%               | 57.8%             | 58.7%             | 63.8%             | 61.7%             |

**(1) Describe the measure. In doing so, provide an explanation of how the measure (1) reflects the purpose of the program, (2) contributes to the *National Drug Control Strategy*, and (3) is used by management of the program. This description should include sufficient detail to permit non-experts to understand what is being measured and why it is relevant to the Agency's drug control activities.**

Alcohol consumption can cause significant birth defects, including fetal alcohol syndrome (FAS). FAS is the leading known and preventable cause of mental retardation. Rates of FAS are higher among AI/AN populations than the general population. Screening for alcohol use among women of child-bearing age 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 far-reaching positive impact on overall health in AI/AN communities. Increases beginning in the FY 2007 rates of alcohol screening can be attributed to specific Agency initiatives emphasizing the importance of behavioral health screenings at either clinical or behavioral health encounters. This measure contributes to the *National Drug Control Strategy* by identifying alcohol usage factors in an effort to "heal America's drug (and alcohol) users."

**(2) Provide narrative that examines the FY 2012 actual performance results with the FY 2012 target, as well as prior year actuals. If the performance target was not achieved for FY 2012, the Agency should explain why this is the case. If the Agency has concluded it is not possible to achieve the established target with available resources, the Agency should include recommendations on revising or eliminating the target.**

The FY 2012 performance target for this measure was exceeded by 5.1%. Since FY 2004, the IHS has increased the screening rate nine-fold, from 7% in 2004 to 63.8% in 2012, through promoting and incorporating alcohol screening as a routine part of women's health care.

**(3) The Agency should describe the performance target for FY 2012 and how the Agency plans to meet this target. If the target in FY 2012 was not achieved, this explanation should detail how the Agency plans to overcome prior year challenges to meet targets in FY 2013.**

The goal for FY 2013 is to increase the screening rate to 61.7%. The measure is categorized as high priority, but low cost, which means health care providers can conduct the screening in conjunction with any health care visit or encounter. Within the context of the Agency's current overall health services funding, projections based on increasing the existing performance rate may ultimately prove ambitious, but are achievable.

**(4) The Agency should describe the procedures used to ensure performance data for this measure are accurate, complete, and unbiased in presentation and substance. The Agency should also describe the methodology used to establish targets and actuals, as well as the data source(s) used to collect information.**

#### Clinical Reporting System (CRS) Documentation

##### Data Collection

The IHS relies on the RPMS to track and manage data at facilities and clinical sites. The RPMS CRS software automates the data extraction process using data from patient records in the IHS health information system (RPMS) at the individual clinic level. CRS is updated at least annually to reflect changes in clinical guidelines for existing measures as well as adding new measures to reflect new healthcare priorities. Software versions are tested first on developmental servers on large data bases and then are beta tested at facilities, before submission to IHS Software Quality Assurance, which conducts a thorough review prior to national release. The new version of the application is released as Class 1 software throughout the IHS. In 2005, the Healthcare Information and Management Systems Society selected the Clinical Reporting System for the Davies Award of Excellence in public health information technology.

##### Completeness

After local sites submit their data, IHS Area coordinators use CRS to create Area level reports, which are forwarded to the national data support team for a second review and final aggregation. CRS software automatically creates a special file format of Area data for use in national aggregation, which eliminates potential errors that could occur if manual data extraction were required. These national aggregations are thoroughly reviewed for quality and accuracy before final submission. Specific instructions for running quarterly reports are available for both local facilities and each IHS Area.

CRS generated data reports are comprehensive representations of patient data and clinical performance for those facilities that participate and include data from 100 percent of all IHS direct facilities. At this time however, not all Tribes have elected to participate in the RPMS.

Because Tribal participation is voluntary, results include data for only those Tribal clinics and hospitals that utilize RPMS.

#### Reliability

Electronic collection, using CRS, ensures that performance data is comparable across all facilities and is based on a review of 100% of all patient records rather than a sample. Facility reports are submitted on a quarterly and annual basis to the GPRA coordinator for their Area, who is responsible for quality reviews of the data before forwarding reports for national aggregation. Because the measure logic and reporting criteria are hard coded in the CRS software, these checks are primarily limited to assuring all communities assigned to a site are included in the report and to identifying measure results that are anomalous, which may indicate data entry or technical issues at the local level. Comprehensive information about CRS software and logic is at [www.ihs.gov/cio/crs/](http://www.ihs.gov/cio/crs/).

**Decision Unit 5:** Office of Clinical and Preventive Services, Division of Behavioral Health, IHS

***Measure 5: Suicide Surveillance: Increase the incidence of suicidal behavior reporting by health care (or mental health) professionals***

| Table 1: Measure 5 |                   |                   |                   |                   |                   |                   |
|--------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|
| FY 2008<br>Actual  | FY 2009<br>Actual | FY 2010<br>Actual | FY 2011<br>Actual | FY 2012<br>Target | FY 2012<br>Actual | FY 2013<br>Target |
| 1,598              | 1,687             | 1,908             | 1,930             | 1,807             | 1,461             | 1,376             |

**(1) Describe the measure. In doing so, provide an explanation of how the measure (1) reflects the purpose of the program, (2) contributes to the National Drug Control Strategy, and (3) is used by management of the program. This description should include sufficient detail to permit non-experts to understand what is being measured and why it is relevant to the Agency's drug control activities.**

The suicide surveillance measure has evolved from developing a data collection tool for use by behavioral health providers to integrating the suicide reporting form (SRF) into the RPMS and making it available to all providers. A baseline usage level by primary care, emergency, behavioral health, and other providers was established in 2006. The suicide surveillance (RPMS Suicide Reporting Form) captures data related to a specific incident, such as date and location of act, method, contributing factors, and other useful epidemiologic 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 method. Increased utilization of suicide reporting forms throughout the Indian health system will provide more comprehensive information about the incidence of suicidal ideations, attempts, and completions, provide far more timely and accurate data to national policy makers, and allow interventions to be evaluated in ways not previously possible. Unfortunately, suicide is often the result of ongoing life management concerns such as depression, domestic/intimate partner violence, and alcohol and substance abuse. Early identification of depression, interpersonal difficulties, and suicidal ideation will contribute to "stopping drug use before it starts" and "healing America's drug users."

**(2) Provide narrative that examines the FY 2012 actual performance results with the FY 2012 target, as well as prior year actuals. If the performance target was not achieved for FY 2012, the Agency should explain why this is the case. If the Agency has concluded it is not possible to achieve the established target with available resources, the Agency should include recommendations on revising or eliminating the target.**

This performance target was not met in FY 2012. The FY 2012 target was 1,807 forms; the FY 2012 actual results were 1,461 forms.

This is due to a number of reasons. First, it was noted during a data quality review that data exports received at the National Data Warehouse (NDW) from the IHS Areas may be comprised of duplicate records. These duplicates would also apply to suicide reporting forms. To address this issue, the IHS Division of Behavioral Health directed the Indian Health Performance Evaluation System (IHPES) staff to identify duplicate records and to develop a procedure to de-duplicate all exported records received by the NDW. IHPES proposed a 4-step process by which all records were sorted; cross-referenced and duplicate records were removed. As a result, the annual total number of forms submitted nationally was reduced. However, de-duplicated trend data from 2004 through 2012 suggests uniform variance and an overall upward trend.

Second, one IHS Service Area informed IHS that they objected to the collection and reporting of suicide surveillance data. In consideration of Tribal data ownership and given the very sensitive nature of suicide in some IHS Areas, IHPES was directed to no longer collect and report on suicide surveillance data for that IHS Area.

Third, there is a lag time between suicide and suicide-related events and reporting in RPMS and subsequent data exports. Therefore, data reported above in Table 1: Measure 5 may not include all forms submitted in FY 2012. For all the above reasons, there was an overall decrease in the number of suicide reporting forms exported and thus the performance target for FY 2012 was not met. Results for FY 2012 represent a more accurate estimate of provider reporting of suicide and suicide-related events due to improved data quality processes and serve as the benchmark going forward.

**(3) The Agency should describe the performance target for FY 2013 and how the Agency plans to meet this target. If the target in FY 2012 was not achieved, this explanation should detail how the Agency plans to overcome prior year challenges to meet targets in FY 2013.**

The FY 2013 target performance measure is the number of suicide reporting forms exported. To continue to increase the utilization of the suicide reporting form, IHS will increase and improve awareness of the form and the importance of suicide surveillance activities among providers, facility and Area managers, and administrators. Similarly, RPMS Site Managers and Electronic Health Record Clinical Application Coordinators will be made aware of the SRF and the appropriate application set-up and exporting processes.

**(4) The Agency should describe the procedures used to ensure performance data for this measure are accurate, complete, and unbiased in presentation and substance. The Agency should also describe the methodology used to establish targets and actuals, as well as the data source(s) used to collect information.**

The suicide surveillance measure logic utilizes SRF data entered by providers at the point of care. Once entered into the database, the SRF information is then electronically exported from the documenting site to the national suicide database in Albuquerque, New Mexico. Processes are in place to accurately document receipt of the electronic file(s), notify the sending site that the file(s) have been received by providing electronic file name(s) and record counts. Once received, the national suicide database is automatically updated with the new information. Sites must initiate the electronic export process for data to be included in the performance measurement report. The source system is the RPMS SRF data entered at the point of care and the national RPMS suicide database maintained by IHS. The SRF was designed by clinical, epidemiology, and informatics subject matter experts. The targets are determined by an analysis of the previous year's utilization rates by each of the 12 IHS Areas.