



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



January 12, 2016

TO: Susan V. Karol, MD
Chief Medical Officer
Indian Health Service

Ann M. Church
Acting Chief Financial Officer
Indian Health Service

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

SUBJECT: Independent Attestation Review: Indian Health Service Fiscal Year 2015
Detailed Accounting Submission and Performance Summary Report for National
Drug Control Activities and Accompanying Required Assertions
(A-03-16-00351)

This report provides the results of our review of the attached Indian Health Service (IHS) detailed accounting submission, which includes the table of Drug Control Obligations, related disclosures, and management's assertions for the fiscal year ended September 30, 2015. We also reviewed the Performance Summary Report, which includes management's assertions and related performance information for the fiscal year ended September 30, 2015. IHS management is responsible for, and prepared, the detailed accounting submission and Performance Summary Report to comply with the Office of National Drug Control Policy Circular *Accounting of Drug Control Funding and Performance Summary*, dated January 18, 2013 (the ONDCP Circular).

We performed this review as required by 21 U.S.C. § 1704(d)(A) and as authorized by 21 U.S.C. §1703(d)(7) and in compliance with the ONDCP Circular.

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. An attestation 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.

Based on our review, nothing came to our attention that caused us to believe that IHS's detailed accounting submission and Performance Summary Report for fiscal year 2015 were not fairly stated, in all material respects, based on the ONDCP Circular.

IHS's detailed accounting submission and Performance Summary Report are included as Attachments A and B.

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 any questions or comments about this report, please do not hesitate to call me, or your staff may contact Carla J. Lewis, Acting Assistant Inspector General for Audit Services, at (202) 619-1157 or through email at Carla.Lewis@oig.hhs.gov. Please refer to report number A-03-16-00351 in all correspondence.

Attachments



NOV 17 2015

Indian Health Service
Rockville MD 20852

MEMORANDUM TO: Director
Office of National Drug Control Policy

THROUGH: Sheila Conley
Deputy Assistant Secretary of Finance
Department of Health and Human Services

FROM: Ann M. Church
Acting Chief Financial Officer
Indian Health Service

SUBJECT: Assertions Concerning Drug Control Accounting

In accordance with the requirements of the Office of National Drug Control Policy Circular *Accounting of Drug Control Funding and Performance Summary*, I make the following assertions regarding the attached annual accounting of drug control funds for the Indian Health Service (IHS):

Obligations by Budget Decision Unit

I assert that obligations reported by budget decision unit are the actual obligations from the bureau's accounting system of record for these budget decision units, consistent with the drug budget methodology discussed below.

Drug Methodology

I assert that the drug methodology used to calculate obligations of prior year budgetary resources by function for all bureaus was reasonable and accurate in accordance with the criteria listed in Section 6b(2) of the Circular. In accordance with these criteria, I have documented/identified data that support the drug methodology, explained and documented other estimation methods (the assumptions for which are subjected to periodic review) and determined that the financial systems supporting the drug methodology yield data that fairly present, in all material respects, aggregate obligations from which drug-related obligation estimates are derived.

The IHS methodology for estimating the drug control budget was established using the amounts appropriated for the Alcohol and Substance Abuse Prevention programs authorized under P.L. 102-573, the Indian Health Amendments of 1992. See attached table "Alcoholism and Substance Abuse Prevention Treatment Program Authorized under P.L. 102-573" for a list of programs. This table reflects estimated amounts. When originally authorized and appropriated, the funds were allocated to Tribes in their self-determination contract by specific programs. However, when the programs were reauthorized and captured under P.L. 102-573, some IHS Area Offices allocated the funds in lump sums while others maintained the specific program

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breakouts. Therefore, at the current time precise amounts of funding for each program are not available. The table is maintained to estimate current funding levels and is the basis of the drug budget control methodology. Excluded is the amount for the Adult Treatment programs, which represents the original authorization for IHS to provide alcohol treatment services. The focus on alcoholism treatment is the reason for the exclusion.

Drug Resources by Decision Unit: The IHS drug control funds are appropriated in two budget line items: 1) Alcohol and Substance Abuse (ASA) and 2) Urban Indian Health Programs (UIHP). The ASA funds are primarily allocated to Tribes under self-determination contracts and compacts through which they manage the programs and have authority to reallocate funds to address local priorities. The portion of the ASA included in the drug control budget methodology is as described above, i.e., the entire budget excluding the amount for adult treatment. The UIHP funds are allocated through contracts and grants to 501(c)(3) organizations. The portion of UIHP funds included in the drug control budget methodology is for the National Institute on Alcohol Abuse and Alcoholism programs transferred to the IHS under the UIHP budget.

Drug Resources by Function: Under the methodology, two programs through FY 2007 were identified as Prevention programs: Community Education and Training as well as Wellness Beyond Abstinence. In FY 2008, one half of the new funds appropriated for Methamphetamine and Suicide prevention and treatment were also included in the Prevention function. The treatment function comprises the remaining program excluding adult treatment. In addition, the amount of UIHP funds is included under the treatment function.

Application of Drug Methodology

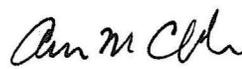
I assert that the drug methodology disclosed in this section was the actual methodology used to generate the table required by Section 6a of the Circular.

Reprogramming or Transfers

IHS did not reprogram or transfer any funds included in its drug control budget.

Funds Control Notices

IHS was not issued any Fund Control Notices by the Director under 21 U.S.C. 1703 (f) and Section 9 of the ONDCP Circular, *Budget Execution*, dated January 18, 2013.


Ann M. Church

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Attachments: ¹

1. Table – Alcoholism and Substance Abuse Prevention Treatment Program Authorized under P.L. 102-573
2. Table – FY 2015 Drug Control Obligations

¹ The first table attached to this report is necessary for understanding the IHS drug control budget methodology. The table titled “Alcoholism and Substance Abuse Treatment and Prevention Program Authorized under P.L. 102-573” shows the Alcohol and Substance Abuse budget line item broken out by the activities originally authorized in P.L. 100-690 and later included under P.L. 102-573. This table also includes the funding within the Urban Indian Health budget line item that supports alcohol and substance abuse treatment services. However, funds are not appropriated or accounted for by these specific categories, but rather as the lump sum funds of Alcohol and Substance Abuse and Urban Health. The second table shows the obligations of these funds as required by the Office of National Drug Control Policy Circular *Accounting of Drug Control Funding and Performance Summary*.

Indian Health Service
Alcoholism and Substance Abuse Prevention
Treatment Program

Authorized under P.L. 102-573
(Dollars in Thousands)

Amount of Funds	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Enacted	Drug Control & Moyer Reports
ALCOHOL & SUBSTANCE ABUSE						
Adult Treatment.....	\$102,781	\$102,731	\$97,926	\$98,633	\$101,312	Excluded*
Regional Treatment Centers	\$21,226	\$21,215	\$20,223	\$20,369	\$20,922	Treatment
Community Education & Training.....	\$9,544	\$9,540	\$9,094	\$9,159	\$9,408	Prevention
Community Rehabilitation/ Aftercare.....	\$31,003	\$30,988	\$29,539	\$29,752	\$30,560	Treatment
Gila River.....	\$237	\$237	\$226	\$228	\$234	Treatment
Contract Health Service.....	\$10,914	\$10,909	\$10,398	\$10,473	\$10,758	Treatment
Navajo Rehab. Program....	\$420	\$420	\$400	\$403	\$414	Treatment
Urban Clinical Services.....	\$895	\$894	\$852	\$859	\$882	Treatment
Wellness Beyond Abstinence.....	\$1,031	\$1,031	\$982	\$989	\$1,016	Prevention
Meth Prev & Treatment.....	\$16,358	\$16,332	\$15,513	\$15,513	\$15,475	50/50 Tx & Prev
Total.....	\$194,409	\$194,297	\$185,154	\$186,378	\$190,981	

URBAN HEALTH PROGRAM 1/

Amount of Funds	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Enacted	
Expand Urban Programs....	\$4,403	\$4,403	\$4,403	\$4,492	\$4,492	Treatment

INDIAN HEALTH FACILITIES 2/

Amount of Funds	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Enacted
Construction.....	0	1,997	0	15,500	17,161

Alcohol/Substance Abuse	\$194,409	\$194,297	\$185,154	\$186,378	\$190,982
Urban Health Program	4,403 #	4,403	4,403	4,492	4,492
Facilities Construction	0	1,997	0	15,500	17,161
GRAND TOTAL.....	\$198,812	\$200,697	\$189,557	\$206,370	\$212,635

1/ The Urban Program was funded under P.L. 100-690, and is now funded under P.L. 102-573.

2/ These funds are included in the Outpatient Sub-sub-activity.

*Adult Treatment funds are excluded from the ONDCP Drug Control Budget and Moyer Anti-Drug Abuse methodologies because this program reflects the original authorized program for IHS with the sole focus of alcoholism treatment services for adults. This determination was made in consultation with ONDCP when the drug control budget was initially developed in the early 1990s.

INDIAN HEALTH SERVICE
FY 2015 Drug Control Obligations
(Dollars in Thousands)

	<u>Enacted</u>	<u>Obligated</u>
Drug Resources by Function		
Prevention	\$18,161	\$16,100
Treatment	\$76,000	\$73,557
Construction*	\$17,161	\$
	<u>\$111,322</u>	<u>\$89,657</u>
 Drug Resources by Decision Unit		
Alcohol and Substance Abuse	\$89,669	\$85,165
Urban Indian Health Program	\$4,492	\$4,492
Facilities Construction*	\$17,161	\$
	<u>\$111,322</u>	<u>\$89,657</u>

*Although Facilities Construction is broken out, it is not a separate line and is included under Treatment (in Function) and Alcohol and Substance Abuse (in Decision Unit)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

DEC 22 2015

Indian Health Service
Rockville, MD 20852

Memorandum to: Director
Office of National Drug Control Policy

Through: Norris Cochran
Deputy Assistant Secretary, Budget

From: Susan V. Karol
Chief Medical Officer
Indian Health Service

Subject: Assertions Concerning FY 2015 Performance Summary Report

In accordance with the requirements of the Office of National Drug Control Policy circular "Accounting of Drug Control Funding and Performance Summary," I make the following assertions regarding the attached FY2015 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 revision 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.

A handwritten signature in black ink, appearing to read "Susan V. Karol".

Susan V. Karol, MD

**FY 2015 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

YRTC Accreditation Table 1: Measure 1					
FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Target	FY 2015 Actual	FY 2016 Target
91%	90%	90%	100%	90%	100%

- (1) Performance Measures-** The report must describe the performance measures used by the agency to assess the National Drug Control Program activities it carried out in the most recently completed fiscal year and provide a clear justification for why those measures are appropriate for the associated National Drug Control Program activities. The performance report must explain how the measures: clearly reflect the purpose and activities of the agency; enable assessment of agency contribution to the National Drug Control Strategy; are outcome-oriented; and are used in agency management. The description must include sufficient detail to permit non-experts to understand what is being measured and why it is relevant to those 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), or State licensure. This measure contributes to the *National Drug Control Strategy* to “integrate treatment for substance abuse disorders into health care and expand support for recovery.” This is accomplished in part by working to ensure that 100 percent of Youth Regional Treatment Centers (YRTCs) achieve and maintain accreditation status. Accreditation status serves as evidence that the centers meet rigorous person-centered standards that emphasize an integrated and individualized approach to services provided to American Indian and Alaska Native (AI/AN) youth who enter residential treatment for alcohol and substance abuse. Agency management uses the performance measure as a tool to monitor the commitment to quality services provided by the centers.

- (2) Prior Years Performance Targets and Results -** For each performance measure, the report must provide actual performance information for the previous four fiscal years and compare the results of the most recently completed fiscal year with the projected (target) levels of performance established for the measures in the agency's annual performance budget for that year. If any performance target for the most recently completed fiscal year was not met, the report must explain why that target was not met and describe the agency's plans and schedules for meeting

future targets. Alternatively, if the agency has concluded it is not possible to achieve the established target with available resources, the report should include recommendations concerning revising or eliminating the target.

The 100 percent accreditation performance measure was not met in FY 2015. One federally-operated YRTC accreditation was up for review in September 2015. A review was completed. The center did not initially pass but did appeal the findings. Upon a second review which occurred on October 29 and 30, 2015, the accreditation body noted improvements and had no findings and was ultimately reaccredited in November 2015.

- (3) Current Year Performance Targets - Each report must specify the performance targets established for National Drug Control Program activities in the agency's performance budget for the current fiscal year and describe the methodology used to establish those targets.**

The FY 2016 performance target for the YRTCs will remain unchanged at 100 percent for accreditation status. The methodology utilized to establish the fiscal year target is 100 percent of YRTCs achieving and maintaining accreditation as a reflection of the quality of care associated with accreditation status. The methodology utilized to determine the actual results at the end of the fiscal year is the number of accredited YRTCs as the numerator and the total number of YRTCs used as the denominator.

- (4) Quality of Performance Data- The agency must state the procedures used to ensure that the performance data described in this report are accurate, complete, and unbiased in presentation and substance. Agency performance measures must be supported by data sources that are directly pertinent to the drug control activities being assessed and ideally allow documentation of small but significant changes.**

On an annual basis, the Indian Health Service (IHS) Office of Clinical and Preventive Services (OCPS), Division of Behavioral Health (DBH) requires all YRTCs to verify their current 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 are continually being met and deficiencies are addressed. To ensure data for this performance measure are accurate, complete, and unbiased, the IHS DBH collects, evaluates, and monitors individual program files for each YRTC.

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.

Domestic Violence Table 2: Measure 2					
FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Target	FY 2015 Actual	FY 2016 Target
61.5%	62.4%	63.5%	61.6%	63.6%	N/A*

*Current Measure will be retired after 2015 and replaced with a new measure with the same name in FY 2016 to denote the change in the denominator.

- (1) **Performance Measures-** The report must describe the performance measures used by the agency to assess the National Drug Control Program activities it carried out in the most recently completed fiscal year and provide a clear justification for why those measures are appropriate for the associated National Drug Control Program activities. The performance report must explain how the measures: clearly reflect the purpose and activities of the agency; enable assessment of agency contribution to the National Drug Control Strategy; are outcome-oriented; and are used in agency management. The description must include sufficient detail to permit non-experts to understand what is being measured and why it is relevant to those activities.

Measure No. (2) The FY 2015 results for this measure were calculated from the Clinical Reporting System (see discussion in number 4 below) using the same measure logic as in previous years. FY 2016 Clinical GPRA Measure logic changes: changed the denominator age range from 15 to 40 years to reflect the age range for child-bearing woman in Healthy People 2020 to screen women between the ages of 14 to 46 for domestic violence. Research suggests that alcohol and drug use can worsen and, in some cases, accelerate domestic violence situations. By identifying victims of domestic violence, the Agency also has the opportunity to identify substance abuse issues that may be occurring in the home. This measure contributes to the *National Drug Control Strategy* in an effort to “expand access to treatment for Americans struggling with addiction.” Agency management uses this performance measure as a tool to assist in protecting the safety of the victim and family, improve quality of life, and provide access to advocacy, justice, and social services.

- (2) **Prior Years Performance Targets and Results -** For each performance measure, the report must provide actual performance information for the previous four fiscal years and compare the results of the most recently completed fiscal year with the projected (target) levels of performance established for the measures in the agency's annual performance budget for that year. If any performance target for the most recently completed fiscal year was not met, the report must explain why that target was not met and describe the agency's plans and schedules for meeting future targets. Alternatively, if the agency has concluded it is not possible to achieve

the established target with available resources, the report should include recommendations concerning revising or eliminating the target.

The FY 2015 target for domestic violence screening was met and exceeded. IHS will continue to provide standardized training through its Forensic Healthcare learning management system. The training is available at no-cost with continuing education credits/units available through an online system.

- (3) Current Year Performance Targets - Each report must specify the performance targets established for National Drug Control Program activities in the agency's performance budget for the current fiscal year and describe the methodology used to establish those targets.**

The performance target for FY 2016 is baseline screening rate. Because the denominator logic expands the screening age between FY 2015 and FY 2016 and IHS has no historical data on this larger denominator, the FY 2016 baseline target will establish a result based upon the new change.

- (4) Quality of Performance Data- The agency must state the procedures used to ensure that the performance data described in this report are accurate, complete, and unbiased in presentation and substance. Agency performance measures must be supported by data sources that are directly pertinent to the drug control activities being assessed and ideally allow documentation of small but significant changes.**

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 CRS software automates the data extraction process using data from patient records in the IHS health information system (RPMS) at the individual clinic level. The CRS is updated annually to reflect changes in clinical guidelines for existing and 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 System Society selected the CRS 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 nation 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. Tribes have the option to voluntarily participate, thus, results include data from 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/.

Decision Unit 3: Office of Clinical and Preventive Services, Division of Behavioral Health, IHS

Measure 3: Behavioral Health: Proportion of American Indian and Alaska Native adults 18 and over who are screened for depression

Depression Screening Table 3: Measure 3					
FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Target	FY 2015 Actual	FY 2016 Target
61.9%	65.1%	66.0%	64.3%	67.4%	67.2%

- (1) **Performance Measures-** The report must describe the performance measures used by the agency to assess the National Drug Control Program activities it carried out in the most recently completed fiscal year and provide a clear justification for why those measures are appropriate for the associated National Drug Control Program activities. The performance report must explain how the measures: clearly reflect the purpose and activities of the agency; enable assessment of agency contribution to the National Drug Control Strategy; are outcome-oriented; and are used in agency management. The description must include sufficient detail to permit non-experts to understand what is being measured and why it is relevant to those activities.

Measure No. (3) reflects the number of American Indian and Alaska Native adults over 18 years of age who are screened for depression. Depression is often an underlying component contributing to suicide, accidents, domestic violence, and alcohol and substance abuse. For patients, who have co-occurring substance use disorders and mood disorders, such as depression, this measure is used by the Agency to identify individuals who require intervention, treatment, and referral to appropriate services. The measure contributes to the *National Drug Control Strategy* to “prevent drug use before it ever begins through education,” “expand access to treatment for Americans struggling with addiction,” and “support Americans in recovery by lifting the stigma associated with suffering or in recovery from substance use disorders.”

- (2) **Prior Years Performance Targets and Results -** For each performance measure, the report must provide actual performance information for the previous four fiscal years and compare the results of the most recently completed fiscal year with the projected (target) levels of performance established for the measures in the agency's annual performance budget for that year. If any performance target for the most recently completed fiscal year was not met, the report must explain why that target was not met and describe the agency's plans and schedules for meeting future targets. Alternatively, if the agency has concluded it is not possible to achieve the established target with available resources, the report should include recommendations concerning revising or eliminating the target.

The FY 2015 target for depression screening was met and exceeded. To meet the FY 2016 target for depression screening, IHS will offer standardized training plans for its workforce on depression screening.

- (3) Current Year Performance Targets - Each report must specify the performance targets established for National Drug Control Program activities in the agency's performance budget for the current fiscal year and describe the methodology used to establish those targets.**

The performance target for FY 2016 is 67.2 percent.

Target calculations for GPRA Clinical Measures: The annual budget and individual budget lines are the basis for performance measure target calculations. For the clinical GPRA measures, an approved HHS mathematical formula is used. These targets are reviewed internally by the clinical programs as well as the Director of OCPS. For non-clinical GPRA measures associated with budget lines, each national program lead determines what a reasonable target increase/decrease should be depending upon past performance, the budget amount, and current conditions to achieve the target.

Once targets have been reviewed by the clinical or non-clinical programs, the targets are submitted by the IHS Office of Finance and Accounting to HHS who forwards them to OMB for discussion. Targets changed by HHS and/or OMB are returned to the programs for approval/disapproval. Anomalies are elevated to senior staff for discussion.

Methodology for calculating GPRA clinical targets for the following IHS budget lines H&HC, Dental Services, Mental Health, and Alcohol & Substance Abuse: For purposes of explanation, assume that the budget is increased from one year to the next. Using the H&HC budget line as an example, (1) the relative increase of this year's budget amount is calculated. This same formula is used for the dental and behavioral health measures. The formula is $1 - (\text{President's Budget} + \text{Current Services}) / (\text{President's Budget})$.

The relative increase is then multiplied by the previous year's final result (or target) to establish the actual increase for the measure. The actual increase is added to the previous year's result or target to establish this year's target.

- (4) Quality of Performance Data- The agency must state the procedures used to ensure that the performance data described in this report are accurate, complete, and unbiased in presentation and substance. Agency performance measures must be supported by data sources that are directly pertinent to the drug control activities being assessed and ideally allow documentation of small but significant changes.**

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 RPMS at the individual clinic level. CRS is updated 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 CRS 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 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/.

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

Alcohol Screening Table 4: Measure 4					
FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Target	FY 2015 Actual	FY 2016 Target
63.8%	65.7%	66.0%	66.7%	66.6%	Baseline

- (1) Performance Measures-** The report must describe the performance measures used by the agency to assess the National Drug Control Program activities it carried out in the most recently completed fiscal year and provide a clear justification for why those measures are appropriate for the associated National Drug Control Program activities. The performance report must explain how the measures: clearly reflect the purpose and activities of the agency; enable assessment of agency contribution to the National Drug Control Strategy; are outcome-oriented; and are used in agency management. The description must include sufficient detail to permit non-experts to understand what is being measured and why it is relevant to those activities.

Measure No. (4) reflects the percentage of women of child-bearing age who are screened for alcohol use. The Agency uses this measure to reduce alcohol misuse in pregnancy and to reduce the incidence of Fetal Alcohol Syndrome (FAS). FAS is the leading known and preventable cause of intellectual disability. Rates of FAS are higher among AI/AN populations compared to the general population in the United States. 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 screening at either clinical or behavioral health encounters. This measure contributes to the *National Drug Control Strategy* to “prevent drug use before it begins through education” and “expand access to treatment for Americans struggling with addiction.”

- (2) Prior Years Performance Targets and Results -** For each performance measure, the report must provide actual performance information for the previous four fiscal years and compare the results of the most recently completed fiscal year with the projected (target) levels of performance established for the measures in the agency's annual performance budget for that year. If any performance target for the most recently completed fiscal year was not met, the report must explain why that target was not met and describe the agency's plans and schedules for meeting future targets. Alternatively, if the agency has concluded it is not possible to achieve the established target with available resources, the report should include recommendations concerning revising or eliminating the target.

The FY 2015 performance target for this measure was not met. Since FY 2004, the IHS has increased the screening rate nine-fold, from 7 percent in 2004 to 66.6 percent in 2015,

through promoting and incorporating alcohol screening as a routine part of women's health care.

- (3) Current Year Performance Targets - Each report must specify the performance targets established for National Drug Control Program activities in the agency's performance budget for the current fiscal year and describe the methodology used to establish those targets.**

The target goal for FY 2016 is baseline.

- (4) Quality of Performance Data- The agency must state the procedures used to ensure that the performance data described in this report are accurate, complete, and unbiased in presentation and substance. Agency performance measures must be supported by data sources that are directly pertinent to the drug control activities being assessed and ideally allow documentation of small but significant changes.**

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 RPMS at the individual clinic level. CRS is updated 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 CRS 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 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/.

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*

Suicide Report Form Table 5: Measure 5					
FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Target	FY 2015 Actual	FY 2016 Target
1,709	1,438	1,766	1,419	2,346	1,798

- (1) **Performance Measures-** The report must describe the performance measures used by the agency to assess the National Drug Control Program activities it carried out in the most recently completed fiscal year and provide a clear justification for why those measures are appropriate for the associated National Drug Control Program activities. The performance report must explain how the measures: clearly reflect the purpose and activities of the agency; enable assessment of agency contribution to the National Drug Control Strategy; are outcome-oriented; and are used in agency management. The description must include sufficient detail to permit non-experts to understand what is being measured and why it is relevant to those activities.

Measure No. (5) reflects the number of Suicide Reporting Forms (SRF) collected throughout the Indian health system. The SRF captures data related to specific incidents of suicide, such as date and location of act, method, contributing factors, and other useful epidemiologic information in a standardized and systematic fashion. The Agency uses this measure as a management tool to gather information about the incidence of suicidal ideations, attempts, and completions to influence policy and program decisions. Unfortunately, suicide is often the result of underlying issues such as depression, domestic violence, and alcohol and substance abuse. Early identification of depression, interpersonal difficulties, and suicidal ideation contributes to the *National Drug Control Strategy* to “prevent drug use before it ever begins through education” and “expand access to treatment for Americans struggling with addiction.”

- (2) **Prior Years Performance Targets and Results -** For each performance measure, the report must provide actual performance information for the previous four fiscal years and compare the results of the most recently completed fiscal year with the projected (target) levels of performance established for the measures in the agency's annual performance budget for that year. If any performance target for the most recently completed fiscal year was not met, the report must explain why that target was not met and describe the agency's plans and schedules for meeting future targets. Alternatively, if the agency has concluded it is not possible to achieve the established target with available resources, the report should include recommendations concerning revising or eliminating the target.

The performance target was exceeded in FY 2015. The FY 2015 target was 1,419 forms; the FY 2015 actual results were 2,346 forms. In the FY 2014 report, a clerical error was

identified in the suicide report form table for FY 2012 actual results. The table records 1,461 forms which is the preliminary result for FY 2012. The table should read as 1,709 forms as the actual result. This year, the table above has been correctly annotated. Standard procedures have been set in place to prevent this clerical error from reoccurring.

To continue to increase the utilization of the SRF, the IHS will increase 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.

- (3) Current Year Performance Targets - Each report must specify the performance targets established for National Drug Control Program activities in the agency's performance budget for the current fiscal year and describe the methodology used to establish those targets.**

The FY 2016 target is 1,798. The targets are determined by an analysis of the previous utilization rates by 11 of the 12 IHS Areas. This reflects the FY 2012 decision of Tribes within an entire IHS service area to decline the reporting of suicide surveillance data for their respective Area.

- (4) Quality of Performance Data- The agency must state the procedures used to ensure that the performance data described in this report are accurate, complete, and unbiased in presentation and substance. Agency performance measures must be supported by data sources that are directly pertinent to the drug control activities being assessed and ideally allow documentation of small but significant changes.**

The suicide surveillance measure logic utilizes SRF data entered into RPMS 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 suicide database maintained by IHS. The SRF was designed by clinical, epidemiology, and informatics subject matter experts.