DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

January 15, 2015

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

Kenneth Cannon
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 2014 Detailed Accounting Submission and Performance Summary Report for National Drug Control Activities and Accompanying Required Assertions (A-03-15-00351)

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, 2014. We also reviewed the Performance Summary Report, which includes management's assertions and related performance information for the fiscal year ended September 30, 2014. 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 2014 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 Kay L. Daly, Assistant Inspector General for Audit Services, at (202) 619-1157 or through email at Kay.Daly@oig.hhs.gov. Please refer to report number A-03-15-00351 in all correspondence.

Attachments

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Indian Health Service
Rockville MD 20852

NOV 21 2014

MEMORANDUM TO: Director
Office of National Drug Control Policy

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

FROM: Kenneth Cannon
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 which 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 present fairly, in all material respect, 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 Treatment and Prevention Program authorized under P.L. 102-573" for 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 public law 102-573, some IHS area offices allocated the funds in lump sum while others maintained the specific program breakout. Therefore, at the current time precise amounts of funding for each program are not available. The table is maintained to estimate current funding level 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Indian Health Service
Rockville MD 20852

Drug Resources by Decision Unit: The IHS drug control funds are appropriated in two budget line items: 1) Alcohol and Substance Abuse and 2) Urban Indian Health Programs (UIHP). The Alcohol and Substance Abuse funds are primarily allocated to Tribes under Self-Determination contracts and compacts, where they manage the programs and have authority to reallocate funds to address local priorities. The portion of the alcohol fund included in the drug control budget methodology is as described above, i.e., the entire budget excluding the amount for adult treatment. The Urban Indian Health Program 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 NIAAA 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 and 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.

Kenneth Cannon

Attachments: [1]

1. Table – Alcoholism and Substance Abuse Prevention Treatment Program Authorized Under P.L. 102-573
2. Table – FY 2014 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 authorized originally 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*.

Amount of Funds	FY 2010 Enacted	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Enacted	FY 2014 Enacted	Drug Control & Moyer Reports
ALCOHOL & SUBSTANCE ABUSE						
Adult Treatment.....	$102,748	$102,781	$102,731	$97,926	$98,633	Excluded*
Regional Treatment Centers	$21,226	$21,226	$21,215	$20,223	$20,369	Treatment
Community Education & Training.....	$9,544	$9,544	$9,540	$9,094	$9,159	Prevention
Community Rehabilitation/ Aftercare.....	$31,003	$31,003	$30,988	$29,539	$29,752	Treatment
Gila River.....	$237	$237	$237	$226	$228	Treatment
Contract Health Service.....	$10,914	$10,914	$10,909	$10,398	$10,473	Treatment
Navajo Rehab. Program....	$420	$420	$420	$400	$403	Treatment
Urban Clinical Services.....	$895	$895	$894	$852	$859	Treatment
Wellness Beyond Abstinence.....	$1,031	$1,031	$1,031	$982	$989	Prevention
Meth Prev & Treatment.....	$16,391	$16,358	$16,332	$15,513	$15,513	50/50 Tx & Prev
Total.....	**$194,409** #	**$194,409**	**$194,297**	**$185,154**	**$186,378**	

URBAN HEALTH PROGRAM 1/

Amount of Funds	FY 2010 Approp	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Enacted	FY 2014 Enacted	
Expand Urban Programs....	$4,239	$4,403	$4,403	$4,403	$4,492	Treatment

INDIAN HEALTH FACILITIES 2/

Amount of Funds	FY 2010 Approp	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Enacted	FY 2014 Enacted
Construction.....	0	0	1,997	0	15,500

Alcohol/Substance Abuse	**$194,409** #	**$194,409**	**$194,297**	**$185,154**	**$186,378**
Urban Health Program	**4,239**	**4,403** #	**4,403**	**4,403**	**4,492**
Facilities Construction	**0** #	**0**	**1,997**	**0**	**15,500**
GRAND TOTAL.....	**$198,648** #	**$198,812**	**$200,697**	**$189,557**	**$206,370**

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 treeatment services for adults. This determination was made in consultation with ONDCP when the drug control budget was initiatlly developed in the ealry 1990s.

INDIAN HEALTH SERVICE
FY 2014 Drug Control Obligations

	Enacted	($000) Obligated
Drug Resources by Function		
Prevention	$17,904	$16,646
Treatment	$74,332	$72,090
Construction*	$15,500	$12,849
	$107,737	$101,585
Drug Resources by Decision Unit		
Alcohol and Substance Abuse	$87,745	$84,244
Urban Indian Health Program	$4,492	$4,492
Facilities Construction *	$15,500	$12,849
	$107,737	$101,585

*Construction is included under ASA.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Indian Health Service
Rockville, MD 20852

NOV 21 2014

Memorandum to: Director
Office of National Drug Control Policy

Through: Norris Cochran
Deputy Assistant Secretary, Budget

From: Yvette Roubideaux, M.D., M.P.H.
Acting Director
Indian Health Service

Subject: Assertions Concerning FY 2014 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 FY2014 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.

Yvette Roubideaux

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

FY 2014 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 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Target	FY2014 Actual	FY 2015 Target
81%	91%	91%	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 ensuring 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 2014. The Agency did not meet its target due to one tribally-operated Youth Regional Treatment Center that did not achieve accreditation during FY 2014. Similarly, this same center has failed to gain accreditation in past fiscal years. However, the center made significant progress toward achieving accreditation in FY 2015 by completing the CARF application process and receiving a confirmatory site visit scheduled for November 17 & 18, 2014.

(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 2015 performance target for the YRTCs will remain unchanged at 100 percent for accreditation status. The methodology utilized to establish the fiscal year targets 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 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Target	FY2014 Actual	FY 2015 Target
53.0%	55.3%	61.5%	62.4%	64.1%	63.5%	61.6%

(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) reflects the number of women ages 15 to 40 who are screened for domestic violence in the Indian health system. 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 2014 target for domestic violence screening was not met. When compared to the FY 2013 results, the Agency increased performance by 1.1 percent in FY 2014. Despite the

increase in performance from FY 2013 to 2014, the Agency fell short of the 2014 target by 0.6 percent. Contributing factors to missing the target are a combination of staff turnover, recruitment of new staff unfamiliar with screening processes, and decreases in screening numbers among certain IHS Service Areas.

To meet the Agency's FY 2015 target, IHS is working on an Intimate Partner Violence policy which will establish national screening intervals, require regular training, and identify staff required to conduct domestic violence screenings. Additionally, IHS developed new 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 2015 is 61.6 percent screening rate.

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 OFA 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 - Hospital & Health Clinics (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, 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 – (President's Budget + Current Services)/(President's Budget + Current Services + Program Expansion funds that support direct care). Program expansion funds that support infrastructure such as ICD-10 development or purchases of dental electronic health records are subtracted from the total amount for H&HC program expansion and not included in the formula.

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.

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 voluntary 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 adults ages 18 and over who are screened for depression

Depression Screening Table 3: Measure 3						
FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Target	FY2014 Actual	FY 2015 Target
52.0%	56.5%	61.9%	65.1%	66.9%	66%	64.3%

(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 patients 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 2014 target for depression screening was not met. When compared to the FY 2013 results, the Agency increased performance by 0.9 percent in FY 2014. Despite the increase in performance from FY 2013 to 2014, the Agency fell short of the 2014 target by 0.9 percent which demonstrates the efforts throughout the Indian health system to meet the challenging target. The depression screening measure is a Government Performance

Reporting Act Modernization Act (GPRAMA) measure whose denominator includes patients ages 18 years and older. During 2012 – 2013 and 2013 – 2014, the denominator increased by 1.5 percent each year for a cumulative total of 16,490 new patients during 2012 – 2014. Other contributing factors to missing the target are a combination of staff turnover, recruitment of new staff unfamiliar with screening processes, and decreases in screening numbers among certain IHS Service Areas.

In an effort to provide the necessary skills and tools for depression screening, the Agency provides training, at no-cost, to its healthcare providers. To meet the FY 2015 target for depression screening, IHS established standardized training plans for depression screening through the Tele-Behavioral Health Center of Excellence.

(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 2015 is 64.3 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 OFA 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 – (President's Budget + Current Services)/(President's Budget + Current Services + Program Expansion funds that support direct care). Program expansion funds that support infrastructure such as ICD-10 development or purchases of dental electronic health records are subtracted from the total amount for H&HC program expansion and not included in the formula.

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 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Target	FY 2014 Actual	FY 2015 Target
55.0%	57.8%	63.8%	65.7%	65.9%	66.0%	66.7%

(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 2014 performance target for this measure was exceeded. Since FY 2004, the IHS has increased the screening rate nine-fold, from 7 percent in 2004 to 66.0 percent in 2014,

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 goal for FY 2015 is to increase the screening rate to 66.7 percent. The original target calculation during the preparation of the FY 2015 Congressional Justification was 64.8 percent. The Budget and Performance Coordination Branch (BPCB)/Division of Budget Policy, Execution & Review (BPER)/Office of Budget (OB)/Office of the Assistant Secretary for Financial Resources (ASFR) requested that IHS voluntarily increase targets for ten to fifteen performance measures beyond the mathematically calculated value. The Alcohol Screening (FAS Prevention) was one of the targets increased. The FY 2015 target was increased 1.9 percent from 64.8 percent to 66.7 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 OFA 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 – (President's Budget + Current Services) / (President's Budget + Current Services + Program Expansion funds that support direct care). Program expansion funds that support infrastructure such as ICD-10 development or purchases of dental electronic health records are subtracted from the total amount for H&HC program expansion and not included in the formula.

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 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 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Target	FY 2014 Actual	FY 2015 Target
1,908	1,930	1,461	1,438	1,668	1,766	1,419

(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 2014. The FY 2014 target was 1,668 forms; the FY 2014 actual results were 1,766 forms. This increased performance represents an increase of 328 forms from FY 2013.

The significant decrease in SRFs from FY 2011 to FY 2012 was a result of a data quality review in FY 2012. It was noted that data exports received at the National Data Warehouse (NDW) from the IHS Areas were comprised of duplicate records. As a result, the issue was resolved and FY 2013/2014 data 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.

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 2015 target is 1,419 SRFs. 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.