



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



January 10, 2017

TO: Mary Smith
Principal Deputy Director
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 2016
Detailed Accounting Submission and Performance Summary Report for National
Drug Control Activities and Accompanying Required Assertions
(A-03-17-00351)

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, 2016. We also reviewed the Performance Summary Report, which includes management's assertions and related performance information for the fiscal year ended September 30, 2016. 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 2016 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 Amy J. Frontz, Assistant Inspector General for Audit Services, at (202) 619-1157 or through email at Amy.Frontz@oig.hhs.gov. Please refer to report number A-03-17-00351 in all correspondence.

Attachments

**NOV 1 0 2016**

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: FY 2016 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.

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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.


Ann M. Church

Attachments: ¹

1. Table – Alcoholism and Substance Abuse Prevention Treatment Program Authorized Under P.L. 102-573
2. Table – FY 2016 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*.

Indian Health Service
Alcoholism and Substance Abuse Prevention
Treatment Program

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

Amount of Funds	FY 2012 Enacted	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Enacted	FY 2016 Enacted	Drug Control & Moyer Reports
ALCOHOL & SUBSTANCE ABUSE						
Adult Treatment.....	\$102,731	\$97,926	\$98,633	\$101,312	\$103,807	Excluded*
Regional Treatment Centers	\$21,215	\$20,223	\$20,369	\$20,922	\$21,438	Treatment
Community Education & Training.....	\$9,540	\$9,094	\$9,159	\$9,408	\$9,640	Prevention
Community Rehabilitation/ Aftercare.....	\$30,988	\$29,539	\$29,752	\$30,560	\$31,313	Treatment
Gila River.....	\$237	\$226	\$228	\$234	\$240	Treatment
Contract Health Service.....	\$10,909	\$10,398	\$10,473	\$10,758	\$11,023	Treatment
Navajo Rehab. Program....	\$420	\$400	\$403	\$414	\$424	Treatment
Urban Clinical Services.....	\$894	\$852	\$859	\$882	\$904	Treatment
Wellness Beyond Abstinence.....	\$1,031	\$982	\$989	\$1,016	\$1,041	Prevention
Meth Prev & Treatment.....	\$16,332	\$15,513	\$15,513	\$15,475	\$25,475	50/50 Tx & Prev
Total.....	# \$194,297	\$185,154	\$186,378	\$190,981	\$205,305	

URBAN HEALTH PROGRAM 1/

Amount of Funds	FY 2012 Enacted	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Enacted	FY 2016 Enacted	
Expand Urban Programs....	\$4,403	\$4,403	\$4,492	\$4,492	\$3,211	Treatment

INDIAN HEALTH FACILITIES 2/

Amount of Funds	FY 2012 Enacted	FY 2013 Enacted	FY 2014 Enacted	FY 2015 Enacted	FY 2016 Enacted	
Construction.....	1,997	0	15,500	17,161	0	

Alcohol/Substance Abuse	# \$194,297	\$185,154	\$186,378	\$190,982	\$205,305	
Urban Health Program	4,403	4,403	4,492	4,492	3,211	
Facilities Construction	# 1,997	0	15,500	17,161	0	
GRAND TOTAL.....	# \$200,697	\$189,557	\$206,370	\$212,635	\$208,516	

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 2016 Drug Control Obligations**

	<u>Enacted</u>	<u>Obligated</u>
Drug Resources by Function		
Prevention	\$23,418	\$21,034
Treatment	\$81,291	\$78,678
	<u>\$104,709</u>	<u>\$99,712</u>
 Drug Resources by Decision Unit		
Alcohol and Substance Abuse	\$101,498	\$96,501
Urban Indian Health Program	\$3,211	\$3,211
	<u>\$104,709</u>	<u>\$99,712</u>



Indian Health Service
Rockville MD 20852

NOV 22 2016

Memorandum to: Director
Office of National Drug Control Policy

Through: Norris Cochran
Deputy Assistant Secretary, Budget

From: Ms. Mary Smith
Principal Deputy Director
Indian Health Service

Subject: Assertions Concerning FY 2016 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 FY2016 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.

Mary Smith
Mary Smith

**FY 2016 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 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target
90%	90%	90%	100%	100%	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 met in FY 2016.

- (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 2017 performance target for the YRTCs will remain unchanged at 100 percent for accreditation status. The methodology used 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 used 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 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target
62.4%	63.5%	63.6%	Retire*	N/A	N/A

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

Domestic Violence Table 2: Measure 2					
FY 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target
N/A	N/A	N/A	Baseline	65.3%	65.3%

- (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. (2): The measure was retired after 2015 and replaced with a new measure with the same name in FY 2016 to denote the denominator logic change based on age range. Beginning in FY 2016, the age range is changed from 15 to 40 years to the ages of 14 through 46 years. The change is consistent with U.S. Preventative Services Task Force screening of women of childbearing age (14 to 46 years) for domestic violence. The FY 2016 result for this measure was calculated from the Clinical Reporting System (see discussion in number 4 below). Research suggests that alcohol and drug use can worsen and, in some cases, accelerate domestic violence situations for both the victim and the perpetrator. By identifying victims of domestic violence, the Agency 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, legal system, healthcare, 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 2016 target for domestic violence screening was set at baseline because the change in the denominator expands the screening age and IHS has no historical data on this larger denominator. During the baseline year, the IHS tracks and reports a measure result. The FY 2016 screening result for the new measure was 65.3 percent. The IHS will continue to provide standardized training through its Forensic Healthcare learning management system and through the IHS Clinical Support Center (CSC). 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 2017 is the baseline screening rate of 65.3 percent. The 2017 target maintains the baseline result.

Target calculations for GPRA Clinical Measures: The targets for the clinical GPRA measures reported for the National Drug Control program are based on the IHS budget which includes individual budget lines. For the domestic violence/intimate partner violence screening measure, the Hospitals and Health Clinics (H&HC) budget line is used to calculate targets.

In general, clinical targets are calculated using an HHS approved mathematical formula based on the budget amount for a specific budget line, current services expected or funded, and the relative budget increase compared to the prior year's President's Budget request. 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 the current year's target. Targets are reviewed and approved during the budget formulation process.

- (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 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. 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 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target
65.1%	66.0%	67.4%	67.2%	67.9%	70.0%*

*Current Measure aged 18 and over.

- (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 proportion of American Indian and Alaska Native adults aged 18 years and over 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 2016 target for depression screening was met and exceeded. To meet the FY 2017 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 depression screening in FY 2017 is 70.0 percent for American Indian and Alaska Native adults aged 18 years and over.

Target calculations for GPRA Clinical Measures: The targets for the clinical GPRA measures reported for the National Drug Control program are based on the IHS budget which includes individual budget lines. For the depression screening measure, the Mental Health budget line is used to calculate targets.

In general, clinical targets are calculated using an HHS approved mathematical formula based on the budget amount for a specific budget line, current services expected or funded, and the relative budget increase compared to the prior year's President's Budget request. 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 the current year's target. Targets are reviewed and approved during the budget formulation process.

- (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.**

As a clinical GPRA measure, the depression screening measure is subject to the same processes described under number 4 for the DV/IPV screening measure. Please refer to measure 2, number 4 for further detail.

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 updates to Universal Alcohol Screening

Alcohol Screening Table 4: Measure 4					
FY 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target
65.7%	66.0%	66.6%	Baseline *	67.2%	Retired

*Denominator was changed in 2016 so no target was established.

Universal Alcohol Screening Table 4: Measure 4					
FY 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target
N/A	N/A	N/A	N/A	N/A	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): The alcohol screening measure (FAS prevention) among appropriate female patients was baselined and then retired after FY 2016. The FY 2016 change reflects the change in women of child-bearing age from 15 through 44 years to 14 through 46 years. The FY 2016 measure reported the percentage of women of child-bearing age (ages 14-46) who were screened for alcohol use. A new FY 2017 measure, Universal Alcohol Screening, reports alcohol screening among patients ages 12 through 75 years. This measure replaces the alcohol screening measure and will be reported in the National Drug Control Strategy in future years. The updated screening rates measure will have a far-reaching positive impact on overall health in AI/AN communities. While still capturing the population from the FAS screening, IHS will expand the total population number by screening all genders and a larger age range. Early intervention of for those at risk for alcohol misuse can be more effective than waiting until patients reach the moderate to severe stages of alcohol use disorders. Screening is an effective tool is identifying risky alcohol use. 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 performance target for FY 2016 was baseline due to logic changes in the age range of women of child-bearing age (from 15 through 44 years to 14 through 46 years). This measure will be retired at the end of 2016.

- (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 the new universal alcohol screening measure in FY 2017 is baseline. The new measure will report alcohol screening among patients ages 12 through 75 years.

- (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.**

As a clinical GPRA measure, the alcohol screening measures (FAS prevention and universal alcohol screening) are subject to the same processes as the depression screening and the DV/IPV screening measures. Please refer to measure 2, number 4 for further detail about the quality of performance data.

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 2013	FY 2014	FY 2015	FY 2016	FY 2016	FY 2017
Actual	Actual	Actual	Target	Actual	Target
1,438	1,766	2,346	1,798	N/A*	2,536

*FY 2016 final results for FY 2016 will be available in March 2017.

- (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 guide 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 final SRF data for FY 2016 will be available March 2017.

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 2017 target is 2,536 completed forms. 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.

Decision Unit 6: Office of Clinical and Preventive Services, Division of Behavioral Health, IHS

Measure 6: Behavioral Health: Depression Screening of American Indian and Alaska Native youth ages 12 to 17

Depression Screening Table 6: Measure 6					
FY 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target
N/A	N/A	N/A	N/A	N/A	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. (6): American Indian and Alaska Native youth 12 to 17 years of age are screened for depression is a baseline measure for FY2017. While depression can begin at any age, the first episode of major depressive disorder (MDD) often occurs during childhood or adolescence. The linkage between suicide deaths and longer-term MDD among adolescents warrants widespread depression screening in the Indian health system given the high rates of suicide among AI/AN youth. Additionally, research in depression in ages 12 to 17 youth has shown risks of difficulty in carrying out daily activities and higher risk of depression and other mental health problems as adults. 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 would contribute 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 2017 Youth Depression Screening target is set at baseline because it is a new measure. During the baseline year, the IHS tracks and reports a measure result. The IHS provides standardized training through the IHS Telebehavioral Health Center of Excellence (TBHCE). 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 target goal for the new Youth Depression Screening in FY 2017 is baseline. The new measure will report depression screening among patients ages 12 to 17 years of age.

- (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.**

As a clinical GPRA measure, the youth depression screening measure is subject to the same processes described under number 4 for the DV/IPV screening measure. Please refer to measure 2, number 4 for further detail.

Decision Unit 7: Office of Clinical and Preventive Services, Division of Behavioral Health, IHS

Measure 7: Screening, Brief Intervention and Referral to Treatment (SBIRT)

SBIRT Table 7: Measure 7					
FY 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Target	FY 2016 Actual	FY 2017 Target
N/A	N/A	N/A	N/A	N/A	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. (7): The SBIRT among appropriate patients is baselined for FY 2017. A new FY 2017 measure, SBIRT reports alcohol positive alcohol risk screening and the level of intervention type either a brief intervention/brief negotiated interview or a referral for brief treatment or more intensive treatment among patients ages 9 through 75 years. The SBIRT model will be used at primary care and other departments as a way to integrate behavioral health into care. Research shows that intervening earlier with alcohol risking drinking patterns can deter more significant issues later in life. By providing identification of risky drinking patterns early on, IHS will be able to provide interventions that will reduce the long term effects of alcohol use and the medical complications associated with alcohol use for AI/AN population. 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 2017 SBIRT target is set at baseline because it is a new measure. During the baseline year, the IHS tracks and reports a measure result. The IHS provides standardized training through the IHS Telebehavioral Health Center of Excellence (TBHCE). 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 target goal for the new SBIRT in FY 2017 is baseline. The new measure will report alcohol screening among patients ages 9 through 75 years who screened positive for risky or harmful alcohol use during the reporting period.

- (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.**

As a clinical GPRA measure, the SBIRT measure is subject to the same processes described under number 4 for the DV/IPV screening measure. Please refer to measure 2, number 4 for further detail.