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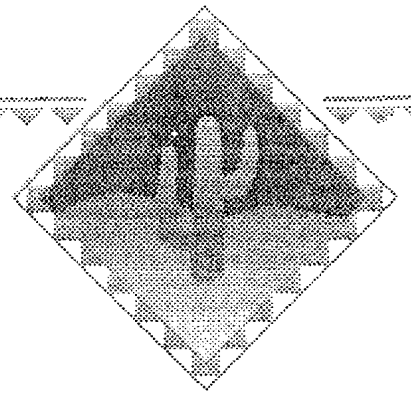
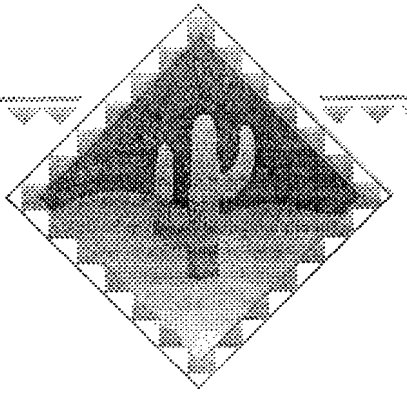


TWO HEALING FEATHERS

BASELINE MEASURES WORKGROUP FINAL REPORT

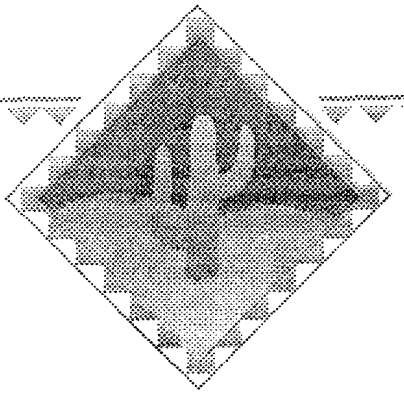
Prepared for the
American Indian and Alaska Native People & the Indian Health Service



BASELINE MEASURES WORKGROUP – FINAL REPORT

Prepared for
Indian People and the
Indian Heath Service

September 1996



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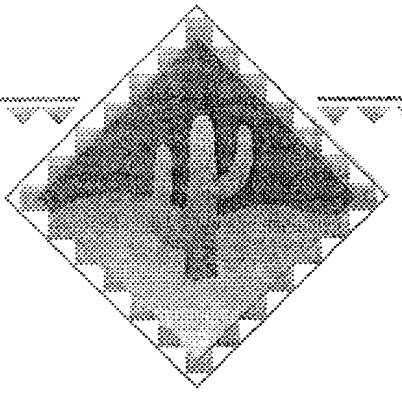

BASELINE MEASURES WORKGROUP

I. EXECUTIVE SUMMARY

The federal responsibility for American Indian/Alaska Native (AI/AN) health care is grounded in treaty obligations, case laws, the Snyder Act of 1921 (P.L. 83-568), the Indian Health Care Improvement Act (P. L. 94-437), as well as historical obligations for the health of AI/AN people.

The provision of health care to AI/AN people in Indian country and urban areas has become increasingly complex. Health care delivery systems are expected to be more flexible even though health care dollars are becoming scarce. New ideas in delivery methods and funding sources are now a necessity. To meet this challenge, Tribal governments can opt to exercise their sovereign rights in three ways: through P.L. 93-638 (Title I) contracts, P.L. 93-638 (Title III) compacts, or by retaining federally operated health programs.

To justify national funding and maintain a high quality of health care, baseline measures must be established. A baseline measure is a tool used to monitor the performance of a health care program. Repeated periodically, a baseline measure may provide a direction for change in a health care program over time.

With this understanding, the Baseline Measures Workgroup (BMW) began completing the tasks outlined by the Director of Indian Health Service (IHS). The BMW is composed of professionals from varied geographical areas and backgrounds. A conscious effort was made to ensure that all views are represented. The BMW is divided between employees of IHS, compacting Tribes, contracting Tribes, and Tribes with federally operated health care systems.

The BMW worked in a spirit of collaboration and cooperation always striving to achieve consensus. With an awareness of the difference in programs, the BMW drafted a set of baseline measures that can be adapted and modified to meet the needs of local health programs and the communities they serve. It should be emphasized that not all measures pertain to all Tribes.

The BMW acknowledged the following assumptions:

1. The recommendations of the BMW are not binding nor regulatory; they are guidelines for community based primary care models that integrate public and personal health.

2. All programs are competent, whether Tribal, urban, or federal. The BMW recognizes that AI/AN programs differ from site to site in terms of level of services provided, and varying cultural and community traditions. The BMW recognizes that each program strives to operate quality health care.

3. IHS has an advocacy role for AI/AN health programs.

4. To assess personal health services, community health status, and the effectiveness of health care delivery, a set of common baseline measures is important to AI/AN wellness. These baseline measures include both standard national measures and some unique AI/AN measures.

5. Accurate, complete and timely program data are essential for program management. Data needed for baseline measures should be readily available from IHS or other resources and feasible to collect.

6. Where feasible, baseline measures should be population/Tribal based. The measures should be based on all AI/ANs eligible for the local program, not just those who access the system (user population).

7. The recommendations contained in this report should not be linked with funding decisions for Tribal shares or other Tribal allocations.

The database that will be developed from baseline measures and other sources will provide information that is needed to set national policy and make funding decisions. Participating in this database is optional but strongly encouraged in order to preserve the recognition of an AI/AN specific health care agenda at the national level.

Recommendations outlined in this report are consistent with those of the Indian Health Design Team (IHDT).

The Director of Indian Health Service gave the following charges to the BMW:

1. **Define the public health responsibility of the IHS under Self-Governance.**

The workgroup recognized that the national public health responsibilities of IHS are not residual. The initiative should begin and remain at the Tribal (local) level. The BMW recommends that public health functions be viewed in three major categories: assessment, policy development, and assurance.

2. **Develop a process to identify, test and disseminate a set of health status indicators that are to be used to monitor the performance of Self-Governance Tribes.**

The BMW used resource documents as well as their experience to devise a recommended set of standards. Recognizing each Tribe has the right to negotiate its own set of baseline measures, it is felt that these recommendations will be useful if accepted in their entirety or if used as guidelines.

The BMW recognizes that health care programs by and for Tribes require a holistic approach that goes well beyond the traditional health status indicators. With this in mind, the BMW developed six categories of measures that are applicable to all health care systems: (1) health promotion, (2) health protection, (3) preventive services, (4) access, (5) resource management and utilization, and (6) strategies for the community's health.

Community traditions, and spiritual or religious healing or beliefs, play a major role in maintaining health and returning people to balance. The BMW strongly recommends that each local community include them in their baseline measures.

Appendix 2-A lists approximately 150 measures suggested by the BMW. The vast majority of these are obtainable from national and State data sources. Ten measures are marked with an asterisk (*) designating them as highly recommended (not mandatory) measures for all health programs. These asterisked measures are not available from national sources; they must be derived locally. These data are necessary for the planning and advocacy role of the IHS and the Tribes. The highly recommended list does not include many important items (e.g., birth rates, prenatal care rates, homicide, suicide, and motor vehicle crash fatality rates) which are derived from national vital statistics and require no additional reporting of data. The entire appendix is a menu of health care measures for Tribes and programs to use in accordance with their needs.

The ten highly recommended (not mandatory) measures are:

1* *Age specific overweight and obesity prevalence rates*

2* *Prevalence of tobacco use*

3* *Prevalence of alcohol and drug dependence of adults, youth, and pregnant women*

4* *Rate of family violence (child, spouse, elder abuse and neglect)*

27* *Number and percent of homes (existing and new) with deficiencies in sanitation of drinking water and waste disposal, by community*

28* *Rate of hospital discharges and ambulatory clinic visits for injury*

52* *Proportion of population screened for cancer of the uterine cervix, breast cancer; and for colo-rectal cancer*

53* *Immunization rates of all age groups in accordance with Advisory Committee on Immunization Practice (ACIP) recommendations*

54* *Incidence and prevalence of diabetes mellitus*

73* *Collaboration or incorporation of community values or spiritual healing ~~at~~ facility, with respect for individual beliefs*

3. **Define the relationship between the IHS data reporting requirements, in particular the core data set requirements and the responsibilities of Tribes participating in the Self-Governance Demonstration Project (SGDP).**

The BMW believes that revising the entire core data set was beyond its scope. The BMW strongly supports the principle that Self-Governance and contracting Tribes have the legal right to negotiate core data set reporting requirements. While participation in the core data set is negotiable, it is strongly encouraged in order to preserve the recognition of AI/AN specific health care agenda at the national level. Any form and software may be used to collect and report data, although the existing Resource and Patient Management System (RPMS) is recommended. However, there are recognized inadequacies with the RPMS. The BMW further recommends the establishment of a separate work group to revise the core data set in the future.

4. **Advise and make recommendations to the Office of Tribal Self-Governance and the Director of IHS regarding the scope and method used in the evaluation of the SGDP.**

The BMW believes that the methodology and design of the evaluation should be developed with the participation of the SGDP Tribes.

The BMW developed the following list of principles:

1) The evaluation instrument must be neutral in design with no hidden agendas.

2) The evaluations should be perceived as worth the time and effort by IHS and Tribal groups.

3) The evaluation should address the central Self-Governance concept of local control and identify ways to improve the process.

4) The design of the instrument to evaluate individual compacts should be based on specific community needs in order to be relevant.

5) The evaluation should be non-punitive and not linked to funding levels.

6) Actual Tribal participation in the SGDP evaluation must be negotiated with the Tribes.

The BMW recommends two parallel evaluation arms, each with a separate steering committee. One steering committee would focus on the perspective of the SGDP Tribes, and would emphasize issues related to the compacts and negotiation process. A second steering committee would focus on the perspective of non-SGDP Tribes regarding the impact of SGDP on non-SGDP Tribes.

Conclusion

The BMW recognizes that development, dissemination and implementation of baseline measures is an ongoing process. Therefore it recommends that these baseline measures be widely distributed for discussion and revision on a regular basis. The measures should be used by Tribal, federal, and urban programs. AI/AN data systems must be improved to include cost accounting tools, timely flow back of information to contributors, and linkage of federal, State and Tribal data. Energy should be devoted to ensuring that local programs have the capacity and training

to extract and interpret local data from their systems. Pilot sites should be funded with a small amount of seed money to test the usefulness of these baseline measures. As IHS, urban, and Tribal programs restructure, efforts should be made to maintain and improve a voluntary unified data set that is useful to advocate effectively for all AI/AN people.

II. INTRODUCTION

The views expressed in this report reflect the expenditure of much time and energy by a diverse group to produce an evolving document which will be relevant to all its customers--American Indian/Alaska Native (AI/AN) people, local health care programs whether Federal, Title I, or Title III operated, urban programs, Indian Health Service, and Congress. The report is the result of a search for consensus and does not necessarily indicate unanimous agreement on all issues. Members strove to find a common ground that would assist all AI/AN health care programs to deliver a quality product that will continue to accomplish the objective of "raising the health status of Indian people to the highest possible level".[1] Prior to finalization, over 1,000 copies of the draft of this report were disseminated to IHS and Tribal groups so the views reflected in this document seek to include many perspectives. All comments were reviewed by group members and incorporated into the body of the report as appropriate. In addition, the draft report was presented at several national meetings. Long after the IHS restructuring and down-sizing is completed, this report should be relevant to Indian health care programs.

III. BACKGROUND

The Federal responsibility for AI/AN health care is grounded in treaty obligations, case laws, the Snyder Act of 1921 (P.L. 83-568), the Indian Health Care Improvement Act (P.L. 94-437), as well as historical obligations for the health of AI/AN people. The Tribal Self-Governance Research and Demonstration Project (SGDP) was enacted by Congress as Title III (P.L. 100-472) of the Indian Self Determination and Education Act in 1988 (P.L. 93-638). The original legislation pertained to the Department of Interior but was amended (P.L. 102-184) to extend the Self-Governance Demonstration Project to Indian Health Service. Title III was amended again in 1992 (P.L. 102-573) to authorize the Secretary of Health and Human Services to negotiate Self-Governance compacts with Tribes that had completed the required planning activities. The Office of Tribal Self-Governance was established to coordinate this program. In 1994, P.L. 103-435 was enacted to extend this authority to 2012 and allow for the addition of up to 30 Tribes each fiscal year.

The Self-Governance Demonstration Project is a Tribally driven initiative. It is designed to strengthen the government-to-government relationship between the Federal and Tribal governments. "Conceptually, Self-Governance reflects the unique relationship between the U.S. Government and the individual Indian Tribes. Self-Governance recognizes that Tribes are governments with the inherent right to

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[1]IHS Mission Statement

govern themselves. The Tribal Self-Governance Project was designed to reduce Federal control over decision making and enhance fiscal control, resource allocations and management at the Tribal level."[2]

Title III, Section 305 of Public Law 93-638 as amended requires that the Secretary "... submit to Congress a written report on July 1 and January 1 of each of the five years following the date of enactment of this Demonstration Project, on the relative costs and benefits of the Tribal Self-Governance Demonstration Project. Such a report shall be based on mutually determined "baseline measurements" jointly developed by the Secretary and participating Tribes and shall separately include the views of the Tribes."

The term baseline measures is not defined in Section 305 of the Act. Recognizing that baseline measures have unique, Tribal specific dimensions, the legislation allows the Secretary and the Tribe(s) to determine the actual measurements. Health status indicators are an example of a category of baseline measure. Other examples include workload data; population data; program accreditation; Tribal-based needs; financial; including cost ratio data; productivity standards; and unmet needs.

Baseline measures have been a matter of discussion since the SGDP was extended to IHS. Distinctive baseline measures have been proposed by participating Tribes. However, IHS had not met with Tribes as a group to jointly develop baseline measures. In addition, IHS has not yet reported to Congress on the status of the SGDP, despite regular submission of reports by compacting Tribes.

For the purposes of this report, a baseline measure is a tool used to monitor the performance of a health care program. Repeated periodically, a baseline measure may provide a direction for change in a health care program over time.

In order to develop joint IHS and Tribal baseline measures, the BMW was established by the Director of IHS, as recommended by the Office of Tribal Self-Governance.

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[2]Senate Report No. 103-205

Charges to the workgroup are to:

1) Define the public health responsibility of the IHS under Self-Governance

2) Develop a process to identify, test and disseminate a set of health status indicators that are to be used to monitor the performance of Self-Governance Tribes (i.e., "baseline measures").

3) Define the relationship between the IHS data reporting requirements, in particular the Core Data Set Requirements and the responsibilities of Tribes participating in the SGDP.

4) Advise and make recommendations to the Office of Tribal Self-Governance and the IHS Director about the scope and conduct of SGDP.

These charges extend far beyond the scope of Section 305 of Title III reporting. The charges concentrate on public health responsibilities, and address health data, and health status measures.

In order to address the charges and these issues, this report will examine and make recommendations on long term public health issues for all AI/AN programs whether they are Tribal (Title I and Title III) urban or Federally operated. The workgroup strongly endorses the principle that Tribes have the legal right to negotiate Tribal specific baseline measures on an individual basis during compact and contract negotiations. However, it is in the mutual self-interest of all AI/AN health care programs to maintain a Tribal (community) and national database. **This database provides local information for Tribes as well as national data for setting policy and advocating for funding. Participating in this database is optional but strongly encouraged in order to preserve the recognition of an AI/AN specific health care agenda at the national level.**

The BMW did not examine resource allocation issues. **It is not the intent of the BMW to link its recommendations with the funding priorities for Tribal shares or other tribal allocations.**

IV. WORKGROUP STRUCTURE AND PROCESS

The intent of the BMW was to have equal representation from Self-Governance Tribes, Non-Self-Governance Tribes and IHS. Every effort was made to ensure equal representation from all three groups. Official members of the BMW in alphabetical order are listed in Appendix 5-A.

During the first meeting of the BMW, it was decided that the consensus method would be utilized as the decision making process. If there were any areas of strong dissension, a minority report would be written. However, this was not necessary.

V. ASSUMPTIONS

The following assumptions were adopted and refined as guiding principles for the recommendations of the BMW:

A. **The recommendations of the BMW are not binding nor regulatory**; they are guidelines for community based primary care models that integrate public and personal health.

B. All programs are competent, whether Tribal, urban, or federal. The BMW recognizes that AI/AN programs differ from site to site in terms of level of services provided, and varying cultural and community traditions. However, the BMW realizes that each program strives to operate a quality health care.

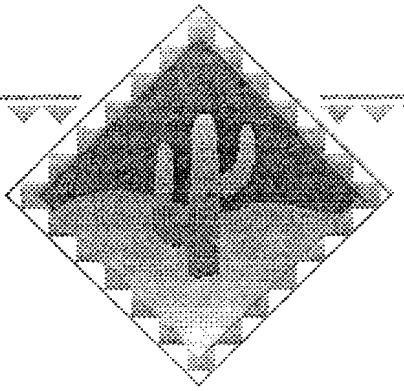
C. IHS has an advocacy role for AI/AN health programs.

D. To assess personal health services, community health status, and the effectiveness of health care delivery, a set of common baseline measures is important to AI/AN wellness. These baseline measures include both standard national measures and some unique AI/AN measures.

E. Accurate, complete and timely program data are essential for program management. Data needed for baseline measures should be readily available from IHS or other resources, or feasible to collect.

F. Where feasible, baseline measures should be population/Tribal based. The measures should be based on all AI/ANs eligible for the local program, not just those who access the system (user population).

G. The recommendations contained in this report should not be linked with funding decisions for Tribal shares.



CHARGE ONE: DEFINE THE PUBLIC HEALTH RESPONSIBILITY OF THE IHS UNDER SELF-GOVERNANCE.

A. Introduction

The first charge to the BMW requested that the BMW develop a statement defining the public health responsibility of the Indian Health Service (IHS) to compacting Tribal organizations.

The BMW approached this task in the context of broad principles, utilizing the same model as the Clinical and Public Health Operations Workgroup of the Indian Health Design Team. Both workgroups have utilized the basic model of public health, and related core functions, that are developed in the Institute of Medicine publication entitled "The Future of Public Health." As the BMW developed this document, it became clear that many, perhaps most, of the IHS public health responsibilities described are not residual IHS responsibilities, and could be performed by a national AI/AN organization. At the present time such an organization does not exist, and the responsibilities remain with the IHS.

The BMW agrees with the basic principle that the public health responsibility must be addressed at both the national and Tribal level. The sections that follow describe the BMW recommendations, starting with a mission statement, and developing a model specific to the IHS. Examples of key activities in each of the core function areas are found in Appendix 1-A. A section in the baseline measures report is devoted to assessment of the core public health functions. It is important to note that the list of activities is the joint responsibility of the entire public health

apparatus, including other federal agencies, State, county, municipal and Tribal health organizations. For the vast majority of these activities, the Tribe has ultimate responsibility and will decide whether to accomplish the task alone, by contract, by agreement with another agency, or by other collaborative arrangement.

B. Mission

The BMW suggests the mission of public health for AI/AN be defined as the activities that society does collectively to assure the conditions in which AI/ANs can be healthy. This includes organized community efforts to prevent, identify, preempt, and counter threats to public health. Ideally, the mission activities should be organized under a community-based primary care model that functionally integrates public and personal health under a shared vision with a clear policy mandate to provide the resources necessary to carry out the functions of both public health and medical care. A shared vision must be owned by the AI/AN communities as well as by public health and medical entities.

C. Governmental Role of Public Health

The BMW recommends adopting a generally accepted definition of the core functions of public health. The core functions implemented by agencies at all levels of government are **assessment, policy development**, and **assurance**. The governmental levels responsible for these functions may include Tribal, county, State, municipal, and federal. The interaction among these levels of government may differ according to locale. The federal level consists of many federal agencies responsible for public and personal health, including IHS. Tribal governments must themselves be strengthened as part of the process of becoming effective providers of Tribal based, community health systems. The level of ownership at the local Tribal community is the most critical factor for the success of any community health effort.

Assessment is the systematic collection, analysis and dissemination of information on health status, health needs and health problems. *The BMW recommends that at every level public health agencies engage in assessment activities. In order to be maximally effective, however, these efforts must be well coordinated. No agency may be large enough to conduct all these activities directly or comprehensively. Collaboration among agencies is essential, based on government to government relations and mutual need.*

Policy development is the determination of health needs, and the process of defining the best method to address them, including resource allocation and collaborative agreements. *Federally recognized Tribes, as sovereign nations have the independent authority to determine their own standards and measures; set policy, set priorities; and carry out public health functions. Tribal policy development is established by involving many individuals and organizations. Tribal health boards, elected officials, community groups,*

public health professionals, health care providers, and Tribal members should be involved in decision making about the relative importance of various public health problems. County, State, municipal and federal policy, as it relates to AI/AN people, must be developed in partnership with AI/AN communities.

Assurance is providing a service or making sure someone else does it and does it well. *The BMW recommends that IHS and Tribal governments assure AI/ANs that services and activities necessary to achieve agreed upon goals are provided, either by encouraging actions by other private or public entities, by requiring such actions through Tribal regulations, or by providing services directly. Each public health agency must work in collaboration with Tribal leaders and the Tribal community in determining and providing a set of high-priority personal and community-wide health services.*

D. Levels of Responsibility

In addition to the functions of assessment, policy development, and assurance which are common to federal, State, county, municipal and Tribal governments, each level of government also has unique responsibilities. Appendix 1-A includes a list of public health activities categorized under the three core functions.

1. Federal

The BMW recommends that the public health duties of federal agencies should include the following:

a) Support of knowledge development and dissemination through data gathering, analysis, research, and informational exchange, and collaboration with Tribes, the IHS, and States for integrated AI/AN data.

b) In collaboration with Tribes, establishment of national health objectives and priorities for AI/ANs.

c) Provision to make available technical assistance to help Tribal governments determine their own objectives and how to carry out actions on national and local objectives. With respect to Tribes operating under compact or contract, the IHS will provide services and technical assistance as defined and funded in the Annual Funding Agreement.

d) Provision of funds to Tribal governments to develop and strengthen Tribal capacity to achieve local and national objectives.

e) Responsibility of advocacy in the interest of AI/ANs. This advocacy extends to Congress as well as other governmental agencies, and non-government organizations.

2. Tribal

AI/AN Tribal governments exercise broad sovereign authority for both their members and their territory. Because of the great diversity in size, authorities, and capacities of Tribal governments, generalizations must be made with caution. Nevertheless, no AI/ANs from any Tribe, no matter how small or remote, should be without identifiable and realistic access to the benefits of public health protection. This is possible only through a local, Tribal component of the public health delivery system. Some Tribes may choose to provide some or all of the local core functions, whereas many other Tribes may choose to negotiate services through inter-Tribal, county or multi-county public health departments.

The BMW believes that Tribes are and must be the central force in public health programs for AI/ANs. They bear primary responsibility for assuring public health. Each sovereign Tribe has the independent authority to determine their own standards and measures, set public health priorities, and carry out public health functions.

E. Tribal Assessment of Local Public Health Capacity

The BMW concluded that it would be helpful to include a brief assessment survey that could be used by Tribes to assess their performance of core functions. A well validated survey instrument[3] consisting of ten questions is found in Appendix 1-B. These questions can be used by Tribes that have assumed complete responsibility for these functions or others who have assumed responsibilities for a subset of these activities, as well as for IHS directed activities.

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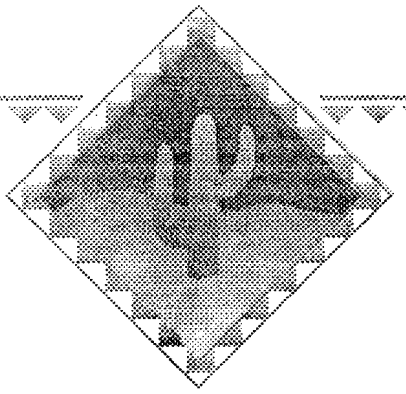
[3]Turrock B.J., Handler, A., Hall, W., Potsic, S., Nalluri, R., Vaughn, E.H., Local Health Departments Effectiveness in addressing the Core Functions of Public Health. Public Health Reports, 1994; 109:653-658.



CHARGE TWO: DEVELOP A PROCESS TO IDENTIFY, TEST AND DISSEMINATE A SET OF HEALTH STATUS INDICATORS THAT ARE TO BE USED TO MONITOR THE PERFORMANCE OF SELF-GOVERNANCE TRIBES (I.E. "BASELINE MEASURES").

A. Summary

The BMW reviewed a number of baseline measures, including Health Plan Employer Data Information System (HEDIS), Healthy People 2000, and a draft of the Performance Partnership Grants. The BMW first developed a set of guiding principles, and then a framework for classifying baseline measures that attempts to capture a holistic picture of health systems, integrating personal health service and public health practice. Drawing from their diverse backgrounds, the BMW chose, and developed a set of guidelines, with a subset of highly recommended baseline measures. Recommendations are based on the guiding principles held in common by the BMW members.

B. Applicability of Baselines

Although the charge of the BMW is to develop baseline measures that may be used to monitor the progress of the SGDP, the BMW felt it important that the measures be applicable to any health program, including IHS, Tribal, urban, and other systems. The measures are particularly pertinent to IHS and Tribal health systems because they reflect these systems' holistic approach of integrating public and community health services with personal health. It is the intent of the BMW that

these measures be employed as tools for self-evaluation and performance improvement. Recognizing that measures must be negotiated with each compacting Tribe, the BMW chose measures that should have utility for Tribes, so that they may voluntarily adopt many of them. In addition, the workgroup believes that IHS should also adopt many of the same measures for monitoring and performance improvement of the federally operated system.

C. Participation in Data Bank – Information Flow Back

The baseline measures are designed to be locally useful in the context of planning, monitoring, and evaluating a comprehensive health system. These functions are facilitated by comparisons to similar health programs and systems. It is important, therefore, to share with the contributors information aggregated centrally, while maintaining the confidentiality of individual providers. The flow back of aggregated information should provide incentive for Tribes and federal facilities to develop similar information to compare to the BMW's benchmark.

D. Relationship to Existing Performance Indicators

Several documents have been published in the last several years that prescribe or recommend performance indicators for the IHS and Tribes. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (HP 2000) is a prevention initiative that embodies a national strategy for significantly improving the health of the American people in the decade preceding the year 2000. In addition to objectives for the general population, sub-objectives are also specified for minorities and other special populations to meet the unique needs and health problems of these populations.

Through the Indian Health Care Amendments of 1992 (P.L. 102-573), the Congress declared its intent that the Nation meet 61 health objectives with respect to Indians by the year 2000. All but 5 of the Indian-specific sub-objectives from HP 2000 are included as part of these 61 objectives. Also included are 38 HP 2000 objectives that were established for the general population with no Indian-specific target. Therefore, between HP 2000 and P.L. 102-573, there are a total of 66 different health objectives that the IHS needs to be concerned about. Associated with each of these objectives is a measure that is calculated for the baseline (the starting point) and target (the level to be reached). The BMW also reviewed a draft of measures within the performance partnership objectives (PPO) under development in the Office of the Secretary of Health and Human Services.

The BMW borrowed from these and other documents for several reasons. IHS and the Tribes are already using or will be required to use some of these measures. Much work went into the development of the objectives, and they were based on many of the same principles that the BMW adopted.

E. Dimensions of Health Systems

Community traditions, and spiritual or religious healing or beliefs, have major roles in maintaining health and returning people to balance. Such traditions, healing, and beliefs are vastly neglected in most sets of baseline measures. The BMW recognizes the community traditions, and spiritual or religious healing or beliefs, are not part of its set of baseline measures to the extent comparable to their importance, but they are included in some measures. The integration of such traditions, healing, and beliefs into baseline measures must occur at the local level. Working on local integration will also bridge the communication gap between the western health care system and the Tribal community. The BMW strongly recommends that more work in each community should be done to develop baseline measures that include the traditions, healing, and beliefs prevalent in that community.

The BMW developed six categories of measures that are applicable to health systems: (1) health promotion, (2) health protection, (3) preventive services, (4) access, (5) resource management and utilization, and (6) the community's health. The first three categories are taken directly from *Healthy People 2000*:

> ***Health promotion*** *strategies are those related to individual lifestyle - personal choices made in a social context - that can have a powerful influence over one's health prospects. These priorities include physical activity and fitness, nutrition, tobacco, alcohol and other drugs, family planning, mental health and mental disorders, and violent and abusive behavior. Educational and community-based programs can address lifestyle in a crosscutting fashion.*
>
> ***Health protection*** *strategies are those related to environmental or regulatory measures that confer protection on large population groups. These strategies address issues such as unintentional injuries, occupational safety and health, environmental health, food and drug safety, and oral health. Interventions applied to address these issues are generally not exclusively protective in nature - there may be a substantial health promotion element as well - but the principal approaches involve a community-wide rather than individual focus.*
>
> ***Preventive services*** *include counseling, screening, immunization, or chemoprophylactic interventions for individuals in clinical setting. Priority areas for these strategies include maternal and infant health, heart disease and stroke, cancer, diabetes, and chronic disabling conditions, HIV infection, sexually transmitted disease, and infectious diseases. Cross-cutting professional and access considerations in the delivery of clinical preventive services are also addressed.*[4]

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[4]Healthy People 2000: National Health Promotion and Disease Prevention Objectives

Definition of the fourth category of measures, access, is less well standardized in the literature reviewed by the BMW. The Institute of Medicine report, *Access to Health Care in America*, limits the definition to personal health services. The BMW chooses also to include community and public health services as part of the working definition:

> **Access** describes the availability of community and facility based services. This includes measurements of how close facilities are to the population served; numbers of various types of providers, both community and facility based per population; time required in obtaining appointments with health care providers for various services; and waiting times within facilities.
>
> Access may also be gauged in terms of health problems that may be preventable through alteration of the availability of personal or public health services. Measures of access should also address financial, cultural, and personal barriers to obtaining services.[5]

The fifth category, resource management and utilization, is often neglected in non-financial evaluation of public health systems. The BMW feels that it is essential, however, to develop measures to create a useful management baseline. As long as resources are limited, efficiency and cost effectiveness have a direct bearing on personal health and public health outcomes. Historically, this has not been a primary focus within the Indian Health Service. However, since the advent of Diagnosis Related Groups (DRGs) it has been the primary method of performance evaluation in the private sector.

> **Resource management and utilization** measures offer a standard set of parameters to compare and evaluate health systems in terms of human work, dollars, time, resource requirements, and resources available. Many traditional measures of quality of service and system operation are included in this category, such as satisfaction surveys, time flow analyses, and financial parameters used to manage and ration health system resources.

The sixth and final category, measures of the community's health, is unique to this report. The workgroup believes that it is necessary for the complete description of any comprehensive health system. Yet these measures are only provisional. Each measure must be further developed within and modified by each community.

> **Measures of the Community's Health** describe how a community promotes and protects its own health and that of its members. Their subjects may overlap with those for health promotion, protection, preventive services, and access. These Measures are unique, however, because they describe how a community advances its own issues of health. Important aspects of these Measures include that they are community oriented, holistic in coverage or subject areas, holistic in methods, and locally controlled.

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[5]Access to Health Care in America

Self-determining AI/AN communities use Measures of the Community's Health for several purposes. The purposes include: to decide which strategy(ies) to adopt and to measure; to pay attention to and assess major community strengths and weaknesses; to respect and assess emotional and spiritual health; to get both quantitative and qualitative information, using community forums, focus groups, elders as experts, and similar methods; and to start or improve local programs to help solve local problems.

These sample Measures are general suggestions for consideration. Most Tribes and Service Units (SUs) will adopt one or more Measures that are relevant to their community's needs. They are described in Appendix 2-A, on pages 64-87.

F. Criteria

Early in its deliberation, the BMW developed criteria for selecting baseline measures. The eight characteristics listed below were considered in choosing rates of illness or pathological conditions for consideration as outcome measures of health status for a defined population, and thus as measures of the health system's performance.

Criteria	Examples to measure
Severe	tuberculosis
Frequent	diabetes
Preventable	measles
Controllable	sanitation systems
Locally important	Fetal Alcohol Syndrome
Globally important	motor vehicle crash injury
Costly	occupational injury
Sentinel	suicide

An additional criterion for choosing preventive services is:

Effective prevention	screening for cervical cancer

Baseline measures were chosen with consideration of the feasibility of collecting information given available resources, the relevance to existing program activities, the expectation of other systems of measures (e.g., HEDIS), and the relevance of the measure to the mission of the health systems expected to adopt them.

G. Notes on Methods

A distinction must be made between information systems, data collection, databases, and baseline measures. Health-related data are collected or obtained for a variety of reasons which include patient management, budget formulation and justification, program planning and evaluation, resource management, and epidemiology. One use of these data are for the calculation of baseline measures. The data used for baseline measures do not encompass all of the data necessary to manage a health care program at the Tribal, regional, or IHS headquarters level. Many sources of data are useful for baseline measures. Some sources are related to health, such as State death certificates or hospital discharge data. Other sources are not directly related to health, such as Tribal census, Bureau of Indian Affairs (BIA) reports, or Department of Labor statistics. The most useful and powerful information will come from the integration of data across program boundaries, between agencies, and between governments. Using data as beneficial information is work which requires improved technical capacity and commitment.

Commonly used quantitative or statistical data and examples of their sources include:

Census data: counts and descriptions of community members.

Example: 1990 US Census, Tribal census.

Vital records: collected and maintained by State offices of vital statistics and by some Tribes.

Example: birth and death certificates, marriage records.

Patient care data: resulting from encounters between patients and a health care delivery system.

Example: Patient Care Component (PCC) data from Resource and Patient Management System (RPMS), Emergency Medical System (EMS) ambulance run reports, and Medicaid/Medicare data from the Health Care Financing Administration (HCFA).

Health surveys: scientifically developed questionnaires administered to individuals in communities.

Examples: Behavioral Risk Factor Surveillance (BRFS) administered by States and by Tribes; Health Risk Appraisals (HRA) and, other locally developed surveys.

Qualitative information may also serve in the development of baseline measures. Such information may be developed through community focus groups, open meetings, interviews, and observation. These techniques are suggested in the section on measures of the community's health, and also described in the case studies.

H. Confidentiality

The primary goal of confidentiality in health care is to permit patients to be totally frank about facts which bear on their health, and to subject themselves to examination and tests which reveal facts about them. Without confidentiality, sick people are faced with having to choose between revealing important information relative to treatment, or retention of their privacy. Individuals expect, and are entitled to, careful, confidential treatment of information about their health and about their choices in behavior.

Baseline measures explore patterns or relationships within populations, but do not require information that can identify particular individuals. Privacy considerations were taken into account in developing the baseline measures recommended in this document. Some recommended baseline measures do not entail confidentiality problems when applied to most population groups, but may present problems for small-sized groups. If there is any doubt about violating the confidentiality of an individual with a particular baseline measure, then the measure should not be used for the subject population group.

I. Time Lag, Time Horizon

In order for a baseline measure to be a useful tool for measuring changes in performance it should be related to initiatives that are put in place to improve performance. For example, prenatal care rates on birth certificates may be followed to assess the effect of a prenatal care initiative. It is desirable that the baseline measure demonstrates the effect of an initiative within a relatively short time period. In this sense, prenatal care rates is a good measure since the effects of a prenatal care program will begin to be reflected in birth certificate information the year

following the initiation of the program. It is not always possible to use measures that have a relatively short time gap related to the implementation of an initiative. For example, although the alcoholism death rate may be a good measure for judging the success of a residential treatment program, it may be ten years before the results begin to be reflected in the mortality rate. The emphasis in this document is on baseline measures that have a relatively short time lag. However, measures of varying time lags are presented.

J. Explanation of Tables in Appendix 2-A

Each table in Appendix 2-A is labeled as a worksheet for one of the six categories of baseline measures. Items are not listed in order of importance. Additional measures may be created to reflect local priorities. Ten measures are marked with an asterisk (*), however, as highly recommended (not mandatory) by the BMW.

These highly recommended measures meet the following criteria:

1) Not readily available from national data. Thus, communities must choose to collect data from other sources, such as local medical records and Medicaid. Some data may only be available from community surveys.
2) Viewed by the work group as important for national planning and advocacy.
3) Pertain to issues important to AI/AN communities.
4) Developed through a group planning process involving Tribal, IHS, and multi disciplinary professional expertise with consideration of reviewer comments. Furthermore, the list should be periodically reviewed and revised.

Although the asterisk list may be a good starting point, communities are encouraged to select their own measures based on seriousness, extent of the problem locally, feasibility of implementing a corrective intervention, and local interest or concern.

The asterisk list does not include many important items (e.g., teen pregnancy rates, prenatal care rates, homicide, suicide, and motor vehicle crash fatality rates) which may be estimated from national vital statistics. Tribes and IHS should, however, work with State vital statistics offices to improve the accuracy of birth and death certificate records for AI/AN people. In many States AI/AN race is under reported

on vital events records. If these records also included AI/AN communities of residence and Tribal enrollment, then more detailed information would be available, especially for smaller Tribes and Tribal communities. Currently only New Mexico lists Tribal communities and Tribe on birth and death records.

The asterisked measures are listed below, with references to the numbered measures in Appendix 2-A.

Highly Recommended Baseline Measures

1* *Age specific overweight and obesity prevalence rates*

2* *Prevalence of tobacco use*

3* *Prevalence of alcohol and drug dependence of adults, youth, and pregnant women*

4* *Rate of family violence (child, spouse, elder abuse and neglect)*

27* *Number and percent of homes (existing and new) with deficiencies in sanitation of drinking water and waste disposal, by community*

28* *Rate of hospital discharges and ambulatory clinic visits for injury*

52* *Proportion of population screened for cancer of the uterine cervix, breast cancer, and for colo-rectal cancer*

53* *Immunization rates of all age groups in accordance with Advisory Committee on Immunization Practice (ACIP) recommendations*

54* *Incidence and prevalence of diabetes mellitus*

73* *Collaboration or incorporation of community values or spiritual healing at facility, with respect for individual beliefs*

In Appendix 2-A, each measure is labeled as process, outcome, or capacity. These terms are defined in the glossary. The third column includes notes on criteria, methodology, or other comments. A fourth column on the access category worksheet indicates whether the measure is appropriate for hospitals, ambulatory clinics, or community based programs.

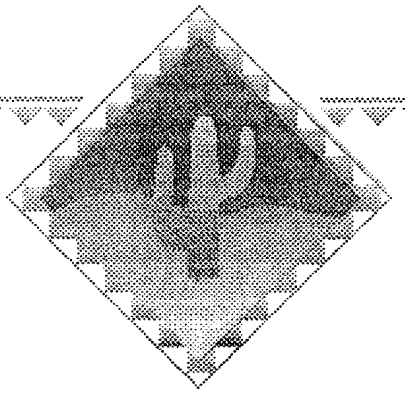
K. Suggestions for Using List of Measures

The BMW developed examples of baseline measures to cover a broad spectrum of health-related issues. The set of measures is a starting point, which can be used

as a menu from which the Tribes and IHS can select. The Tribes and IHS can also develop additional measures. The section on measures of the community's health, and the case studies provide additional guidance on developing measures locally.

It is not possible or desirable for a Tribe or IHS to adopt a large number of measures. In particular, a Tribe should only select a manageable number of measures (5-15) that have relevance to and acceptance by the local community.

Also, not all baseline measures that a Tribe chooses to adopt need to be reported to the IHS. See case studies, beginning with page 92, for sample scenarios.



CHARGE THREE: INDIAN HEALTH SERVICE DATA REPORTING REQUIREMENT

A. Introduction

The third charge to the BMW is to define the relationship between the IHS data reporting requirement, in particular the Core Data Set Requirements (CDS), and the responsibilities of Tribes participating in the SGDP.

The CDS consists of lists of required data element for 17 different services that constitute subsets of data collected in their information systems. The purpose of the CDS is to gather data that will assist the IHS in its internal management and to satisfy "Congressional and other mandatory reporting requirements." In practice the data are used by IHS to justify to Congress the need for funding resources, as well as for internal evaluation and funding allocation purposes. The CDS defines the essential subset of data and how to transmit it to the central database. All IHS facilities and most Tribal facilities use the RPMS ANSI MUMPS system for data collection and transmission.

B. Background

The BMW met with the IHS Office of Health Programs to discuss CDS. It became apparent that there was an expectation among external parties that the BMW would be responsible for a comprehensive revision of the IHS CDS.

The BMW recognizes that there is an important relationship between baseline measures and the CDS. In the indicator section listing the proposed baseline measures in this report, we highlighted the data elements necessary to calculate the 'highly recommended' and 'recommended' sets of baseline measures. However, the workgroup determined that a full revision of the CDS by the BMW is not appropriate , nor in our original charge. A letter to the IHS Director clarified our view of this issue; see Appendix 3-A.

We agree that revision of the CDS is imperative. Once the work of the BMW is completed, another workgroup needs to be formed. Several members of the BMW indicated an interest in working with this group. In addition, the BMW believes that additional technical expertise in budget formation, program planning, program evaluation, information system, and resource allocation areas would be required, as well as Tribal representatives more familiar with the CDS systems.

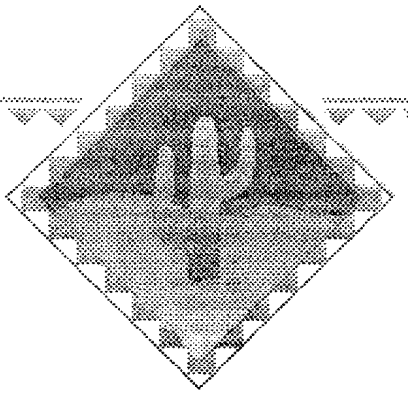
The CDS was published as a general notice in the *Federal Register* and not as a regulation applicable to Tribal organizations. Also, the recently passed Indian Self-Determination Act Amendments of 1994 make it clear that data reporting for self-determination contracts are negotiable. It does not follow that IHS may insist on compliance with the CDS unilaterally in negotiating compacts but may only negotiate them for contracts.

The BMW strongly supports the principle that Self-Governance Tribes have the legal right to negotiate reporting requirements on an individual basis during compact negotiations. However, Self-Governance Tribes must consider provisions that would assure reporting of information to IHS that it needs to provide to the Congress with justification for appropriations. Provision should also be made for data used by IHS/Tribes as a basis for compact resource methodology and the planning/evaluation process. This should not preclude eliminating reporting requirements which Tribes find burdensome and which are not essential to meeting IHS and Tribal information needs.

C. Recommendations

1) Participation in the reporting process is negotiable, but strongly encouraged in order to preserve the recognition of the AI/AN specific health care agenda at the national level.

2) Any form and software may be used to collect and report data, although RPMS is recommended.



CHARGE FOUR: SCOPE AND CONDUCT OF THE EVALUATION OF THE SELF-GOVERNANCE DEMONSTRATION PROJECT

A. Introduction

The fourth charge to the Baseline Measures Workgroup (BMW) requested that the BMW advise and make recommendations about the scope and conduct of the evaluation of the SGDP.

The BMW believes that the methodology and design of the evaluation should be developed with the participation of SGDP Tribes. A comprehensive objective evaluation of the SGDP extends beyond just baseline measures. The following principles and evaluation elements are **suggestions only.**

The BMW was established and constituted primarily to address issues of concern to Self-Governance Tribes. It recognizes that a comprehensive evaluation of the SGDP would require that consideration be given to the impact of Self-Governance on non-SGDP Tribes.

B. Evaluation Approach

Several strategies are possible to insure that all stakeholders have appropriate participation in the design and implementation of the SGDP evaluation plan. The **first strategy** has two parallel evaluation arms, each with a separate steering committee. One steering committee would focus on the perspective of Tribes participating in the SGDP, and would emphasize issues related to the compacts

and negotiation process. A second steering committee would focus on the perspective of non-SGDP Tribes regarding the impact of the SGDP on those Tribes. Each steering committee would exercise control over the evaluation process directed at its primary areas of interest. In order to insure that a single, inclusive document is developed, it may be advisable that both arms of the evaluation are completed by a single contractor, and that a small group including the chairs of each steering committee participate in the development of the final document.

A **second strategy** is to convene a single steering committee charged with overseeing an evaluation plan which takes into account the perspective of all stakeholders. The perspectives of SGDP and non-SGDP Tribes would be represented through a consensus process to design an evaluation relevant to all stakeholders.

The BMW considered the following factors in choosing between the two strategies:

1) All BMW members endorsed the absolute necessity to avoid divisiveness between SGDP and non-SGDP Tribes, and to provide an environment which allows for free and comfortable expression of ideas.

2) Some representatives of SGDP Tribes expressed concern regarding the appropriateness of non-SGDP Tribes evaluating elements related to the negotiation and implementation of compacts.

3) Non-SGDP Tribal representatives expressed concern regarding long-term impact of evaluation, negotiation, and implementation of compacts on all AI/AN Tribes.

4) Funding constraints should not exclude any Tribe's perspective from the process.

After considering both strategies, the relative merits of each approach and comments from reviewers, the consensus of the BMW is to recommend the first strategy. The BMW feels that this approach will maximize the ability of the evaluation to highlight the successes and benefits of the SGDP, as well as to identify areas for improvement. This will permit an objective assessment of concerns regarding the impact on non-SGDP Tribes, and the mutual concerns of all stakeholders.

C. Scope and Evaluation Content

The BMW wishes to emphasize that the contents of the evaluation strategy recommended in this report are related to the evaluation of compacts, and the relationship of the IHS to the compacting Tribes. The BMW recommends that a similar scope of work for the "impact on non-SGDP Tribes" evaluation should be developed by a properly constituted group.

Below is a list of principles to be considered in the evaluation of the SGDP:

1. The evaluation instrument must be neutral in design, with no hidden agendas.

2. The evaluation should be perceived as worth the time and effort by IHS and Tribal groups.

3. The evaluation should address the central Self-Governance concept of local control and identify ways to improve the process.

4. To be relevant, the design of the instrument to evaluate individual compacts should be based on specific community needs.

5. The evaluation should be non-punitive, and not linked to funding levels.

6. Actual Tribal participation in the SGDP evaluation must be negotiated with the SGDP Tribes.

The evaluation of a compact can only extend to compacted programs and services. The activities included in the scope should be evaluated objectively, with a view to highlighting improvements the Tribe has made in process, availability of services, quality of services, and Tribal participation. It is not realistic to expect major changes in health status measures over any time period shorter than three to five years. Evaluation of compacts, either individually or as a group, should not depend on this category of measurement.

It may not be possible to do an on-site yearly evaluation of each compact because of resource constraints. The BMW therefore suggests two types of evaluations:

1. A large group of compacts could be evaluated utilizing mail or phone surveys, and an examination of the compacts and their AFAs.

2. A selected sample of individual compacts, whose Tribes agree to participate, could be evaluated with a more detailed on-site process.

Individual evaluations will provide positive examples of Tribal problem-solving, which could, with Tribal permission, be converted to case studies, and distributed to all Tribes.

Suggested elements for both individual and group evaluations follow in the two sections below:

1. Group evaluation elements

   a) Number of compacting Tribes participating in a national information network.

   b) Number of new programs or facilities receiving accreditation operated by compacting Tribes.

   c) Number of accredited facilities operated by compacting Tribes.

   d) Percent of compacting Tribes, who, when asked to participate in an on-site evaluation, agreed to participate.

   e) Percent of compacting Tribes with a Tribal health plan.

   f) Percent of compacting Tribes who perform community needs assessment.

   g) Percent of compacting Tribes who have negotiated baseline measures.

2. Individual evaluation elements

   a) Presence of Tribal specific baseline measures.

   b) Changes under compacting that have resulted in administrative improvements, cost savings, streamlined personnel and purchasing procedures, and other examples the Tribe can provide.

   c) Tribal process for involving community members in determining and prioritizing local health needs.

   d) Presence of Tribal information management system.

   e) Program additions and/or improvements.

f) Percent of staff who are AI/AN.

g) Percent increase or decrease in Tribal employees since compacting.

h) Presence of a Tribal health plan.

I) Presence of employee/patient satisfaction surveys.

j) Satisfaction of any Tribes giving a resolution of support for services.

k) Tribal evaluation of the compacting process.

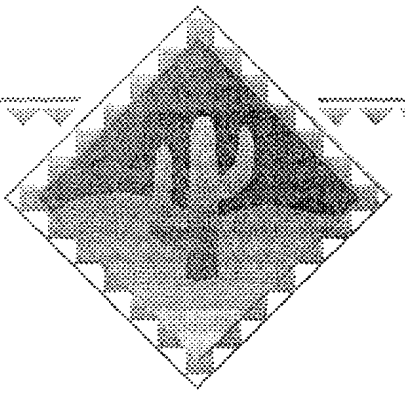
D. Evaluation Process

The BMW strongly feels that the process should have a steering committee of compacting Tribal representatives. Consideration should be given to including non-compacting Tribes, as well. The BMW makes the following recommendations with respect to evaluation:

1. Sample size - The individual evaluations should include a group of stratified compacts that include both small and large programs.

2. Mechanism - The BMW recommends that the evaluation instrument be developed by a joint IHS-Tribal group assisted by a contractor. The evaluation of individual compacts should be accomplished by a team with IHS and Tribal membership. The evaluation report should reflect only the content of the debriefing session.

3. Time line - Development of an evaluation instrument, and a pilot evaluation should take place as soon as possible in FY 1996.



VI. FUTURE NEEDS/RECOMMENDATIONS

The forces effecting all AI/AN health care programs are complex. Communities must secure adequate funding for Tribal, urban, and federal programs to deliver quality health care. The BMW makes the following recommendations for the future:

A. This document should be circulated widely for discussion and use.

B. Baseline measures should be considered primarily tools for self-evaluation and performance improvement, and secondarily a reporting mechanism for the Tribal, urban and IHS operated programs.

C. IHS operated systems should also select, apply and monitor these baseline measures.

D. All entities collecting data should ensure and work toward timely flowback of current information to contributors of data. The flowback information should allow comparison of similar facilities, programs, and systems.

E. Baseline measures should be periodically reviewed and revised by the IHS and Tribes to improve their usefulness.

F. IHS and Tribes should pursue increasing collaboration in the collection of better data for their own use. This includes Tribal and community specific vital statistics and sharing other State, and federal data sets to assess, monitor, and improve performance.

G. A state-of-the-art cost accounting system is needed for effective resource utilization.

H. Seed money should fund Tribal and IHS programs to pilot test these baseline measures with programs of varying size and computer capabilities.

I. A separate workgroup should revise the core data set. The revised core data set should eliminate unnecessary elements and support baseline measures.

J. Increased resources and time should be devoted to training all local health facilities in data extraction, acquisition, and epidemiologic interpretation. Many programs currently have computers to perform these tasks but lack on-site expertise.

K. Tribal, urban, and IHS programs should maintain a unified data system that is useful to advocate effectively for AI/AN people.

L. Integration of personal health care and community oriented public health principles is critical for the operation of all quality health care programs. Title I, Title III, urban, and federal entities need to continue to expend time, energy, and resources toward integration.

APPENDIX 1-A

List of Public Health Activities for American Indians/Alaska Natives Categorized by Three Core Functions

Assessment

1 Develop operate, and make available, an integrated information management system incorporating federal, State and Tribal health data, with private sector linkage.

2 Develop, operate, and assure the quality of data management systems which meet local needs.

3 Conduct and publicize epidemiologic, sociologic and other investigations which assess the health of the community and access to health care.

4 Identify barriers to health care access in communities, and collaborate to develop strategies that assure access to personal and preventive services.

5 Link with local, State and federal databases, in both public and private sectors.

6 Conduct a regular community health assessment, using standardized format.

7 Identify barriers in a community related to transportation, culture, age, disability, education, information, and service delivery system design that affect access to health services.

8 Develop standards for data use and dissemination.

9 Provide consultation and technical assistance.

10 Assess the supply and distribution of health care providers, facilities, and services.

11 Evaluate program efforts.

Policy Development

1 Develop policy, promote legislation, and enact regulations at Tribal, State and federal levels, that reduce public health risk, and promote healthy behavior.

2 Help develop and evaluate prevention and control measures, research strategies, and policy options.

3 Provide data and analysis to the community and collaborate with providers to provide information about health status, and to develop strategies to reduce risk.

4 Develop budgets in collaboration with the community and providers utilizing agreements with other agencies to replace costs which address priority public health problems.

5 Enact policies and procedures within the existing legal scope of authority.

6 Involve the community in developing and analyzing policies of the public health jurisdiction.

7 Provide accurate, timely, understandable information and data to policy makers.

8 Provide legal counsel to review policy decisions.

9 Identify and address communicable disease control issues, and assure access to preventive and intervention services.

10 Translate enacted policy into program procedures.

11 Identify policy outcomes, develop outcome measures, evaluate them on a regular basis, and communicate the findings.

12 Mobilize the community, and in particular health care providers, in a systematic and periodic process to set community priorities, develop policies and formulate strategies to address key public health program, and for action on community issues.

13 Collaborate with community members and health care providers to inform the public about the current health status of the community.

14 Provide information and data to the community.

Policy Development - Continued

15 Develop a long range strategic plan and time-limited, measurable agency program objectives.

16 Maintain a management information system and electronic communication capacity that allows the analysis of administrative, demographic, epidemiologic and service use data to provide information for planning, administration, and evaluation.

17 As appropriate, participate in agreements with other jurisdictions to manage costs.

18 Develop budgets which reflect jurisdictional priorities and programs, address health problems, and implementation.

19 Involve professional and community groups in development, presentation, and justification of the budget.

20 Collaborate with public and private agencies, and health care providers in developing strategies to address public health risk factors.

21 Maintain information and a referral system.

22 Assure the provision of public health services which affect the community and high risk population.

23 Collaborate with communities in developing local, State and federal-wide emergency response plans.

24 Identify and control potential and actual hazards to public health.

25 Agree to develop, in collaboration with county, State and federal regulations.

26 Support and assist local agencies' crisis response efforts.

27 Help coordinate and incorporate local emergency response plans into State and federal comprehensive emergency management plan.

Assurance - Continued

13 Assure access to, and appropriate use of personal, primary, and preventive health services.

14 Establish criteria to assess the competency of health professionals as well as design, implement, and evaluate credentialing and certification methods.

15 Assure that local health jurisdictions, contractors, health care sites, and providers comply with appropriate regulations and standards and meet contractual obligations. (Each sovereign Tribe has the independent authority to determine their own standards and baseline measures, set urgent public health priorities, and carry out public health functions.)

APPENDIX 1-B

Survey Instrument

These measures cover the core functions of public health. They are modified from a survey of state, county, and city-local health departments (Turnock BJ, et al. Local health department effectiveness in address the core functions of public health. Public Health Reports 1994; 109:653-658). Tribes and SUs can use it, perhaps with more modifications, to assess themselves. A "Yes" response under each measure means that all elements listed in the practice are present.

Core functions of public health in local programs:				
Function		**Provided by:**		
		Tribe (Y/N)	**IHS (Y/N)**	**other agency (Y/N)**
	Assessment Practices			
1. **Assess**	Does a community needs assessment systematically describe the health status and needs of the community?			
2. **Investigate**	Are timely investigations of adverse health events and health hazards conducted on an ongoing basis?			
3. **Analyze**	Has an analysis been completed with contributing factors, adequacy of existing health resources, and the populations group(s) most affected?			
	Policy Development Practices			
4. **Advocate**	Is there a network of support and communication relationships which includes health related organizations, the media, and the general public?			

Function		Provided by:		
		Tribe (Y/N)	IHS (Y/N)	other agency (Y/N)
5. **Prioritize**	Have the community health needs, identified from a community needs assessment, been prioritized?			
6. **Plan**	Does the health department have a health action plan for the community and a long-range strategic plan? Do the plans include the current year, address priority community health needs, and reflect the participation of constituents and other groups in their development?			
	Assurance Practices			
7. **Manage**	Does the health department have an identified organizational structure, an organizational self-assessment process, and a strategy to secure funding for the priority needs identified in the community health needs assessment process?			
8. **Implement**	Are the priority health needs effectively addressed in the community with programs and services by the health department or other agencies?			
9. **Evaluate**	Do the health department programs and services comply with applicable professional and regulatory standards? Does each priority community health need have impact and effectiveness standards? Are they regularly assessed? Are the standards used to direct programs and resources?			
10. **Inform**	Is the public informed and educated about current health status, health needs, positive health behaviors, and important health policy issues?			

APPENDIX 2-A

SIX CATEGORIES OF BASELINE MEASURES

Explanation of Tables in Appendix

Each table in the appendix is labeled as a worksheet for one of the six categories of baseline measures. Items are not listed in order of importance. Additional measures may be created to reflect local priorities. Ten measures are marked with an asterisk (*), however, as highly recommended (not mandatory) by the BMW.

Although the asterisk list may be a good starting point, communities are encouraged to select their own measures based on seriousness, extent of the problem locally, feasibility of implementing a corrective intervention, and local interest or concern.

The asterisk list does not include many important items (e.g., teen pregnancy rates, prenatal care rates, homicide rates, suicide rates, and motor vehicle crash fatality rates) which may be estimated from national vital statistics. Tribes and IHS should, however, work with State vital statistics offices to improve the accuracy of birth and death certificate records for AI/AN people.

In the appendix each measure is labeled as process, outcome, or capacity. These terms are defined in the glossary. The third column includes notes on criteria, methodology, or other comments. A fourth column on the access category worksheet indicates whether the measure is appropriate for hospitals, ambulatory clinics, or community based programs.

Suggestions for using List of Measures

The BMW developed examples of baseline measures to cover a broad spectrum of health-related issues. The set of measures is a starting point, which can be used as a menu from which the Tribes and IHS can select. The Tribes and IHS can also develop additional measures. The section on measures of the community's health, and the case studies provide additional guidance on developing measures locally.

It is not possible or desirable for a Tribe or IHS to adopt a large number of measures. In particular, a Tribe should only select a manageable number of measures (e.g., 5 to 15) that have relevance to and acceptance by the local community. Also, not all baseline measures that a Tribe chooses to adopt need to be reported to the IHS.

Measure reference	Type of measure	Criteria, methods, comments
1 * Age specific overweight and obesity prevalence rates Ref: HP2000 2.3d (overweight), PPO page 19 #6	Outcome	User population data available from Patient Care Component (PCC) if entered; service population data requires survey or study. Overweight and obesity are defined in terms of weight/height ratio in children, and body mass index in adults.
2 * Prevalence of tobacco use Ref: HP2000 3.4f, 3.5, 3.6, 3.7(cigarettes), 3.9 (smokeless tobacco); PPO page 17 #1	Outcome	PCC based user data probably underestimate; may require BRFS, HRA, or other survey
3 * Prevalence of alcohol and drug dependence of adults, youth, and pregnant women Ref: HP2000 4.5, 4.6, 4.7, 4.8 (alcohol, drug use)	Outcome	Data based on PCC user statistics, DSM-IV criteria, or data sources such as NHSDA, STHSSANA
4 * Rate of family violence (child, spouse, elder abuse and neglect) Ref: HP2000 7.4, 7.5 (children, women)	Outcome	PCC data available for user population
5 Teen pregnancy rate Ref: HP2000 5.1 (teens 15-17)	Outcome	Data from vital statistics
6 Alcohol related motor vehicle crash death rate Ref: HP2000 4.1a (alcohol related motor vehicle crash deaths)	Outcome	Total MVC mortality rates, from vital statistics, may be an approximation if interpreted in light of proportion of alcohol involvement data from law enforcement.

Measure reference	**Type of measure**	**Criteria, methods, comments**
7 Suicide rate Ref: HP2000 7.2d (suicides)	Outcome	Estimates available from vital statistics
8 Homicide rate Ref: HP2000 7.1f (suicides)	Outcome	Estimates available from vital statistics
9 Drug related mortality rate Ref: HP2000 4.3 (drug-related deaths)	Outcome	Data from vital statistics
10 Liver cirrhosis mortality rate Ref: HP2000 4.2b (cirrhosis deaths)	Outcome	Data from vital statistics
11 Proportion of adults age 18 and older who engage in moderate physical activity for a least 30 minutes per day Ref: HP2000 1.3 (physical activity), PPO page 18 #4	Outcome	Requires survey such as BRFS or HRA
12 Breast feeding proportion at discharge from hospital and at 5-6 months after delivery Ref: HP2000 2.11d (breast feeding)	Outcome	User statistics from PCC. Service population statistics require survey
13 Iron deficiency anemia in infants, children, and women of childbearing age Ref: HP2000 2.10d (iron deficiency)	Outcome	User data from PCC; service population data from WIC, survey, or study
14 Dietary fat intake Ref: HP2000 2.5 (dietary fat)	Outcome	Requires nutrition survey
15 WIC participation	Capacity	Requires survey

Measure reference	Type of measure	Criteria, methods, comments
16 Smoking prevention and cessation counselling in primary care setting Ref: HP2000 3.16 (tobacco cessation counselling)	Process	PCC based data available, but only if entered
17 Smoke free policies in workplace or enclosed public places Ref: HP2000 3.11, 3.12 (smoking policies)	Process	Requires survey
18 Prescription drug abuse incidence and prevalence	Outcome	PCC data for user population
19 Proportion of alcohol and other drug abusers/ or dependents who are receiving treatment	Capacity	User population data based on PCC user statistics; service population data require survey or study
20 Proportion of sexually active, unmarried people who use condoms Ref: HP 2000 18.4 (condoms)	Outcome	Some PCC data available; service population data require survey
21 Presence in community of comprehensive, sequential school health education Ref: HP2000 8.4 (health education)	Capacity	Requires survey
22 Difference in age between male/female pairings in teens	Outcome	Requires community survey; may be indicative of community dysfunction
23 Major mental illness diagnosis prevalence Ref: HP2000 6.3, 6.4 (mental illness in children, adolescents, and adults)	Outcome	User data available from PCC; community data may require survey
24 Mental health hospital discharge rate	Outcome	User statistics available from PCC

Measure reference	Type of measure	Criteria, methods, comments
25 Integration of mental health, health, education, housing, vocational rehabilitation, justice, and social services for behavioral health planning and services Ref: PPO 8, 9, 11, 12, pp. 32-34	Process	"Yes" or "no" answer
26 Presence of culturally and linguistically appropriate community health promotion program. Ref: HP2000 8.11 (community health promotion)	Capacity	"Yes" or "no" answer

Measure reference	Type of measure	Criteria, methods, comments
27 * List number and percent of homes (existing and new) with deficiencies in sanitation of drinking water and waste disposal, by community. Ref: HP2000 11.9 (drinking water)	Outcome	The number and percentage of homes at each deficiency level (DL), including those with no deficiency (DL 0). Current source: Data from community deficiency profiles, Sanitation Deficiency System (SDS); Housing Report, Sanitary Survey, Sec. 302 P.L. 94-437.
28 * Rate of hospital discharges and ambulatory clinic visits for injury Ref: HP2000 9.2 (injury hospitalizations)	Outcome	User statistics available from PCC; more complete data require local surveillance.
29 Unintentional injury mortality rate, all causes Ref: HP2000 9.1a (unintentional injury deaths)	Outcome	Preventable. A leading cause of mortality; estimates available from vital statistics.
30 Residential fire mortality rate Ref: HP2000 9.6 (residential fires)	Outcome	Estimates available from vital statistics
31 Drowning mortality rate Ref: HP2000 9.5 (drowning deaths)	Outcome	Estimates available from vital statistics
32 Proportion of children who have received protective sealants on the occlusal (chewing) surfaces of permanent molar teeth. Ref: HP2000 13.8 (sealants), PL 102-573 #25	Outcome	User data from PCC; or surveys
33 Child safety seat usage Ref: HP2000 9.12a (child safety seats)	Outcome	Requires community level survey

Measure reference	Type of measure	Criteria, methods, comments
40 Percent of households with water which meet EPA microbial standards. Percent of households with chlorinated water supply Ref: HP2000 11.9 (drinking water)	Outcome	Number of EPA MCL and monitoring violations and enforcement actions. Source: EPA data systems; Operation and Maintenance (O&M) Data System; Sanitary Survey.
41 Presence in or near community of hazardous waste, dumps, or storage sites Ref: HP2000 11.14 (hazardous waste sites)	Outcome	Number of open dumps greater than ½ acre. Number of Treatment, Storage, and Disposal (TSD) facilities. Source: EPA data systems; Operation and Maintenance (O&M) Data System; Sanitary Survey
42 Proportion of homes without working smoke detectors Ref: HP2000 9.17 (smoke detectors)	Process	Requires survey
43 Presence of emergency response system	Capacity	Does the Tribe have a emergency response plan? Organization? "Yes" or "no" answers. Source: Sanitary Survey
44 Training for operation of water and sanitation systems	Process	Requires survey
45 Food borne illness incidence rates (e.g. shigella, salmonella, hepatitis A, listeria, etc.) Ref: HP2000 12.1 (food borne illness)	Outcome	User data from PCC; more complete service population data from State's surveillance of reportable diseases

Measure reference	Type of measure	Criteria, methods, comments
46 Presence of pharmacy participating in linked system to alert others dispensing medication to potential drug reactions Ref: HP2000 12.5 (linked pharmacies)	Process	Requires survey
47 Proportion of households with optimally fluoridated water supply. Ref: HP2000 13.9 (community water fluoride)	Process	Source: Fluoridation Data System, Sanitary Survey
48 Baby bottle tooth decay prevalence rate Ref: 2.12b (care giver feeding practice)	Outcome	User data from PCC
49 Age specific caries prevalence rates Ref: HP2000 13.1, 13.1b, 13.1d (dental caries in children)	Outcome	User data from PCC
50 Age specific gingivitis prevalence rates Ref: HP2000 13.5b (gingivitis)	Outcome	User data from PCC
51 Age specific periodontal disease prevalence rates Ref: HP2000 13.6 (periodontal disease)	Outcome	User data from PCC

Measure reference	Type of measure	Criteria, methodology, comments
52 * Proportion of population screened for cancer of the uterine cervix, breast cancer; and for colo-rectal cancer Ref: HP2000 16.11, 16.12, 16.13 (clinical breast exams, mammograms, pap smears, fecal blood test, sigmoidoscopy)	Outcome	User statistics available from PCC. Population screening rates require survey or special study
53 * Immunization rates of all age groups in accordance with Advisory Committee on Immunization Practice (ACIP) recommendations Ref: HP2000 20.11, 21.2 (immunizations)	Outcome	User statistics available from PCC. Population rates require surveillance or special study
54 * Incidence and prevalence of diabetes mellitus Ref: HP2000 17.11 (diabetes)	Outcome	User statistics available from PCC. Population rates require survey or special study
55 Infant mortality rate; neonatal mortality rate; post-neonatal mortality rate Ref: HP2000 14.1b (infant mortality)	Outcome	Standard vital statistics measures. Deaths per 1000 live births during same interval (infants - up to 365 days, neonates - up to 28 days, post-neonates - 28 to 365 days)
56 Level of prenatal care rate Ref: HP2000 14.11b (prenatal care in first trimester)	Process	Frequently cited health measure, anecdotally may not correlate with birth outcomes in all AI/AN communities. Commonly used Kessner index combines initiation with frequency of care. Other indices exist. Population estimates available from vital statistics.

Measure reference	Type of measure	Criteria, methodology, comments
57 Cardiovascular disease mortality rate Ref: HP2000 15.1 (coronary heart disease deaths)	Outcome	Estimates available from vital statistics
58 Lung cancer mortality rate Ref: HP2000 16.2 (lung cancer deaths)	Outcome	Estimates available from vital statistics
59 Diabetes mortality rate Ref: HP2000 17.9b (diabetes related deaths)	Outcome	Estimates available from vital statistics
60 Substance use (e.g. alcohol, tobacco, drugs) during pregnancy Ref: HP2000 14.10 (abstinence from tobacco, alcohol, cocaine, and marijuana during pregnancy)	Outcome	Estimates available from vital statistics, although it may be under-reported
61 Blood pressure screening Ref: HP2000 15.13 (blood pressure screening)	Outcome	User statistics available from PCC. Service population screening rates require survey or special study
62 Cholesterol screening Ref: HP2000 15.14 (blood cholesterol screening)	Outcome	User statistics from PCC. Service population statistics require survey
63 Incidence and prevalence of diabetes complications: Lower extremity amputation, retinopathy, blindness, ESRD, congenital malformations Ref: HP2000 17.10b (complications of diabetes)	Outcome	User statistics from PCC. Service population statistics require survey. Congenital malformation estimates available from vital statistics
64 Limitation of physical activity due to chronic condition Ref: HP2000 17.2b, 17.3 (limitation in major activities and personal self-care)	Outcome	May require survey of community.

Measure reference	Type of measure	Criteria, methodology, comments
65 HIV infection incidence and prevalence rate Ref: HP2000 18.1, 18.2 (AIDS incidence an prevalence)	Outcome	Data from State reportable disease register
66 Age specific prevalence of high risk sexual behavior Ref: HP2000 18.3, 18.4 (early initiation of sexual activity, condom use)	Outcome	May require survey
67 Availability of HIV screening, testing, counselling, referral, and treatment services Ref: HP2000 18.13 (sexually transmitted disease services)	Capacity	"Yes" or "no" answer
68 Pneumococcus and influenza immunization rates for elderly and high risk populations Ref: HP2000 20.11 (immunizations)	Outcome	User statistics from PCC; population data may require surveillance or special study.
69 Tuberculosis incidence rate Ref: HP2000 20.4d (tuberculosis incidence)	Outcome	Data from State reportable disease register
70 Incidence of otitis media in children Ref: HP2000 20.9 (acute middle ear infection)	Outcome	User statistics from PCC
71 Incidence of congenital anomalies and birth defects (e.g. alcohol related birth defects, cleft lip, cleft palate, spina bifida) Ref: HP2000 14.4a (Fetal Alcohol Syndrome)	Outcome	User statistics from PCC; population estimates available from vital statistics; also use State registries.
72 Incidence of sudden infant death syndrome (SIDS) Ref: HP2000 14.1 (infant mortality)	Outcome	Estimates available from vital statistics

Measure reference	Type of measure	Criteria, methods, comments
34 Presence in the community of qualified sanitation system operator or functioning operation and maintenance organization.	Capacity	Number of EPA MCL and monitoring violations and enforcement actions. Level of operator certification by a national organization, State, or Tribal regulatory agency. Source: EPA data systems; Operation and Maintenance (O&M) Data System; Sanitary Survey. Difference between this and several other measures may be in method of assessment of capacity rather than outcome.
35 Injury rate of elders Ref: HP2000 9.4a, 9.4b, 9.7 (fall related mortality, hip fracture hospitalizations)	Outcome	Mortality estimates available from vital statistics; user data from PCC
36 Prevalence of cancer associated with radiation exposure (e.g. mining, radon) Ref: HP2000 11.6 (radon testing)	Outcome	User data from PCC; service population data from cancer register
37 Occupational injury rates Ref: HP2000 10.2 (work-related injury)	Outcome	User data from PCC, especially hospitalizations
38 Cost of occupational injuries	Outcome	User data from PCC, CHS
39 Blood lead levels among children aged 6 months to 5 years which exceed 15 ug/dl and 25 ug/dl Ref: HP2000 11.4 (lead), PL 102-573 #18	Outcome	National Health and Nutrition Examination survey; Agency for Toxic Substances and Disease Registry; User data from PCC if recorded

Measure reference	Type of measure	Criteria, methods, comments
73 * Collaboration or incorporation of community values or spiritual healing at facility, with respect for individual beliefs Ref: HP2000 8.11, 8.12 (community based health promotion and health services)	Process	"Yes" or "no" answer
74 Health care providers per 100,000 service population (e.g. physicians, nurses, mid-level practitioners, dentists, public health nurses, nutritionists, optometrist)	Capacity	Comparable to other systems of health care and to IHS RRM formulas. Comparisons may be valid only for like systems. Need to account for contract care
75 Average distance to health care facility (e.g. hospital, clinic, tertiary care referral center, psychiatric inpatient facility, intermediate/skilled nursing facility)	Capacity	Comparable to other systems of health care and to IHS RRM formulas. Can be estimated for users through PCC community data. For service population, requires map analysis or survey.
76 Ratio of user to service population	Capacity	User population from PCC, service population from census, Tribe, or other source. Census may be an underestimate
77 Hospital beds per service population; Hospital beds per general population	Capacity	Comparable to other systems of health care, as well as to parallel system in same region. Beds/general population data available from HRSA Area Resource File

Measure reference	Type of measure	Criteria, methods, comments
78 Contract health service (CHS) budget per capita service population	Capacity	Service population from census, Tribe, or other source
79 Availability of local or community enrollment in Medicaid	Process	"Yes" or "no" answer
80 Proportion of population eligible for Medicare or Medicaid; Proportion of population enrolled in Medicare, Medicaid, or private insurance	Capacity	User statistics available from PCC. Population data require survey.
81 Intermediate/skilled nursing beds per service population	Capacity	Comparable to other systems of health care
82 Substance abuse beds per adult, adult female, and teen service population	Capacity	Comparable to other systems of health care
83 School based clinics per service population	Capacity	Comparable to other systems of health care
84 Average EMS response time	Capacity	EMS system data
85 EMS calls and transports/service population	Capacity	EMS system data
86 Presence of community based hospice	Capacity	"Yes or "no" answer
87 Presence of home health care services	Capacity	"Yes or "no" answer
88 Presence of day treatment for substance abuse, chronic mental illness, elderly	Capacity	"Yes or "no" answer
89 Cost for transportation per outpatient visit	Process	May require estimate or local study
90 Routine availability of translator for locally spoken language	Capacity	"Yes or "no" answer