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Evaluation of local Indian health board involvement in the management of Indian Health Service delivery system.

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An Evaluation of Local Indian Health Board Involvement in the Management of Indian Health Service Delivery System

A Final Report of the Phase II Evaluation Project of the National Indian Health Board

August 7, 1975
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Background

The National Indian Health Board is a non-profit, tax exempt organization serving American Indians and Alaska Natives throughout the United States. The membership is composed of representatives from all 12 Indian Health Service geographical areas in the United States.

The National Indian Health Board is charged with the basic responsibility of advising the Directors of the Indian Health Service on programs, policies, services, personnel, and on budgetary concerns.

Overview

Indian health boards have developed at the service unit, area, and national levels.

The service unit boards are agencies of the tribal governments with representation elected or selected by the tribal organization.

The area boards are composed of representatives of each of the service units in the area; however, area representatives are usually chosen by the tribal chairman or council rather than by the service unit health boards.

The National Indian Health Board is composed of representatives of the area boards, selected by these boards.
IDS views the boards as primary sources of Indian input into IHS policy-making and looks forward to the time when IHS policy will be made conjointly by the boards and IHS.

IHS has left it up to each area and each service unit as to whatever pace was taken.

Formally the boards are advisory; no law passed by congress gives them authority within the IHS structure.

It is questionable whether IHS can legally delegate to a board's specific authority delegated by congress to IHS.

IHS cannot issue a regulation stating that the board shall select the Service Unit Director; it can only state that the board shall advise IHS on selection and that IHS shall listen.

But IHS still makes the final decision. If the Area Director does listen and then makes a decision contrary to that advice, no IHS regulation has been violated, because the only official board authority is that of advise.

Therefore every act taken by IHS in regards to the boards determines how much power the boards actually hold.
This study therefore focused upon the development of health boards from purely advisory roles toward program management.

Problem

It is the stated policy of the Indian Health Service to encourage the participation of Indian people in health services program management. The National Indian Health Board recognizes that local health boards can be an effective mechanism for providing direct Indian involvement in the Indian Health Service delivery system, and that effective consumer participation is essential to the Indian Health Service in carrying out its mission. The National Indian Health Board recognizes that the local health boards may be encountering many problems in their development as involved and concerned participants in the management process of Indian Health Services.

Rational

The rational for this Phase II project stems directly from the National Indian Health Boards recognition of the stated problem. Therefore recognizing the problem the National Indian Health Board moved to evaluate present levels of local health board involvement in order to develop and to put into action plans to increase health board involvement in local health services delivery.
The Indian Health Services policy of encouraging Indian community participation in program management would be much enhanced by increased levels of involvement by the Indian health boards.

Objectives

A project to evaluate consumer involvement in the management of the Indian Health Services delivery system:

1. To establish criteria for identification of health board involvement in the decision making process.

2. To develop methods and techniques for use by a board to determine:
   a. Current level of involvement in the management system.
   b. Desired levels and the necessary priorities to achieve those levels (where do you want to be, and how do you get there).

3. To evaluate findings so as to develop and implement guidelines for board involvement in program management.
Use of Evaluation Results

The results may be used to begin to establish baseline information in health board development, and which can be used to identify needs for assistance and most importantly, the kinds of assistance needed.

Problem Area Identification

The National Indian Health Board is carrying out a series of projects to determine needs of Indian health boards.

Phase I in the series was an identification of specific problems and issues based on Indian community opinion. The method utilized in this initiating effort was a series of town meetings in self-selected Indian communities.

In these town meetings consumer representatives were on the local delivery of services by Indian Health Service.

The participants in these sessions were selected by local tribal councils as representative of local community viewpoints.

Ultimately 16 communities self-selected to participate in this services consumer opinion survey.
Topics which were identified as issues in the town hall meetings fall into seven general categories:

1. Indian Involvement
   a. Health board training
   b. IHS personnel problem
   c. Patient - provider relationships
   d. Facilities standards and operations
   e. Contract health services
   f. Community Health Representative Program
   g. Environmental Health 86-121 Program

2. Relationships between IHS and other resources

3. IHS eligibility requirements

4. Suicide problems

5. Transportation problems

6. Alternatives to IHS care
A. Health Board Concerns

In the course of Phase II, particularly, the initial meetings with local health boards, a number of problem areas were identified by the board and the evaluators in mutual discourse on functions and roles of health boards.

These problem areas are of particular importance at these stages in health board development, so that plans can be made to solve them by other boards, out of the shared experiences of the local boards contacted during Phase II.

1. Cheyenne and Arapaho Health Committee concerns:
   a. The patient rights concept
   b. Contracting of I.H.S. programs, and assignment of federal personnel
   c. Program standards development

2. Crow Creek Sioux Interim Health Board concerns:
   a. Coordination of health services program and projects
   b. Follow up by the Tribal Council in health services efforts
   c. Continuity of leadership and direction, because of Tribal Council membership changes due to elections
   d. Agency confusion on tribal identities and consequently on needs
e. Small population, and therefore, a low priority for federal agency attention

3. Rapid City Indian Health Board concerns:
   a. A need to move the board to an action oriented attitude
   b. The effects of inter-family problems on board decision making and operational processes
   c. A need to develop an increased attendance of members at board meetings.

B. Local Health Board - Indian Health Service Involvement

Health board involvement in services management was examined at several locations so that a range of efforts could be seen.

In the Phase I report one end of the involvement spectrum was described in this paraphrase: "This committee doesn't know enough about health problems to actually set priorities and it isn't fair to ask them to. The S.U.D.'s relationship is one of informing the committee on what is being done. There is no formal training of the health committee other than a few information sessions. One of the main attitudinal problems is that the local people feel that the facility belongs to them and nobody else. The personnel are there to serve
them at all times."

This situation then is one end of a developmental continuum with a wide spectrum of board efforts toward a functioning health board management effort.

1. Crow Creek Sioux Interim Health Board

The interim health board was appointed as an ad hoc committee by the tribal council. The interim health board was given the mission of studying methods to bring about improved coordination and communication between existing health related programs in order to achieve more effective health services for the people of the Crow Creek reservation.

The first meeting of the interim board as the recognized tribal council resolution health component occurred on March 12, 1975. A part of the resolution designated the interim board as also having the mission to plan for a permanent health board.

The opportunity to include an initiating effort in the preliminary stages of health board development to compare to already established organizations was deemed to be important to the study.

As a direct service provider and the fund resource of contract health services, the local service unit operates autonomously of the tribe. Decisions in regard to services to be provided are almost totally decided by
the service unit and the IHS area office. Efforts to coordinate local IHS services with services of tribal health programs by individual tribal health program coordinators have been almost totally ignored. Coordination between IHS services and tribal health program services has been achieved largely due to efforts of individual IHS employees and tribal health program workers. For the most part, coordination of IHS services and tribal health program services is accomplished by the tribal health programs. The situation in regard to coordination of services is one in which IHS makes the decision as to what services it will provide, where it will provide the services, when it will provide the services, how it will provide the services, and who will provide the services; and tribal health programs and patients are expected to direct their efforts and services in such a manner as to utilize IHS services within the framework which IHS provides them.

In the area of managerial involvement of the service unit, there is no regularly recurring involvement in the operation of the service unit except agency-dictated (higher agency management determines matters the service unit is to take to the tribe for "input") or situation dictated (usually a situation in which the service unit informs the tribe it cannot provide regular routine services it normally provides because of
staffing or fund problems). Otherwise involvement in the managerial area is almost nonexistent.

Other situations identified which contribute to the lack of tribal involvement are:

A. The Service Unit Director is non-Indian. It was the feeling of the tribal people that the SUD cannot relate to the needs of the Indian people on the reservation because of non-Indian background. Rather, it was the feeling the SUD was relating more to the needs of higher agency management and to the needs of achieving recognition for adherence to administrative procedure.

B. The Service Unit headquarters is located 20 miles off reservation in a non-Indian community. Most contact of IHS staff with tribal people is during business and clinic hours. Outside of these times, there is very little contact between Service Unit staff and tribal people. IHS staff living off reservation do not relate to reservation conditions except second-handedly to the results brought on by the conditions "e.g., patients seen in clinic, morbidity, prescriptions brought in by tribal health workers for refilling, billings for contract services, etc.

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The coordination of IHS programs with the tribes is carried out by individual persons on the IHS staff working within their own program areas. The initiation of meetings with the IHS management and decision making staff has been done by the tribal council.

Involvement of Health Service Providers and Other Agencies Funding Agencies

At the present time, tribal health projects and programs services contracted with various agencies, are, for the greater part, determined by the funding agencies. The involvement of the funding agencies with the tribal council are usually limited to formal activities with the tribal council (i.e., securing permission to introduce a program or project, negotiating of contract, formal contract signing, and protocoltype involvement thereafter). Aside from the formalities, involvement of the funding agencies is usually restricted to working with program or project personnel. The activities of funding agencies are then reported back to the tribal government by the programs. Monitoring of programs by the funding agencies is usually accomplished through activity reports following a format prescribed by the funding agencies. The tribal administration functions as tribal reviewer of programs by approving reports submitted to funding agencies.

Tribal Council Involvement with Tribal Health Programs

The tribal council is the contractor for all contracts and grants with funding agencies. As such, it bears the responsibility for assuring that contract services and grants programs are carried out. Routine administration
of services and grant programs is usually a delegated function of the administration. In carrying out this function, the administration relies on the program directors (coordinators) to carry out services and to submit for approval required reports, contract renewal proposals, and preparation of other required documents. In the area of planning, the responsibility of program planning usually lies with the program coordinator. Program plans are subject to review of and approval of the tribal administration (program plans are usually contained in the renewal proposals submitted to funding agencies). Tribal Council involvement in planning of the overall tribal health program is usually limited to the securing of additional resources to obtain services which are not being provided through existing programs. In the area of program supervision, routine supervision is left largely to program coordinators. Coordinators are expected to correct program problems brought to the attention of the Tribal Council or administration. Failure to handle complaints or to furnish services specified by the Council or administration is followed up by Council. In personnel selection, personnel actions recommended by program coordinators must be approved by the Council or Administration. In summarization of Tribal Council involvement with the tribal health programs, the Tribal Council functions as:
1. the overall authority and initiator of programs
2. the overall employer; and
3. the overall policy maker and enforcer

Meeting Schedule of the Health Board

The Interim Health Board presently meets on a weekly basis, usually on Wednesdays.

When the permanent Health Board is established, meetings will be on the first and third Wednesday of each month.

Board Operations

At present, the Interim Health Board has planned the organization of the Health Board and activities to initiate the operation of a permanent Health Board. The interim Health Board is in the process of getting the word out to the people in regard to the establishment of a permanent Health Board, giving information as to its organizational and intended role, reasons for establishment and activities leading to the establishment of the Health Board to become operational. All activities of the Interim Health Board have to be approved by the Tribal Council or Tribal administration at present.

As stated previously, the permanent Health Board will have the responsibility for all health matters and programs on behalf of the Tribe. This responsibility will also include operation of all health projects and programs. The Tribal Council will retain review and final approval of all actions and decisions of the
permanent Health Board.

Meetings with individual programs are for the most part generated by the programs themselves.

Occasionally the Tribal Council will enact resolutions and some follow up meetings will take place. However, due to the fact that the Tribal Council usually has its hands full with other matters which have a higher priority, health matters have a tendency of ending up in the 'should do when there's time' category.

Current Health Problems

The major health programs on the Reservation at present are:

1. CHR Program began in 1969 as part of a combined program with the Lower Brule Sioux Tribe until about 1972. After the Tribe took the initiative to separate the programs and projects which were jointly sponsored and operated with the Lower Brule Sioux Tribe. At the present time, the Program has no CHR positions.

2. Alcoholism Program funded through a grant from the NIAAA. The Program employs a Coordinator and three counselors.

3. T.B. Eradication Program contracted with the State of South Dakota. A Coordinator and a secretary are employed full time. Part time secretaries are employed on the Lower Brule Reservation and the Crow Creek Reservation.
2. **Rapid City Indian Health Board**

The participation of the Rapid City Indian Health Board presented an opportunity to see whether or not an urban board experiences developmental processes similar to those encountered by reservation boards. In addition, the Rapid City Board is not attached administratively to a tribal government in contrast to the other health boards participating in the Phase II study.

**Board Programs**

Rapid City Health Board programs and project consist of the following:

a. Alcoholism Project - operated under a grant from NIAAA. Employs four persons which include a Director and two counselors. The project is for the purpose of securing treatment for alcoholics and assisting them to find employment by supplementing wage costs of the employer if necessary.

b. CHR Project - Six persons are employed (includes a Coordinator). Services of CHR's are available to all Indian people of the Rapid City Area (includes both residents and transient Indians), IHS funded.

c. Community Development Project - Employs one person as an Administrative Secretary. Aside from this staff cost and costs of office operations, all other funds are utilized for board training purposes.

The project is currently funded at the $23,000 level and
is completing its second year.

Coordination of administrative matters are handled through the Administrative Secretary. Coordination of board health program services are performed by the Alcoholism Director and the CHR Coordinator.
The Board has developed its own personnel system and policies which applies to all of its programs.

Elections:
Election of board members takes place annually in October with five board seats filled in odd-numbered years. Members are selected for two-year terms. Terms expire at the end of October. Board officers are elected annually at the first regularly scheduled meeting in November of each year. Terms of officers also expire at the end of October.

Vacancies which occur on the Board are filled from a poster of candidates from the previous annual election which lists the vote totals received by the candidates. The lesser number of votes an unsuccessful candidate receives determines the order in which the candidate appears in the order to fill board vacancies. Members selected from the roster complete the unexpired term of office of the board members whom they have replaced.

Meetings:
Regularly scheduled meetings are held in the evening of the second Tuesday of every month unless postponed to the following week by some other event. All board
meetings are held in the basement conference room of the "Old Administration Building" (also sometimes referred to as the LPN School Building).

Board training sessions are held at various sites and at variably scheduled times.

Board Contact:
Outside of business meetings, most board activities are channeled through the board Chairman. The board maintains an office in the same building previously described as the meeting place of the board. The board office is staffed by a Secretary during business hours. The Secretary relays messages and information to the Chairman. Another contact utilized by the board is the IHS liaison person with the board, the Health Educator at the Service Unit, who, in addition to his liaison duties with the board, works with the board on board projects.

3. Rapid City Indian Health Committee -- I.H.S. Involvement
The local IHS Service Unit operates very much autonomously of the board, except in those instances (a) in which the result will put IHS in a bad light in the community; or (b) to relay information that a bad situation has developed and the Service Unit wants to know what the board expects to do about it. When the board begins positive developmental steps in the future, the Service Unit level of involvement with this board will need to change drastically. The IHS Area Office is considerably interested in anything
having to do with Rapid City, including the board. However, the purpose of the IHS interest in the board does not always agree with what is best for the board. Rapid City is a nice place to go to get out of the Area Office, to visit, and to have a little fun sometimes. Business dealings are usually directed to imparting information about decisions from the "Great White Father" and how "we all have to live it". Somehow or another area office dealings with the board seem to become so mixed up or so important all of a sudden, that only the area office high level management staff can handle the matter.

4. Colorado River Health Committee

In the first months of the Phase II project the Health Committee was a part of the Colorado River Tribal H.E.W. Committee.

a. H.E.W. Committee is one of seven committees attached to the Human Resources Committee of the Tribal Council. (see attachment 1).

b. H.E.W. Committee as of lately has been entirely responsible for health related issues of the reservation. These are programs such as Senior Citizens, Youth Home, Hospital Auxiliary, C.H.R. program and any other related program dealing in the health aspect.

c. Structure of the committee is composed of three persons. This committee is responsible to the Human
Resource Committee which is a committee directly under the Council's direction.

d. H.E.W. Committee meets once a month and has ongoing meetings with the Service Unit during the month. The Chairperson of the committee is a member of the Service Unit Board. This board is comprised of five observation.

e. Operations of the H.E.W. Committee mainly deals with information issues and activities of the Service Units. It has recently involved itself with some personnel situations which has been taken up with the tribe.

f. The involvement of the committee with health providers is in some questionable status. The clarification by the council is in progress at this time which can give the committee more confidence to move in constructing a better relationship with the Service Unit management.

g. Meetings can be called by the Chairperson at any time the committee needs to have input to a health related issue. A member of the council is appointed to work with the committee and assist them whenever. This is a good relationship.

HEW Committee reported that the last two days of their meeting, the approach used was very informal, hearing and questions to the tribal representatives were beneficial for the team.
The last day of their visit, the tribal people were informed of HEW's intent and how the process was to be implemented. This was reported to have been received in a positive manner and arrangements are being made for a further visit after the next subject is completed.

During this visit it was felt by the H.E.W. Committee that a definite lack of proper information on many things was evident, not only to the committee, but also to the council and the leadership, about functions to I.H.S. and other matters. The lack of involvement in activities related to the community by the Service Unit was common. The Council and committee are not getting Area Office reports as to budget, contracts and matters that pertain to the communities input. Much discussion revolved around this. During the next visit, this subject will be addressed through designing a communication model. It is hoped it can be resolved with the council's clarification of the H.E.W. committee.

The Committee began to move to a more active role, with the direct support of the Colorado River Tribal Council.
Discussion of Methods and Techniques for Health Board Use

The NIHB Phase I Identification of Specific Problems and Issues Report identified a specific problem of local health board involvement in the IHS system management.

This particular issue was found to be of concern in all the town hall meetings of the Phase I study. The Phase II study was therefore, a follow-up on the issue identified in Phase I.

Initially, the Phase II evaluators met with a number of local boards in Indian country to ascertain some general levels of involvement in the management of health services programs. They found several levels of involvement, and most importantly, they found the boards to either be in the process of rapid development, or as in several situations, to be aware of the impending change process that hitherto relatively inactive boards would have to face in the future.

During the study, in fact, one group moved from a status as an HEW Committee of a tribal government to a health board with a strongly assertive role in all areas concerned with IHS programs on their reservations.

Fieldwork Methodology

The evaluators in looking at levels of health board
involvement utilized the methodologies of (1) interviewing health board members; (2) participant observation in health board meetings, which included participation in health board training sessions; and (3) the development of a board self-evaluation master tool. A tool which can also be scored by an outside evaluator.

Let us first review the methodological sequence as it was proposed. Then a description of how each was implemented will follow to provide the necessary clarification. The proposal offered the following:

1. The National Indian Health Board will identify various areas of health board involvement in the decision making process.

2. Develop methods and techniques to determine levels of involvement of local and area health boards.

3. Conduct pilot project to test methods and techniques in at least two sites.

4. Review and revise methods and techniques.

5. Conduct full scale evaluation at various preselected sites, the site locations will be determined during the first quarter phase of the project.

6. Analyze results of evaluation.

7. Develop a final report that will consist of
an analysis of the findings and recommendations
to the Director, IHS.

Further implementation of the methodology is reviewed
in the order in which it was proposed. Any added steps
will be discussed after the last proposed step. Any
changes or modifications will be discussed during the
description of the step in which change or modification
occurred.

**STEP 1.** - The National Indian Health Board will identify
various areas of health board involvement in the decision
making process.

The evaluation project staff felt that interaction
with the local boards was necessary before these areas
could be developed and/or identified. This decision as­
sured the local boards of the relevance of this develop­
mental process. In addition, they were afforded the op­
portunity to provide input into this identification process.
This step was modified to include the participating local
health boards in the identification of the various areas.
The boards were also invited to participate in the defini­
tion of decision making. As this joint, cooperative,
interactive process progressed, it functioned as an educa­
tional experience for the project personnel, the local
health board, and for NIHB.

**STEP 2.** - Develop methods and techniques to determine levels
of involvement of local and Area health board.
personnel, added to their experiences in the field in working with the local health boards to plan effectively and design operational methods and techniques based upon this planning, served to bring about a definition of levels of involvement with local health boards. As these levels were determined at the local level, they became suggested levels for the area health boards.

STEP 3. - Conduct pilot project to test methods and techniques in at least two sites.

Initial contacts were used to test the methods and techniques. This approach proved to be sufficient as the methods and techniques appeared to be contributing to the interaction between the local health board and the consultant/evaluator. It was hoped that the intraboard interaction would increase and that the processes of planning and implementation would be better defined with the use of the methods and techniques.

STEP 4. - Review and Revise methods and techniques.

There was a process of ongoing review and revision of the methods and techniques by both project personnel and the participating local health board.

STEP 5. - Conduct full scale evaluation at various preselected sites, the site locations will be determined during the first quarter phase of the project.
Originally, seven sites were selected for this project, so that a broad base would be available in the event a need could arise to concentrate upon two sites as called for in the contract. It was considered necessary for the evaluators to participate in several board meetings before they would be able to draw a valid sample for this evaluation process.

Therefore, as the fourth quarter began, it was deemed necessary to reconsider and review the status of interaction between consultant and health board. For the evaluations, it was decided to focus upon two areas in which the level of interaction was high and evaluate at least one local board in each area. A final decision was made to evaluate the Colorado River Tribes Health Committee, Parker Service Unit, Parker, Arizona, Phoenix Area; and the Crow Creek Health Board, Crow Creek, South Dakota; Chamberlain Service Unit, Chamberlain, South Dakota, Aberdeen Area.

**STEP 6. - Analyze results of evaluation.**

An analysis of the evaluation follows in Part III: Results. Facing the analysis was the important evaluation question to be answered: "Did the process pursued during the term of the project make a difference?"

The answer, "Yes!," became a positive outcome.
STEP 7. - Develop a final report that will consist of an analysis of the findings and recommendations to the Director, IHS. This report fulfills the requirement under Step 7.

A. The Planning Process

(This section will deal specifically with the planning process of the local health board and its effect or impact upon the operations of the board.)

To achieve expected results, the planning of the evaluation project guided the implementation process in the field.

The objectives and proposed methodology were employed/utilized as important guideposts for the planning process. The implementation was in congruence with the designed operational methodologies. In those instances where modifications or alternative procedures were called for, the evaluator directed his attention toward the planning as a reference in devising the alternative or making the modification. So, it can be said that the planning process served as a viable guide for the operational procedures.

Below are the evaluator's perceptions and the local health board's perception of how their planning guided their operations. These are the results of the evaluation.

Improving the Effectiveness of Operations through Planning (Parker, Arizona - Colorado River Tribes Health Committee)
The functional roles and involvement levels of the committee were:

1. The committees' responsibilities were too broad in scope and that they needed to look at issues in a prioritized manner to complete their identifying needs. The plan was such that this was very difficult to do; only if they were to reorganize the role of the committee.

2. A written clarification of the committee's role in relation to the tribal council was needed. Here again, was where the plan did not give enough balance for the group's functional roles.

3. A lack of understanding of the committee's working relationship with the service unit — this was strictly an IHS miscue and created a tenous situation and minimized the group's effectiveness.

In two visits with the committee, these issues were addressed in a way that they re-evaluated their activities and modified their plan so that the activities and issues could be dealt with for the benefit of the consumer; and in turn the consumer could become aware that a strong liaison force was there to attend their needs.

During these visitations the evaluator shared and brought to the attention of the group, methods and tools to be used in developing functional roles. Here the group began to create, in their plan, measurement techniques to gauge their effectiveness in their stated activities. There first task was addressing the issues that were stated and were causing their performance to malfunction in the process.
Issue 1. - They redeveloped their responsibilities and based their rational upon the community's needs in health related areas. This dovetailed into issue 2.

Issue 2. - Through a resolution in the tribal council, the committee's title was changed from H.E.W. to health. During this readjustment phase the committee completed issue 3.

Issue 3. - The health committee got a full endorsement from the council as the official representative body of the tribe in working with the service unit. This demonstrated a confidence level and attitude that brought about some constructive changes in the service unit's relationship to the community.

Project Planning

In regard to the project matter, it is felt that the end purpose of the contract was a very much needed thing, which could possible stimulate tribal health boards to realize how their development could progress and overcome any standstill. We believe that the project was a first in that it was directed toward tribal health development needs, rather than toward an accumulation of statistics and information in regard to the provision of health services by a health agency. More projects directed toward consumer health management development are greatly needed.
As for the project format, it is the feeling that the approach used (working with the tribal health boards to study their involvement levels before developing an evaluation tool) was the only practical way in which we could develop a constructive tool. By waiting toward the end to develop a tool, there was no pressure on the consultants to try to change the direction of their working with individual boards. Hence, the problems or discussion of problems and matters came spontaneously from the boards, since this spontaneousness was essential with those boards which participated in some measure in the project.

The methods used in carrying out field activities enabled the participating boards to work at their own pace and to devote time necessary to take care of business which was not associated with the project. This near routine activity pace afforded the opportunity for boards to utilize training and orientation given by the consultants.

From the viewpoint of the boards participating, sessions with the consultants were viewed as being training sessions even though they were aware they were participating in the study. It was a very frequent observation of the various boards that the training given by consultants was addressed to the tribal point of view and was the type which they very much needed.

It was the expressed feeling of board members who participated in the project that the self-analysis opportunity
afforded through the project helped them to develop an awareness and a definition of purpose and behavior which encouraged them to recognize some of the barriers to involve in health related programs and decision-making which they had created themselves, not only in working with other agencies but in their own intra-board dealings.

B. Feedback
This section will deal specifically with the feedback provided by the operations methodologies and how this feedback contributed to an ongoing planning process of a local health board. (Below are the evaluator’s perceptions and the local health boards perceptions of how operations contributed to an ongoing planning process.)

Contributions of Operations to the Ongoing Process:
(Parker, Arizona, Colorado River Tribes Health Committee)

1. Evaluator's Perception
In Section III: It was brought out that the committee's functional roles were creating some problems in attempting to resolve issues they were being confronted with, until they readdressed their operational functions in their overall modifications of their planning process. (See page 27) When this was completed the committee began to take on new and meaningful tasks that were very important for the community health. Using methods and tools acquired through their participation in this project, they worked to bring about their own change. They worked on
eight major areas and completed five of those areas while working with the NIHB project. (See Appendix Master tool C and D). (It is felt by the evaluator, that they worked very hard and put in long hours with the evaluator in developing their functional roles as a unit.)

2. Health Committee Perception

During the time of developing the eight areas, the committee along with the evaluator developed a level of action instrument (See Appendix "D") that showed the committees in measurable form how their activities were progressing. This is a simplified management by objectives (MBO) mechanism and the committee is using it with positive results.

There are three major factors that this group has going for them which have contributed to their performance since the NIHB project at Parker.

1. A strong supportive function by the executive officers of the tribal council.

2. An assigned secretary to record and do clerical tasks for committee.

3. A quickness of picking the functional process in performing and managing their objectives.

The Health Committee at Parker has a clear direction and their objectives are measurable.

The project definitely had an impact on the planning processes of the boards. In the beginning of field work, it was observed that activities of the boards were of a rather conservative nature in that most activities of the
boards were in fact reactions or in response to actions initiated by a body other than the health boards themselves. Most actions which were board generated were of the type which showed that the actions were generated more or less by the momentary emotional reaction to given situations or were of the type which requested support of some action taken by someone else. Often, these actions were concluded by the passing of a resolution which showed the feelings of the different boards, but did not include any eventual follow-up planning.

A second impact of the project on planning was that an awareness was created of the rule boards can and should play as the component with their responsibility to the tribe and/or the people they were to serve. Therefore, it was the observation that boards had a tendency to deal only with external matters only. The result of this second impact was that boards begin to look more toward trying to build their tribal health systems to try to improve their own health programs, instead of just trying to bring about improvement in services of other agencies' programs. Board involvement thus became a process of self-development, of self and immediate environment, not developing an alien environment.

A third impact was that the boards being to realize that the capability to handle their health matters and programs would have to be developed within the individual
tribal health system, if long range goals and objectives were to be realized.

This was in realizing the fact that if they wanted for someone or some agency to come along and do this for them they would probably have to wait forever.

It is also the feeling that the project greatly influenced the planning processes of the boards to the extent that planning is now much more deliberate, so that they can recognize elements essential to good planning (i.e., pre-planning activity, identification of previous failure or success, exploration of alternatives, interim activity, work plans, alternatives to methods adopted, etc.).

The responses of the Crow Creek Sioux Tribal Health Board members in regard to the effect the project had on its planning process are as follows:

1. "Planning projects for the health board has become more organized. (I) am now able to put outlines and objectives in proper perspective."

2. "I think it has helped me in health problems on our reservation."

3. "Yes, because we would probably be doing one thing (a project) when planning should have been done first. Planning is very helpful.
It helps to do first things first, rather than to have disorganized plans."

4. "Yes, I realize it (planning) takes more thorough thinking."

For the most parts, health boards are private non-profit corporations (501 (c) (3)), designed to follow a set of purposes as may be specified in their incorporation papers, or goals and objectives.

A further difficulty was the vast difference between health boards, their interests, membership composition, attitudes, and funding. These differences exist across the board in all health board organizations. While some patterns may be found, the levels of involvement would vary. To account for the variations, and for comparability, NIHB designed a measuring tool showing a staging process, with 16 stages. "0" stage was designated as "Total Health Responsibility for the Tribe," and stage XV was the failure level of "No Health Board."

The criteria or stages of growth referred to above and elsewhere (Section I, Page 5) provide the criteria with which the development of a tool to measure/record the level of involvement of health boards could proceed. It was then possible to design a protocol which the consultant/evaluator employed in the presentation, education and application of this tool. (See Appendix D)
The development of the Phase II Evaluation Form dictated a need for a definition of the terms used in the staging of the criteria. This Definition of Terms was then generated and attached to the Phase II Evaluation Form.

Having progressed this far, the project was then ready to embark upon the evaluation process. The process itself was completed with the health boards participating and contributing evaluative comment.

As the results of the evaluation are discussed, the evaluation form will be segmented into four types of responses which will embrace more than one state. Two types (designated E and F) will consist of single stages. These types will refer to stage XIV--inactive (area E) and stage XV--no health board (area F). The other types (A, B, C, and D) will encompass the rest of the stages (0-XIII) and will designate the health boards potential to effect change in the following manner:
Type A--stages 0 - II--maximum potential for effecting change.

Type B--stages III - VII--high potential for effecting change.

Type C--stages VIII - XI--potential for effecting change

Type D--stages XII - XIII--unutilized potential for effecting change.

Type E--stage XIV--unrealized potential for effecting change.

Type F--stage XV--non-existent potential.

The application of these types of response will be situational rather than growth oriented. As a situational response, the question which focuses upon a given criteria, goal, objective, etc. would be scored in the stage consistent with the perceived level of capability to deal with the focus of the question. In this way, the board member or evaluator may fluctuate from maximum potential to potential to high potential to unutilized potential depending upon how capable he feels in dealing with the question at hand.

To more clearly differentiate between growth orientation and situational response, it may be wise to attend the following figures. In figure 1, it can be said that the potential is in the hierarchal development or growth. The health entity in question begins at Type response F and proceeds to evolve through the six types of capability.
In this paradigm, it is assumed that the health board must necessarily progress through the hierarchy by developing those capabilities and/or levels of function before any progression up the hierarchy is possible. In this way, the health board begins at F (Stage XV) and must progress stage by stage. As it does so, the board transcends one type of response only at those instances when and where this progression by stage also moves them into a more comprehensive Type of Response.

With this in mind, it is fair to assume that while the growth implies that the entity is indeed the sum of its parts, it does not possess the capability to function at a more comprehensive (higher level) Type of Response until its growth process has attained that hierarchal level in the growth orientation construct. Therefore, a health board which has not demonstrated the desired
growth to function at all six Types of Response, could not possibly deal with a given problem at a more comprehensive level. Only when the board has attained capability in all Types of Response, may they consider the application of a higher order response.

Conversely, if the focus is placed upon Figure 2 (Situational Response), it may be projected that the health entity could deal with a problem at any level or with any Type of Response.

As the question is asked, the health entity considers its level of expertise and capability and elects to respond with or to apply the appropriate Type of Response. This denies the concept that health boards must necessarily pursue the traditional educational levels of hierarchal achievement before they can function at a given level.

For example, as a board considers a goal, they indicate the Type of Response through the specific stage at which they perceive their capability of functioning to effectively deal with this goal. As soon as a new goal, objective, criteria, etc. is considered, the process is repeated. With this, it is highly possible that the Type of Response would be as different as the item in question. As has been men-
tioned above, the Type of Response may fluctuate and this fluctuation is due to the situation created by the item in question. Hence the reference to the Situational Response.

It is felt that Indian health boards tend to deal with problems in a situational rather than a growth oriented manner. It is for this reason that the Phase II Evaluation Form will be studied and discussed according to the latter application.
<table>
<thead>
<tr>
<th>TYPE A RESPONSE - Maximum Potential</th>
<th>Total Health Responsibility for the Tribe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of the Health Delivery System</td>
<td></td>
</tr>
<tr>
<td>Management of Tribal Health Programs</td>
<td></td>
</tr>
<tr>
<td>TYPE B RESPONSE - High Potential for Effecting Change</td>
<td></td>
</tr>
<tr>
<td>Policy Making for Tribal Health Program Administration</td>
<td></td>
</tr>
<tr>
<td>Policy Making for the Health Delivery System</td>
<td></td>
</tr>
<tr>
<td>Policy Making with IHS for Recruitment, Selection, and Retention</td>
<td></td>
</tr>
<tr>
<td>Policy Making for Tribal Recruitment, Selection, and Retention</td>
<td></td>
</tr>
<tr>
<td>Policy Making for Tribal Health Programs</td>
<td></td>
</tr>
<tr>
<td>TYPE C RESPONSE - Potential for Effecting Change</td>
<td></td>
</tr>
<tr>
<td>Advisory for IHS Recruitment, Selection, and Retention</td>
<td></td>
</tr>
<tr>
<td>Advisory with Limited Authority in Specific Areas</td>
<td></td>
</tr>
<tr>
<td>Advisory - Review and Recommend</td>
<td></td>
</tr>
<tr>
<td>Advisory - No Responsibility</td>
<td></td>
</tr>
<tr>
<td>TYPE D RESPONSE - Unutilized Potential for Effecting Change</td>
<td></td>
</tr>
<tr>
<td>Existing - No Input to IHS</td>
<td></td>
</tr>
<tr>
<td>Existing - No Input to Tribe</td>
<td></td>
</tr>
<tr>
<td>TYPE E RESPONSE - Unrealized Potential for Effecting Change</td>
<td></td>
</tr>
<tr>
<td>Inactive</td>
<td></td>
</tr>
<tr>
<td>TYPE F RESPONSE - Non-existent Potential</td>
<td></td>
</tr>
<tr>
<td>No Health Board</td>
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</tbody>
</table>
## Definition of Terms

**Used in the Phase I Evaluation Form**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Total Health Responsibility for the Tribe: Demonstrated capability and responsibility, with necessary authority, for the operation of the Health Delivery System including contract programs</td>
</tr>
<tr>
<td>I</td>
<td>Management of the Health Delivery System: Incorporating existing IHS and other health agencies' resources and operations for Tribal Health Programs under the direction and management of the Tribal Health Board</td>
</tr>
<tr>
<td>II</td>
<td>Management of Tribal Health Programs: The Tribal Health Board provides management and direction to all Tribal Health/Health Related programs</td>
</tr>
<tr>
<td>III</td>
<td>Policy Making for Tribal Health Program Administration: The Tribal Health Board sets necessary policies for and carries out Tribal Health Program administration to achieve the expectations of the Tribal Council</td>
</tr>
<tr>
<td>IV</td>
<td>Policy Making for the Health Delivery System: The Tribal Health Board sets policy which promotes, establishes, and supports a comprehensive Health Delivery System</td>
</tr>
<tr>
<td>V</td>
<td>Policy Making with IHS for Recruitment, Selection, and Retention: The Tribal Health Board sets recruitment, selection, and retention policies with the IHS Service Unit for staffing, programs, and contract services</td>
</tr>
<tr>
<td>VI</td>
<td>Policy Making for Tribal Recruitment, Selection, and Retention: The Tribal Health Board sets recruitment, selection, retention, and operations policies for tribal health programs</td>
</tr>
<tr>
<td>VII</td>
<td>Policy Making for Tribal Health Programs: The Tribal Health Board sets operational policies for tribal health programs and projects</td>
</tr>
</tbody>
</table>
STAGE DEFINITION

VIII Advisory for IHS Recruitment, Selection and Retention: The Tribal Health Board makes recommendations and suggestions to IHS Service Unit for recruitment, selection, and retention in staffing, programs, and contract services.

IX Advisory with Limited Authority in Specific Areas: The Tribal Health Board assumes limited authority in specific areas for decision making within established guidelines.

X Advisory-Review and Recommend: The Tribal Health Board reviews and makes recommendations regarding health services and issues upon request.

XI Advisory - No Responsibility: The Tribal Health Board has no responsibility other than to function as a reporting/liaison service for the tribe, IHS, and other health related agencies.

XII Existing - No Input to IHS: The Tribal Health Board functions are not recognized by IHS as representative of the tribe.

XIII Existing - No Input to Tribe: The Tribal Health Board functions are not recognized as acceptable input by the tribe.

XIV Inactive: The Tribal Health Board has been formulated but pursues no organized activity or function.

 XV No Health Board:
III. RESULTS

Evaluation of Colorado River Tribal Health Committee Involvement

The perception of health board's and the committee's depends on a variety of factors which are not measured within the scope of this evaluation. Such factors could very well include, attitudes, culture, education level, personal feelings, impact of consultant, attitude (known) of IHS staff, and action or response (positive or negative) of IHS to committee requests.

In the process of evaluating the levels of involvement of the health committee, four tools were used at various times to determine the growth of levels of involvement relating to the established goals and objectives.

The four tools used were the following:
1. Beginning - Master Tool I-A
2. Now - Master Tool I-B
3. Relations to Future Planning - Master Tool II-C
4. Where They Want to Be - Master Tool II-D

The ratings are discussed below, following a brief overview of the health committee's roles and responsibilities as observed in the beginning.

The original contact was with the HEW Committee, which during this project became known as the Tribal Health Committee. Upon the first contact with this committee, the following information was gathered to begin an understanding
of the committee's roles and responsibilities:

1. It is a tribal committee (one of several).
2. It is entirely responsible for health.
3. Three persons comprise this committee.
4. One council is assigned to work with this committee.
5. It has on-going meetings with the IHS Service Unit Director.
6. Activities include informational/communication.
7. New area of involvement is in IHS personnel review.

Part of the concern by the committee appeared to revolve around lack of information from IHS, including budget data, contracts, and functions of IHS. This was essentially the state of involvement, without the application of a measurement tool. However, the committee's commitment to participate in the project had been secured in November, 1974, and it was only a matter of scheduling before the project progressed.

Four Applications of the Evaluation Form
(Parker, Arizona, Colorado River Tribes Health Committee)

With the evaluation instrument which was constructed using a staging form of functional roles for committee's and board performance, this section had a definition of each step from success to failure. When this was completed, the bottom part of the tool was for the participants fill-in planning of engagements and activities. This activity was done as a group, so everyone was in agreement in stating the issues. Once this was done the committee along with the evaluator scored themselves and openly reviewed their reasons
for their input on each of the issues. The instrument played an important role in this activity, first it gave the committee an opportunity to brainstorm in relation to future planning, i.e., where they wanted to be in that process. During that segment, the group brought out very realistic goals and gave a good account of themselves in where they saw themselves in that performance. Secondly the tool demonstrated to the group two important facts:

A. They show a closeness where they felt they were in performing to the criteria put down.

B. The tool gave them a progress scale showing their advancement in these performance categories.

A. Analysis of Measurement - I-A

Question: Where were you at the beginning of the evaluation process in relation to the criteria below?

Following a series of orientation sessions centered around board involvement, the committee participated in the formulation of specific goals and objectives numbering, one to seven. These seven items were inserted in the left column under "Goals, Objectives and Major Tasks," which the health board had planned for implementation. These same goals are utilized for subsequent analysis as the evaluation progressed. Goal number one rating is discussed below:

1. Consolidate other tribal health related programs under present committee.

Result:

The Committee rated its involvement from "policy-
making for tribal health programs," stage VII through XII, "Existing-No Input to IHS." Since this was the first measurement, it was understandable that the initial ratings are individual responses without any further orientation or training, or further implementation.

On all other goals, the committee rated their involvement ranging from "Advisory with Limited Authority in Specific Areas (stage IX)" to involvement at the "Inactive (stage XIV)" level. There would be no rating for the lowest, "No Health Board (stage XV)". There is indication that on all the goals as identified at the outset, the involvement level was ranging from moderate success to near failure.

In the level of "Advisory - No Responsibility (stage XI)" and "Existing - No Input to IHS (stage XII)" there was a heavy concentration of consensus, relating to goals number 1, 2, 5, 6, 7. It further appeared that these same areas of concentration merely coincides with their present areas of concern for which their roles were not originally defined. The evaluator "using E" also rated the committee in approximately the same levels. There were no situations where the ratings could be "Existing - No Input to Tribe (stage XIII)", unless other goals were formulated, and in the beginning the committee commonly had input to the tribe; again with undefined responsibilities.

As we review evaluation form I-A, it is found that there was only a single type B response. The remainder of the
ratings fell under types C and D. In these ratings, eighteen (18) were type C responses and sixteen (16) were type D responses. The inferences which can be drawn from this are that, as a health entity, the Colorado River Health Committee perceived themselves (with the evaluator's agreement) to have a potential for effecting change. However, they also perceived themselves at a stage where their potential for effecting change was unutilized.